



Barnett College
of Public Health

The Language of Obesity

David B. Sarwer, Ph.D.
Senior Associate Dean for Research and Strategic Partnerships
Director, Center for Obesity Research and Education
Department of Social and Behavioral Sciences
Editor-in-Chief, Obesity Science and Practice
Associate Editor, Obesity Surgery



The Psychosocial Burden of Obesity

(Sarwer & Heinberg, 2020)

- Mood
- Anxiety
- Quality of Life
- Self-Esteem
- Body Image
- Sexuality
- Disordered eating
- Substance Misuse
- Physical functioning
- Sleep Disturbance
- Cognitive Impairment
- Bias and Stigmatization



Weight Stigma as a Psychosocial Contributor to Obesity

(Puhl, Himmelstein, & Pearl, 2020)

- Weight stigma is a key aspect of the lived experience of individuals with obesity and adversely affects health.
- Weight stigma is a psychosocial contributor to obesogenic behaviors.
- Weight stigma among individuals seeking obesity treatment warrants additional study and consideration, including mechanisms through which weight stigma may undermine or facilitate treatment outcomes.



Role of Weight Bias and Patient-Physician Communication in the Underutilization of Bariatric Surgery.

Sarwer, Gasoyan, Bass, Spitzer, Soans, SOARD, 2021.

- Despite evidence for safety and efficacy of MBS, it remains profoundly underutilized.
- The reasons for underutilization are likely multifactorial, including health insurance coverage and benefits design, lack of awareness about the positive outcomes of MBS by patients, and anecdotal concerns about safety.
- We believe that there are two other factors—the occurrence of weight stigma and bias and suboptimal communication between patients and providers—that also serve as barriers to greater utilization.
- The review also highlights the science of shared medical decision-making as a potential strategy to promote appropriate conversations between patients and providers, both surgical and nonsurgical, about the efficacy and safety of MBS.
- We believe that it has great potential to contribute to the increased utilization for the millions of individuals who could benefit from MBS.



Shared Decision Making

- Shared decision making (SDM) involves the process where both parties--patient and provider--share information and work collectively to come to a treatment decision. [1]
- Patients must understand risks and benefits of different treatment options, what options they have, and any uncertainties involved with each in order to make a “good” decision.
- The Institute of Medicine has stressed the importance of patients having the education and support they require to make decisions and participate in their own care. Patients must be involved in seeking knowledge they don't have as well as expressing values and preferences for treatment. [2]

1-- McCaffery KJ, Smith SK, Wolf M. The Challenge of Shared Decision Making Among Patients With Lower Literacy: A Framework for Research and Development. *Med Decis Mak* 2010;30:35–44. <https://doi.org/10.1177/0272989X09342279>.

2--Hawley ST, Morris AM. Cultural challenges to engaging patients in shared decision making. *Patient Educ Couns* 2017;100:18–24. <https://doi.org/10.1016/j.pec.2016.07.008>.



Shared Decision Making with Patients with Clinically Severe Obesity

- SDM likely needs to first occur between the patient with clinically severe obesity and the provider overseeing or coordinating medical care. This would require a thorough review of the patient's weight history and history of weight loss efforts.
- Conversations should be frank, but also respectful to ensure that the patient does not feel blamed for the lack of sustained success with previous treatments. Treatments that have not been used, such as pharmacotherapy and bariatric surgery, should be discussed with respect to the relative benefits and drawbacks of each.
- SDM also should be used in conversations between the patient and bariatric surgeon, and, ideally all members of the multidisciplinary team. SDM could be used to discuss the benefits and limitations of different surgical interventions and with the patient's degree of obesity and comorbidities in mind.
- SDM also can be used to discuss the delivery of postoperative care by the integrated health team. Ideally, these discussions would center around the different types of postoperative care available.

(Sarwer et al., Role of weight bias and patient–physician communication in the underutilization of bariatric surgery. *Surgery for Obesity and Related Diseases*, 2021)



IFSO Accepted Nomenclature

- **Use first person language:** authors should not use “obese” as an adjective or noun to describe an individual person or group of people, but instead, use terms such as “people with obesity” and “populations with obesity”.
- **Use “severe obesity” (or reference BMI range or Class);** Not “morbid obesity”, “super obesity” or “extreme obesity” and all derivations.
- **Do not use words such as:** “success/failure”, “recidivism”, “non-compliant”, “gold-standard”, “last-resort”.
- **Avoid the term “weight-loss surgery”;** use “bariatric-metabolic surgery”.



IFSO Accepted Nomenclature (Selected Examples)

OLD

Morbid Obesity

Subjects

Weight Loss Surgery

Inadequate Weight Loss

Weight Regain

NEW

Severe Obesity

Patients or Individuals (or Participants)

Metabolic Bariatric Surgery (MBS)

Suboptimal Clinical Response

Recurrent Weight Gain



The Power of the Public Discourse about Obesity





Making GLP-1 weight loss drugs cheaper isn't enough to address America's obesity problem – here's why

Published: November 21, 2025 8:20am EST

Polling shows that 1 in 8 Americans have tried GLP-1 drugs. zimmytws/iStock via Getty Images Plus



The Trump administration is making a significant effort to reduce the cost of weight loss drugs. Its [agreement with pharmaceutical giants](#), announced Nov. 6, 2025, [will reduce the monthly prices](#) of these medications by hundreds of dollars.

For the past 25 years, I have treated people with obesity and have developed and

Author



David B. Sarwer

Professor of Social and Behavioral Sciences, Temple University



Summary

- All evidenced-based treatments for obesity—lifestyle modification, obesity management medications, as well as metabolic and bariatric surgery (MBS)—are underutilized globally.
- The barriers to greater usage of MBS are numerous. Some fall at the intersection of health care policy and health care delivery. Others are at the individual level, and include misinformation and fear, as well as weight stigma and bias.
- Interventions to minimize internalized weight bias have shown some early promise. There also is optimism that increasing efforts to education medical students and other health professionals about the disease of obesity, as well as the importance of nutrition and physical activity in physical health and mental well-being, may decrease weight bias among health care providers. This includes using bias free language in our clinical conversations, scholarly work, and casual conversations with friends and family.
- It is our responsibility to lead by example if we are to be successful in directing more patients to evidence-based treatment and witness even small success arresting the growth of obesity at the population level.



Stay in touch....

