

Multidisciplinary obesity treatment: Ten considerations from a mental health perspective

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Global prevalence of overweight and obesity has doubled since 1980, with a third of the worldwide population currently classified as overweight or obese. Research on weight control care in various Latin American countries shows that health systems are ill-equipped to address obesity. Gaps include the absence of quality guidelines for evaluation and treatment, inadequate professional training, and financial constraints to access health services due to marked inequalities among the population (Arora et al., 2019).

The purpose of this editorial is to express our adherence to the “ROOTS” position of the World Obesity Federation, which recognizes obesity as a syndemic, in which biological, psychological, and social factors interact (Swinburn et al., 2019). We also support the position of Mexican health professionals, which lists actions for its approach and treatment (Barquera et al., 2022).

In addition, we issue the following mental health considerations for health professionals involved in obesity treatment:

1. The two-way link between obesity and mental health requires the evaluation and treatment given to the main mental health conditions affecting this population, such as depressive and anxiety disorders and eating disorders. According to the Edmonton Obesity Staging System, mental health-related aspects constitute one of the dimensions to be evaluated and treated together with other health problems associated with obesity and the functionality of patients. To this end, we recommend using validated screening instruments such as the Hospital Anxiety and Depression Scale (Petry, Barry, Pietrzak, & Wagner, 2008; Atlantis, Sahebolamri, Cheema, & Williams, 2020).
2. We recognize that people with obesity often experience stigma because of their weight and image are subject to discrimination and unfair treatment in health care and social settings. This impacts their emotional well-being and undermines their physical and mental health. We must therefore promote strategies and programs to mitigate stigma in all its forms, paying particular attention to clinical practice, in addition to teaching academic content that contributes to train stigma-free professionals.
3. Weight discrimination, like other forms of discrimination (gender, age, race, ethnicity, and mental illness), can trigger physiological stress responses that alter neuroendocrine control and contribute to increased adiposity, with a greater risk of metabolic and cardiovascular comorbidities (Schvey, Puhl, & Brownell, 2014).
4. Mental health professionals can provide valuable interventions for a comprehensive, multidisciplinary approach to overweight and obesity and reinforce strategies for changing habits designed to achieve healthy lifestyles, as well as the identification and treatment of mental health disorders associated with obesity. We support the promotion of models to address this problem such as the 5As model of the Canadian Obesity Network, the use of motivational interviewing and Cognitive Behavioral Therapy designed to achieve weight loss (Rueda-Clausen et al., 2014; Armstrong et al., 2011; Shaw, O'Rourke, Del Mar, & Kenardy, 2005).

5. Mental health professionals in the public and private sectors should develop skills to join multidisciplinary teams in obesity treatment, especially during the pre-surgical protocol for bariatric surgery in order to devise personalized treatments using a multidisciplinary approach.
6. The intervention of mental health professionals in obesity treatment should include the detection of depressive or anxiety disorders, as well as the evaluation of abnormal eating behaviors, such as objective binge eating, night eating syndrome, unnoticed or uncontrollable eating between meals and compensatory behaviors that require diagnosis and specialized treatment (Heriseanu, Hay, & Touyz, 2019).
7. As for psychopharmacological treatment in overweight or obese patients, it is advisable, as far as possible, to choose those with a weight-neutral effect or those associated with weight loss. Patients with obesity and affective or psychotic disorders have often achieved remission of their symptoms with second-generation antipsychotics and have gained weight as a side effect. In these cases, it is advisable to add other agents that contribute to neutralizing the negative metabolic impact (McElroy, Guerdjikova, Mori, & Keck, 2016).
8. Since the presence of atypical depressive symptoms in patients with affective disorders contributes to weight gain, the choice of therapy should be guided by the clinical response that contributes to weight loss (Łojko, Buzuk, Owecki, Ruchała, & Rybakowski, 2015).
9. Mental health professionals reinforce messages about obesity as a disease, avoid stigmatizing those who live with it, provide messages of support for patients, and include advice on healthy lifestyles in their interventions.
10. Mental health professionals support the NutriCOI initiative based on the Nutricia Code, whereby they encourage the various academic sectors to behave in an ethical, transparent, and professional manner in the face of potential conflicts of interest (Barquera et al., 2020).

Obesity treatment requires analyzing the weight gain history of each patient and studying the patient's life history, as well as the two-way relationships between life events, psychopathology, and obesity development. Treating obesi-

ty with a multidisciplinary approach constitutes an opportunity for health professionals interested in comprehensive obesity treatment.

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