Dr. David B. Sarwer

dsarwer@temple.edu

 @davidbsarwer



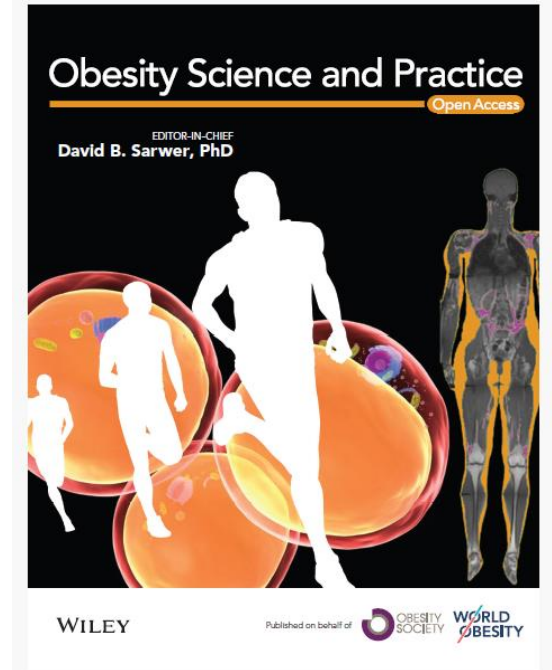
Things to Consider

AI Screening and Disclosure

Person-First Language

The Value of a Narrative Review or Meta-Analysis

Recommending Reviewers



XXX IFSO WORLD CONGRESS

"Advancing Multimodal Obesity Care"

24-27 August 2027

ifso2027.org



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The Impact of Weight Stigma

- Associated with psychosocial distress with 50% of patients meeting criteria for a psychiatric diagnosis. [1]
- Associated with weight gain as well as increased waist circumference, elevated levels of C-reactive protein, and poor glycemic control. [2]
- Internalized weight bias also has been associated with increased odds of having metabolic syndrome.

1-Hatzenbuehler ML, Keyes KM, Hasin DS. Associations Between Perceived Weight Discrimination and the Prevalence of Psychiatric Disorders in the General Population. *Obesity* 2009;17:2033–9. <https://doi.org/10.1038/oby.2009.131>.

2- Pearl RL, Wadden TA, Hopkins CM, Shaw JA, Hayes MR, Bakizada ZM, et al. Association between weight bias internalization and metabolic syndrome among treatment-seeking individuals with obesity. *Obesity* 2017;25:317–22. <https://doi.org/10.1002/oby.21716>.



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Summary

- Most patients with obesity present for evidence-based treatments for obesity—lifestyle modification approaches, OMMs, or MBSs—carrying a significant psychosocial burden.
- Weight loss leads to improvement in numerous psychosocial variables; larger weight losses are associated with greater improvements in many domains.
- Concerns with body image, sexual functioning, depression/self-harm, and substance misuse endure for some and warrant intervention by a mental health professional.
- Successful, long term weight maintenance remains one of the most important challenges faced by the field.
- If we are to witness even small success arresting the growth of obesity at the population level, we need to identify novel strategies to ensure that patients with obesity receive the most appropriate treatments available to them, but also focus on environmental level variables at the population level of prevent weight gain.



Obesity Surgery Terminology

- not accepted nomenclature New accepted nomenclature
- Eliminate "success/failure" "recidivism" "non-compliant"
- "gold-standard" "last-resort" sort of language
- Imagery (no headless, stereotypical/stigma = takeaway boxes, fast food, ill-fitting clothes, etc.)
- Morbid obesity Severe obesity
- Obese/Diabetics Patient or individual with obesity/ diabetes
- Comorbidity Associated medical problems
- Subject/s Patient/s or individual/s
- Weight loss surgery Metabolic Bariatric Surgery (MBS)
- Super or super-super obesity Please use Body Mass Index reference BMI>50 or BMI>60 to refer to this patient population
- respectively
- Gold standard Avoid using this term please
- Mini Gastric Bypass (MGB) One Anastomosis Gastric Bypass (OAGB)
- Revision procedure "Revision or modification" for any procedure that does not encompass conversion to a new procedure with a new mechanism of action or



Obesity Surgery Terminology

- Conversion procedure 'Conversion' entails converting one procedure to another with a different mechanism of action.
- Revision is no longer accepted as a substitution
- Reversal procedure Term can still be used to describe reversing a procedure to the normal standard anatomy
- Insufficient or inadequate weight loss 'Suboptimal clinical response' encompasses maximum total weight loss outcome (TWL%)
- <20%, while also covering no improvement or worsening of any obesity complication that was present preoperatively
- Weight loss failure Failure is no longer an acceptable term. Use suboptimal clinical response if fits these criteria
- Adequate weight loss Optimal clinical response which follows the criteria of TWL% >20% and/or improvement of obesity complication/s
- Success This term is no longer acceptable. Please use Optimal clinical response for primary procedures or optimal clinical response for other revision or conversion procedures
- Restrictive or Malabsorptive procedures
- ~~These terms are not acceptable to use. Please describe procedures per their anatomic features.~~
- ~~Cy-pass, diversion, etc.~~
- Malabsorption/Hypo absorption Both are accepted, but it is essential



Obesity Surgery Terminology

- Weight regain/ recurrence Recurrent weight gain
- BMI 30 < 35kg/m² Obesity I
- BMI 35 < 40kg/m² Obesity II
- BMI 40 < 50kg/m² Obesity III
- BMI 50 < 60kg/m² "Super Obesity" Obesity IV
- BMI 60 < 70kg/m² "Super-Super Obesity"
- Obesity V
- Banded procedures Ring-augmented procedures
- Obesity medications, weight loss medications, anti-obesity medications
- and other nomenclatures for pharmaceutical agents for the medical treatment of obesity
- Obesity Management Medications (OMMs)

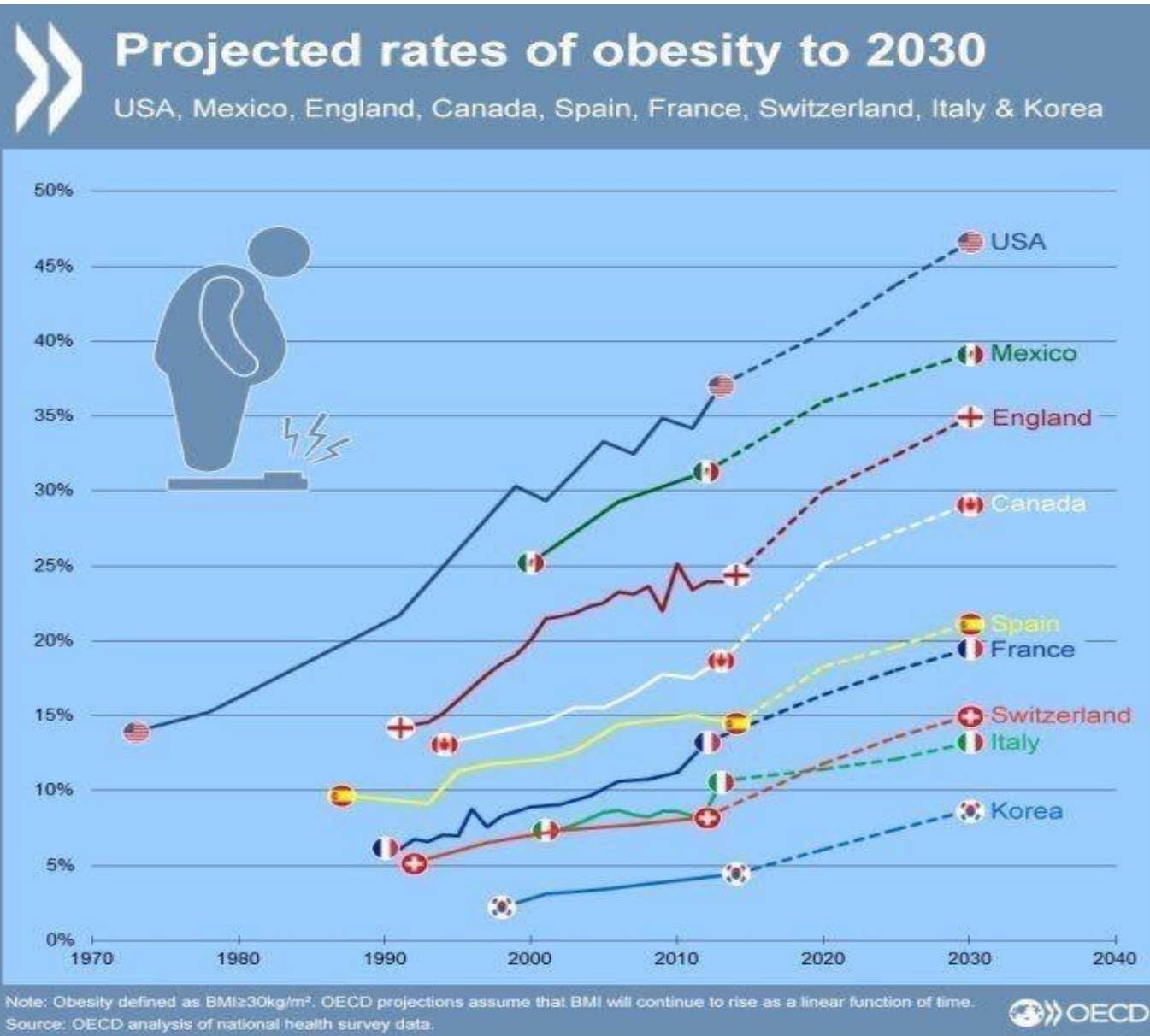


Weight Stigma: Another Barrier to Bariatric Surgery

- Ubiquitous in the general population
- Common among persons with obesity
- Well-established barrier to all forms of obesity treatment

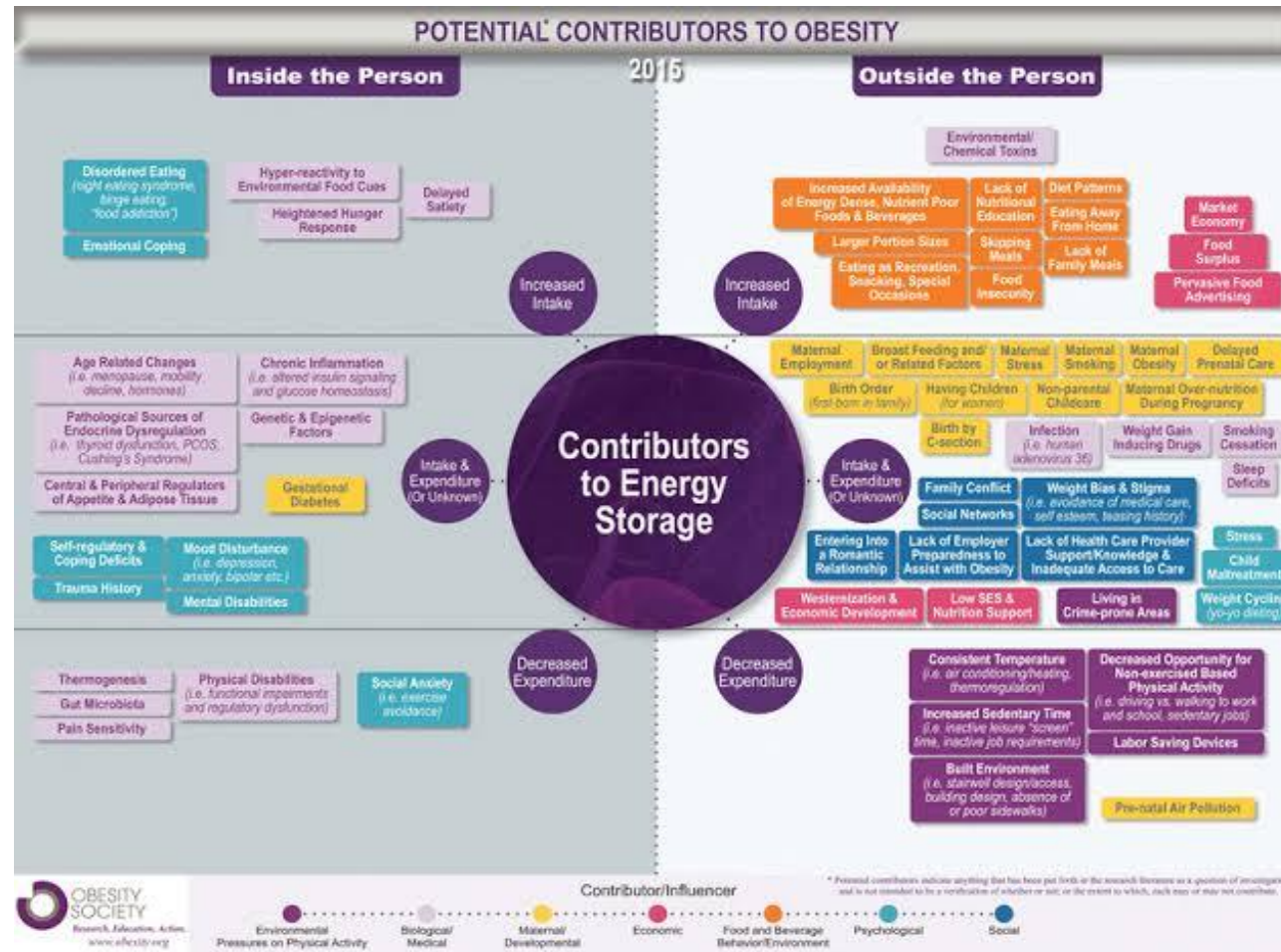


Obesity Projections for 2030





Obesity is Much More than “Calories In, Calories Out”





Obesity and the Social Determinants of Health

- Historically, obesity has been seen as a mental health/behavioral issue and lack of personal responsibility for one's weight and health.
- Environmental contributors, such diet quality (including role of ultra-processed foods and microplastics) and decreased engagement in physical activity, historically have been de-emphasized.
- Greater appreciation of the role of the social determinants of health—the non-medical, environmental, and social conditions in which we live and work—is slowly being recognized for its role in the global obesity problem.



Evaluating Psychosocial Status and Functioning at the Obesity Treatment (Sarwer et al, 2026)

- History of Psychopathology
- History of Mental Health Treatment
- Current Eating Habits and Environment
- History of Weight Gain/Weight Loss Efforts
- Family and Social Support
- Motivations and Expectation
- Timing of Treatment
- Threats to Long Term Success



Evidence-Based Treatments for Obesity

- Lifestyle Modification Interventions
 - Reduce caloric intake/improve diet quality
 - Increase physical activity
 - Behavioral modification
- Obesity Management Medications
 - First generation—concerns with safety and efficacy
 - Second generation—GLP-1s
 - Third generation—multitarget agents coming soon
- Metabolic and Bariatric Surgery



Lifestyle Modification Interventions

- “First Line Treatment”
 - Highest utilization
 - Available in numerous modalities (eHealth)
- Efficacy studies have demonstrated 7-10% weight losses in 6-12 months
- One third of patients regain weight within year; most regain all in 5 years
- Underscores the importance of seeing obesity as a chronic disease



Obesity Management Medications (GLP-1s)

- 1 in 8 American adults have reported using a GLP-1 in the past year.
- Efficacy studies have demonstrated 15-20% weight losses in 6-12 months; “real-world” losses appear to be somewhat smaller.
- Impressive improvements in weight-related comorbidities.
- 50% of patients have discontinued use at 6 months, primarily for cost related reasons.



Metabolic and Bariatric Surgery (MBS)

- 9.9% of women and 5.5% of men have a BMI ≥ 40 kg/m².
- Approximately 200,000 procedures are performed annually in the United States.
- Large majority of patients lose 25-35% of initial weight in 12-24 months.
- Majority of patients maintain these losses over the first decade; impressive improvement in weight-related comorbidities which are superior to the GLP-1s.



Changes in Psychosocial Functioning with Weight Loss

- Mood
- Anxiety
- Quality of Life
- Self-Esteem
- Body Image
- Sexuality
- Disordered eating
- Substance Misuse
- Physical functioning
- Sleep Disturbance
- Cognitive Impairment
- Bias and Stigmatization



Potential Psychological/Behavioral Issues Following Significant Weight Loss

- Body Image Dissatisfaction
- Marital and Sexual Issues
- Return of Pre-existing Psychopathology (Substance Use Disorders and Suicide)
- **Postoperative Weight Regain**

(Sarwer & Heinberg, 2020)



Changes in Body Image and Sexual Functioning Following MBS



- Two years following surgery, women reported almost uniform improvements in body image and sexual functioning. Men also reported improvements but changes in sexual functioning did not reach statistical significance.
- Both women and men experienced significant changes in relevant sex hormones both 1 and 2 years postoperatively.
- The sexual and quality of life benefits of bariatric surgery appear to be more profound for women than men.
- For some women, the self-reported improvements in sexual functioning, body image, and quality of life begin to erode over time.

(Sarwer et al. 2014; 2015; 2018; Steffen et al., 2016; 2019)



Addressing Postoperative Body Image Dissatisfaction and Marital/Sexual Issues

- Great topic for support groups (remote support groups work!)
- Invite guest presenters/co-leaders with relevant expertise
- Be prepared to provide referrals for additional care for issues that cannot be addressed in the group (mental health professionals, plastic surgeons, OBGYNs, urology)

The association between adverse childhood experiences and childhood obesity: A systematic review

Krista Schroeder¹, Brittany R Schuler^{1 2}, Julia M Kobulsky^{1 2}, David B Sarwer^{1 3}

Affiliations + expand

PMID: 33506595 PMCID: [PMC8192341](#) DOI: [10.1111/obr.13204](#)



Abstract

Adverse childhood experiences (ACEs) are associated with numerous physical and mental health issues in children and adults. The effect of ACEs on development of childhood obesity is less understood. This systematic review was undertaken to synthesize the quantitative research examining the relationship between ACEs and childhood obesity. PubMed, PsycInfo, and Web of Science were searched in July 2020; Rayyan was used to screen studies, and the Newcastle-Ottawa Scale was used to assess risk of bias. The search resulted in 6,966 studies screened at title/abstract and 168 at full-text level. Twenty-four studies met inclusion criteria. Study quality was moderate, with greatest risk of bias due to method of assessment of ACEs or sample attrition. Findings suggest ACEs are associated with childhood obesity. Girls may be more sensitive to obesity-related effects of ACEs than boys, sexual abuse appears to have a greater effect on childhood obesity than other ACEs, and co-occurrence of multiple ACEs may be associated with greater childhood obesity risk. Further, the effect of ACEs on development of childhood obesity may take 2-5 years to manifest. Considered collectively, findings suggest a need for greater attention to ACEs in the prevention and treatment of childhood obesity.

Keywords: adverse childhood experiences; obesity; pediatric obesity.



Applying the Principles of Trauma-Informed Care to the Evaluation and Management of Patients Who Undergo Metabolic and Bariatric Surgery

David B Sarwer¹, Krista Schroeder², Sarah R Fischbach³, Sophia M Atwood³, Leslie J Heinberg⁴

Affiliations + expand

PMID: 39592546 PMCID: [PMC11717798](#) DOI: [10.1007/s11695-024-07597-4](#)



Abstract

Evaluation of relevant psychosocial variables is an important aspect of comprehensive, high-quality metabolic and bariatric surgery (MBS) care. Given the high rates of adverse childhood experience (ACEs) and other forms of trauma experienced later in life reported by individuals with class III obesity, it is time to apply the principles of trauma-informed care to the multidisciplinary care of MBS patients. This narrative review begins with a summary of the literature on the psychosocial functioning of individuals who present for MBS. Emphasis is placed upon the relationship between ACEs, class III obesity, and MBS. Trauma-informed care is defined, and its principles are applied to the MBS care continuum. The paper ends with a recommendation on how the field of MBS can integrate trauma-informed care into clinical practice and future research.

Keywords: ACEs; Adverse childhood experiences; Metabolic and bariatric surgery; Obesity; Trauma; Trauma-informed care.



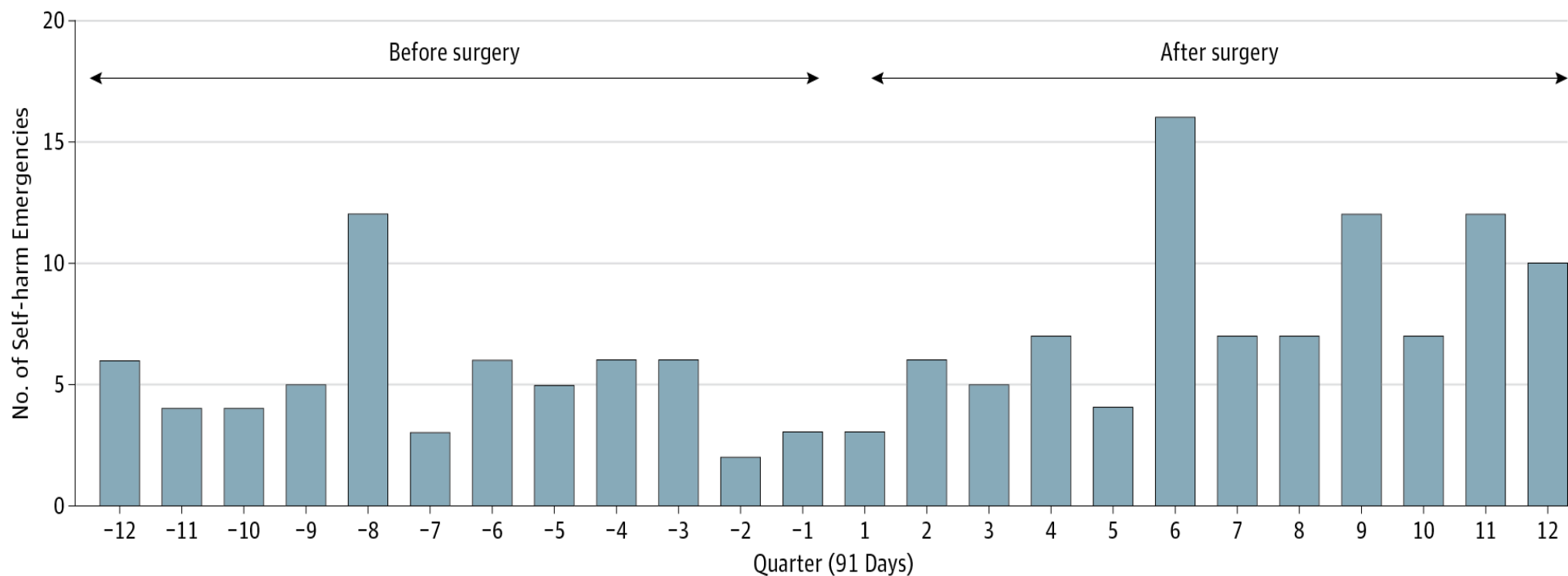
Prevalence of Alcohol Use Disorders Before and After MBS

- 1945 bariatric surgery patients in the LABS consortium studied both before surgery and 1 and 2 years postoperatively.
- Goal to determine the prevalence of preoperative and postoperative alcohol use disorders (AUD).
- Prevalence of AUD symptoms did not differ from before surgery to postoperative Year 1 (7.6% v. 7.3%), but was significantly higher (9.6%) in postoperative Year 2.
- Preoperative variables associated with increased odds of AUD by postoperative Year 2:
 - male, younger age, smoking, consumption of > 2 drinks/wk, recreational drug use, lower sense of belonging, RYGB.
- 20% of RYGB patients characterized with an AUD at postoperative Year 5.

(King et al. 2014; 2019)



Frequency of Self-harm Emergencies Before and After Bariatric Surgery (Bhatti et al., 2016)



Bhatti, J. A., Nathens, A. B., Thiruchelvam, D., Grantcharov, T., Goldstein, B. I., & Redelmeier, D. A. (2015). Self-harm emergencies after bariatric surgery: a population-based cohort study. *JAMA Surgery*.



Blood Alcohol Concentration in RYGB Patients 10 and 60 Min After Alcohol Consumption (Steffen et al. 2013)

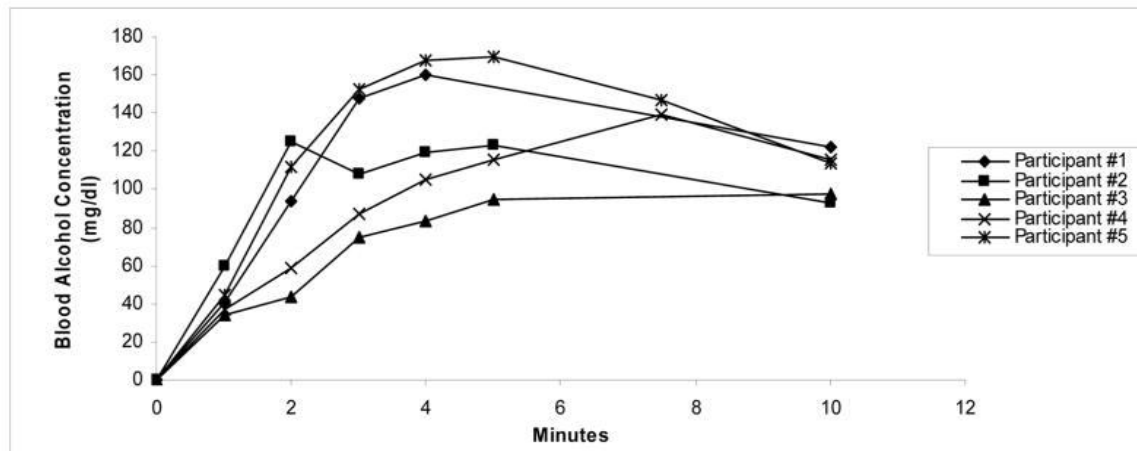


Figure 1a: BAC 10 minutes post-drink

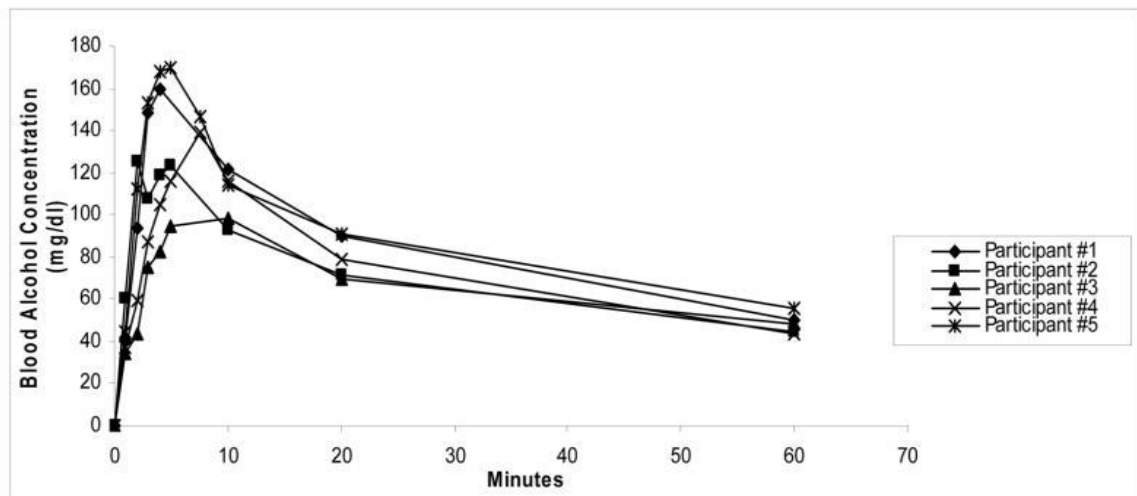


Figure 1b: BAC 60 minutes post-drink



Opioid Use after MBS

- Usage declines in first postoperative year.
- Usage increases in subsequent years. Some individuals resume usage and others start to use/misuse opioids for the first time.
- Same pattern seen with patients who underwent MBS and subsequently underwent body contouring surgery, 6% reporting de novo opioid misuse and 13% exposed to high risk prescribing practices. (Bennett et al., 2019)
- Same pattern of use seen with psychiatric medications (Cunningham et al., 2012)



Addressing Psychopathology: Depression/Suicide, Substance Misuse after Weight Loss

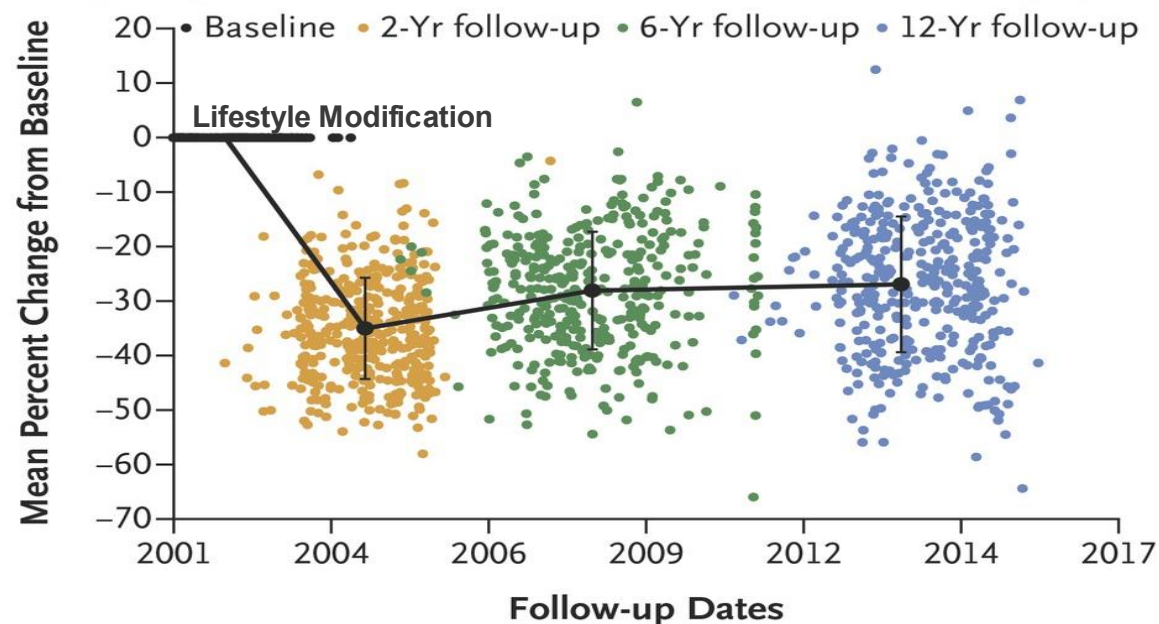
- Typically will require assessment/intervention with licensed mental health professionals
- Have additional professionals with relevant expertise in the practice's referral network



Mean % Wt. Change Following RYGB

(Adams et al 2017)

A Mean Percent Change in Body Weight from Baseline to Years 2, 6, and 12 in the Surgery Group



No. of Patients	Baseline	2 Yr	6 Yr	12 Yr
Surgery group	418	409	379	387
Deaths	—	3	9	14
Total	418	412	388	401



Possible Reasons for Suboptimal Weight Loss following MBS

- Physiological adaptation
- Preoperative psychopathology (depression, binge eating)
- Disordered eating (grazing, night eating)
- Poor adherence to the postoperative diet and recommended behavioral program



Strategies to Address Weight Regain/Improve Weight Maintenance after MBS: Looking to the Future

- Pharmacotherapy
- Increased Physical Activity/Decreased Sedentary Time
- Lifestyle Modification/Dietary Counseling/Acceptance and Commitment Therapy



Pharmacotherapy after MBS

(Vosberg et al, 2022)

- OMMs ideally should be used in combination with nutritional and lifestyle modification interventions.
- Phentermine is one of the most commonly used treatments because of its low cost.
- GLP-1 agonists offer a long duration of therapy and few side effects, but cost may be a deterrent.



Increased Physical Activity

- Increased physical activity plays an important role in long-term weight maintenance.
- Moderate to vigorous physical activity (MVPA) is associated with improved weight maintenance after MBS.
- Most individuals with clinically severe obesity report low levels of MVPA prior to surgery; objective assessment suggest these levels remain low postoperatively.
- There is great need for novel strategies to promote physical activity and decrease sedentary time after MBS to promote weight maintenance.



Lifestyle Modification Interventions After MBS

- Standard lifestyle modification interventions, emphasizing caloric restriction, increased physical activity, and instruction in lifestyle modification, are the cornerstone of obesity treatment.
- In efficacy studies of interventions delivered in person, LM typically produce a 5-10% weight loss in a period of 6 months.
- A number of studies have evaluated the efficacy of adaptations of these interventions to improve outcomes of bariatric surgery.
- A meta-analysis of the major clinical trials found **minimal differences** in weight loss between treatment and a range of control or comparison conditions 6-12 months following the onset of the intervention.



Possible Reasons for Suboptimal Weight Loss following MBS and How to Address Them

- Physiological adaptation (Solution—OMMs)
- Preoperative psychopathology (Solution—Referral to mental health provider)
- Disordered eating (Solution—Referral to mental health provider/dietitian)
- Poor adherence to the postoperative diet and recommended behavioral changes (Solution—Referral to dietitian)

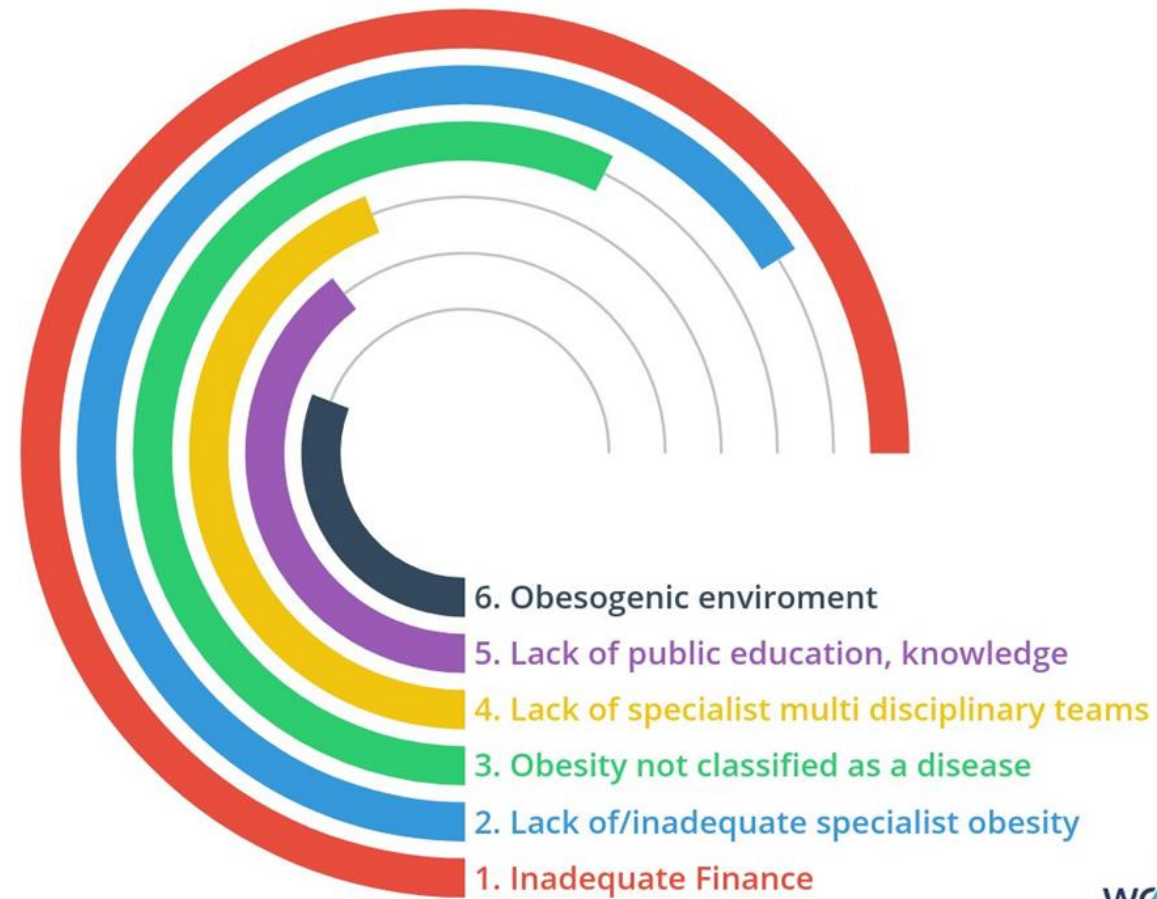


Remote Delivery of Postoperative Interventions

- More frequent postoperative follow-up and/or attendance at support groups is associated with greater weight loss. However, only 40% of patients return for their first year's follow-up visits; support group attendance is low and decreases over time.
- Since the pandemic, many bariatric programs have seen the value of telehealth medical appointments in bariatric care, where care can be delivered efficiently and effectively without requiring the time and expense of an in-person appointment.
- Remote, and, in particular, online delivery of interventions appears well-suited to address these issues. These interventions are particularly desirable, reduced participant burden, and are cost effective. They also have been shown to result in clinically meaningful weight losses.



Top perceived barriers to obesity treatment

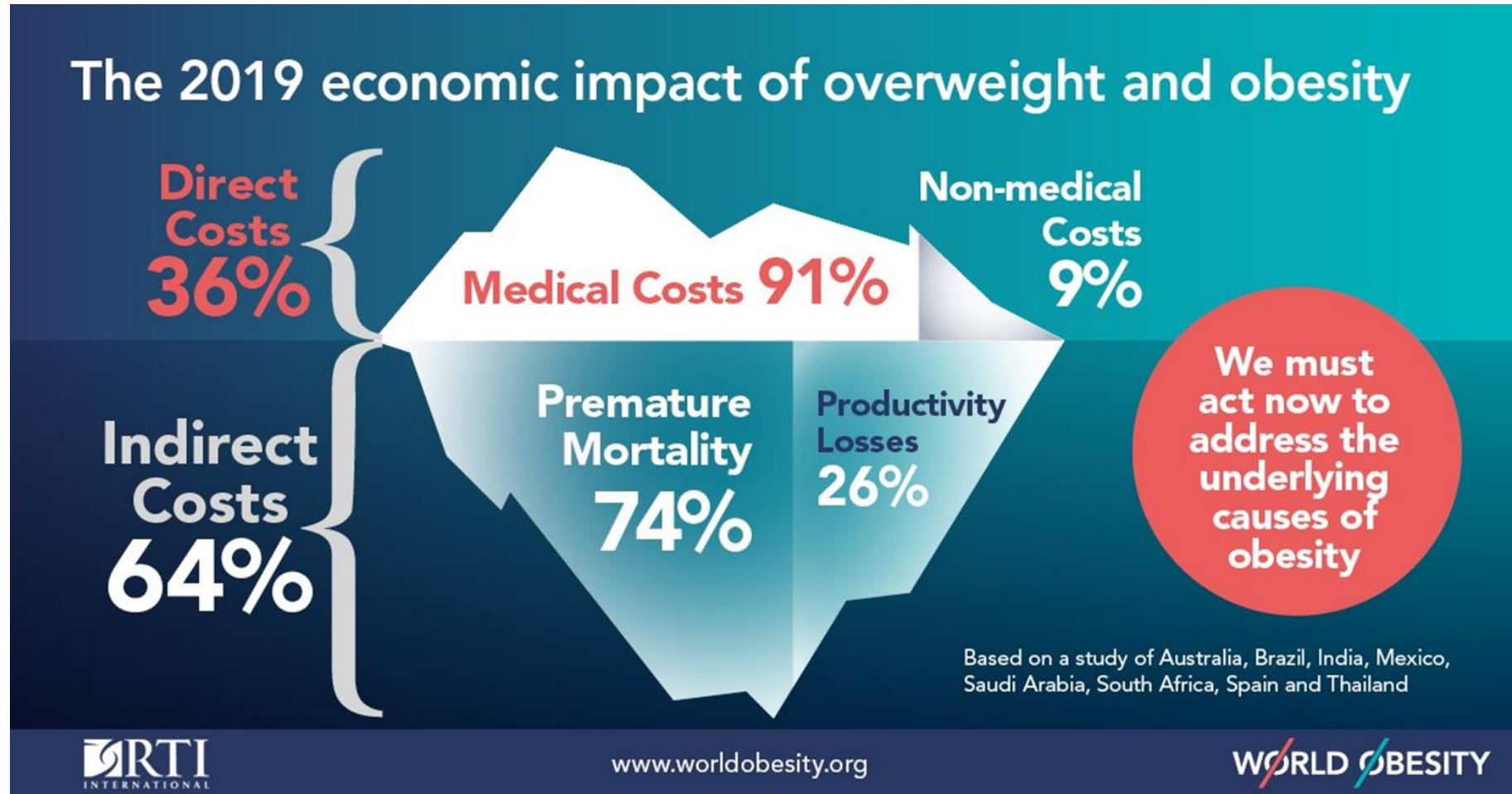


Based on findings from 100 Obesity Specialists from 30 countries





The Economic Impact of Obesity





The Economic Impact of Obesity

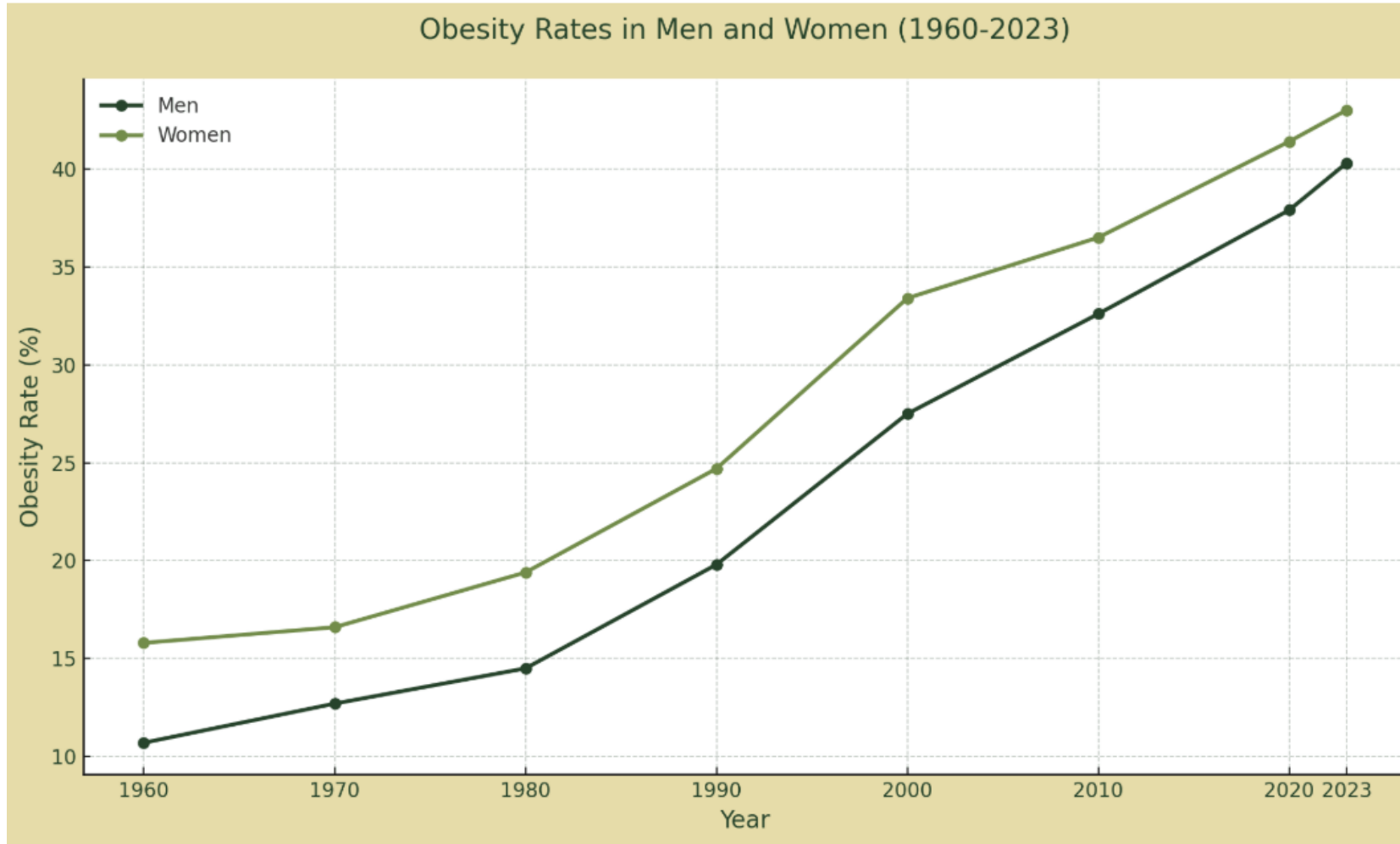
- Among 158 million civilian employees, 30% had obesity and 34% had overweight.
- The combined economic burden was \$425.5 billion (obesity: \$347.5 billion; overweight: \$78 billion).
 - excess medical costs of obesity (\$115 billion)
 - presenteeism (obesity: \$113.8 billion; overweight: \$46.5 billion),
 - absenteeism from obesity (\$82.3 billion),
 - excess medical costs of overweight (\$31.5 billion),
 - obesity-related disability payments (\$31.1 billion),
 - workers' compensation payments (\$5.2 billion).

For a hypothetical firm with 10,000 employees (plus dependents), the annual costs were \$22 million for obesity and \$4.9 million for overweight, with average costs of \$6472 per employee with obesity, \$1244 per employee with overweight, \$1514 per adult dependent with obesity, and \$380 per adult dependent with overweight.

Dall, T.M., Sapra, T., Natale, Z. et al. Assessing the economic impact of obesity and overweight on employers: identifying opportunities to improve work force health and well-being. *Nutr. Diabetes* 14, 96 (2024). <https://doi.org/10.1038/s41387-024-00352-9>



The Increasing Rate of Obesity in the United States





Marijuana Use and MBS

While there are suggested recommendations for tobacco, alcohol and illicit drug use, there is no consensus on marijuana use before surgery.

Regular use is associated with a range of health concerns, putting use at odds with using bariatric surgery as an opportunity to improve overall health.

Use and acceptance of medical marijuana, coupled with changes in state law, further cloud the issue.

Regular questioning/screening, separate from other substances, is recommended.

(Goodpaster et al., 2025)



“Addiction Transfer”

- Modern day example of ‘symptoms substitution’.
- “Addiction transfer” is not an accepted clinical diagnosis
- There is no scientific consensus that food is an addictive substance or eating is an addictive behavior
- There is little support for the notion that addictive behaviors can switch unless the psychological basis for the original problem is resolved (deZwaan et al., 2021)
- *Nevertheless, it is possible that some bariatric surgery patients (particularly those with a history of addiction) could be at increased risk for substance abuse postoperatively.*



Summary

- 20-30% of patients experience suboptimal outcomes, including smaller-than-expected weight loss, weight regain, or unwanted psychosocial experiences (substance use disorders, suicidality).
- The pathway to enduring weight control and improvements in psychosocial functioning for this subset of individuals remain largely unknown.
- The worldwide growth in rates of clinically severe obesity and utilization of MBS necessitate the development of novel strategies to promote lifelong success.
- As we await those treatments, all members of the MBS team should work to identify patients having suboptimal outcomes and refer them for further assessments and treatment by appropriate specialists.



Obesity Projections for 2030



World Obesity Day 4 March 2022

EVERYBODY NEEDS TO ACT

One billion people globally estimated to be living with obesity by 2030.

Adults and children across the globe need bold solutions and coordinated action. An urgent response now will make a meaningful difference to our ability to turn the tide on obesity globally.



World Obesity Atlas 2022
www.worldobesityday.org
@WorldObesity   

 WORLD OBESITY



The Relationship Between Preoperative Psychosocial Status and Postoperative Weight Loss



- Relationship between preoperative psychopathology and postoperative outcomes is less clear
 - Patients with pre-existing psychopathology experience smaller weight losses postoperatively. (Kalarchian et al, 2008; deZwaan et al, 2011)
 - Presence of preoperative BED has been associated with smaller postoperative weight losses or weight regain within the first 2 postoperative years....in some, but not all, studies. (Hsu et al., 1996; Kalarchian et al., 2002; Wadden et al 2010).
 - Two studies have suggested that a history of substance abuse is associated with larger weight losses following bariatric surgery (Clark et al., 2003; Heinberg & Ashton, 2010)



The Majority of Individuals Experience Tremendous Benefits from MBS

- Substantial and durable weight loss.
- Improvement or resolution of many weight-related health problems (T2DM, hypertension, sleep apnea, etc).
- Significant improvements in psychosocial status (self-esteem, quality of life, body image, etc.)