TIBBIYOT
TA'LIMI & INNOVATSIYALARI

O'ZBEKISTON RESPUBLIKASI
TOSHKENT TIBBIYOT AKADEMIYASI
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- 14.00.00 - Tibbiyot fanlari;
- 14.00.01 - Akusherlik va ginekologiya;
- 14.00.02 - Morfologiya;
- 14.00.03 - Endokrinologiya;
- 14.00.04 - Otorinolaringologiya;
- 14.00.05 - Ichki kasalliklar;
- 14.00.06 - Kardiologiya;
- 14.00.07 - Gigiena;
- 14.00.08 - Oftal'mologiya;
- 14.00.09 - Pediatriya;
- 14.00.10 - Yuqumli kasalliklar;
- 14.00.11 - Dermatologiya va venerologiya;
- 14.00.12 - Tibbiy reabilitologiya;
- 14.00.13 - Nevrologiya;
- 14.00.14 - Onkologiya;
- 14.00.15 - Patologik anatomiya;
- 14.00.16 - Normal va patologik fiziologiya;
- 14.00.17 - Farmakologiya va klinik farmakologiya;
- 14.00.18 - Psixiatriya va narkologiya;
- 14.00.19 - Klinik radiologiya;
- 14.00.20 - Tibbiy genetika;
- 14.00.21 - Stomatologiya;
- 14.00.22 - Travmatologiya va ortopediya;
- 14.00.23 - Hamshiralik ishini tashkil etish;
- 14.00.24 - Sud tibbiyoti;
- 14.00.27 - Xirurgiya;
- 14.00.28 - Neyroxirurgiya;
- 14.00.41 - Xalq tabobati;
- 14.00.35 - Bolalar xirurgiyasi;
- 14.00.34 - Yurak-qon tomir xirurgiyasi

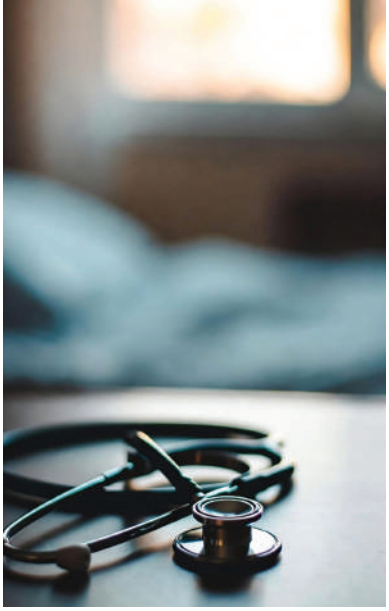
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Litsenziya raqami: №745444













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ilmiy elektron jurnali O‘zbekiston Respublikasi Axborot va ommaviy kommunikatsiyalar agentligi (AOKA) tomonidan 2024-yil 9-oktabrdan boshlab c-5669651 raqami ostida rasmiy ro‘yxatdan o‘tkazilgan.

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MUNDARIJA

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CHANGES IN ANXIETY, EATING BEHAVIOR, AND BODY IMAGE AFTER BARIATRIC SURGERY

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Abstract: Objective: To describe the trajectories of anxiety, depressive symptoms, eating behavior, and body image during the first postoperative year following bariatric surgery and to compare the observed patterns between two patient groups. Results: In the main group, the mean anxiety score decreased from 13.8 at 3 months to 10.5 at 6 months, then increased to 12.4 at 12 months. Depressive symptom scores showed a similar pattern, changing from 11.9 to 10.2 and then to 11.0, respectively. Emotional eating decreased at 6 months but increased by 12 months (3.10, 2.11, and 3.52, respectively). Body image disturbance scores also declined initially before increasing at the final assessment (3.7, 3.2, and 4.0). In the control group, anxiety, depressive symptom, and body image disturbance scores showed a consistent downward trend throughout the follow-up period. Conclusion: The observed patterns indicate differences in the postoperative trajectories of psychological indicators between the two groups. These findings highlight the importance of continued psychological monitoring beyond the early postoperative period. Further statistical analysis using validated longitudinal methods is required to determine the statistical significance of the observed differences.

Keywords: bariatric surgery; anxiety; depression; eating behavior; body image; postoperative follow-up.

Аннотация: Цель: Описать динамику тревожных и депрессивных симптомов, пищевого поведения и нарушений образа тела в течение первого года после бариатрической операции, а также сравнить выявленные закономерности между двумя группами пациентов. Результаты: В основной группе средний показатель тревоги снизился с 13,8 через 3 месяца до 10,5 через 6 месяцев, после чего увеличился до 12,4 через 12 месяцев. Аналогичная динамика наблюдалась в отношении депрессивных симптомов: показатели составили 11,9; 10,2 и 11,0 соответственно. Показатель эмоционального пищевого поведения снизился к 6-му месяцу, но повысился к 12-му месяцу (3,10; 2,11 и 3,52 соответственно). Показатели нарушений образа тела также первоначально уменьшились, а затем увеличились (3,7; 3,2 и 4,0). В контрольной группе показатели тревоги, депрессивных симптомов и нарушений образа тела последовательно снижались в течение всего периода наблюдения. Заключение: Выявленные закономерности указывают на различия в динамике психологических показателей после бариатрической операции между двумя группами. Полученные результаты подчёркивают важность продолжения психологического наблюдения после завершения раннего послеоперационного периода. Для определения статистической значимости выявленных различий необходим дополнительный анализ с использованием валидированных методов продольного статистического анализа.

Ключевые слова: бариатрическая хирургия; тревога; депрессия; пищевое поведение; образ тела; послеоперационное наблюдение.

Annotatsiya: Maqsad: Bariatrik operatsiyadan keyingi birinchi yil davomida xavotir va depressiv simptomlar, ovqatlanish xulq-atvori hamda tana obrazi buzilishlari dinamikasini tavsiflash va ikki guruh bemorlarida kuzatilgan o‘zgarishlarni taqqoslash. Natijalar: Asosiy guruhda xavotirning o‘rtacha ko‘rsatkichi operatsiyadan keyingi 3-oyda 13,8 dan 6-oyda 10,5 gacha pasaydi, 12-oyda esa 12,4 gacha oshdi. Depressiv simptomlar ko‘rsatkichi ham shunga o‘xshash dinamikani namoyon etdi: mos ravishda 11,9; 10,2 va 11,0. Emotsional ovqatlanish ko‘rsatkichi 6-oyda pasayib, 12-oyda oshdi (3,10; 2,11 va 3,52). Tana obrazi buzilishlari ko‘rsatkichi ham dastlab 3,7 dan 3,2 gacha pasayib, keyinchalik 4,0 gacha ko‘tarildi. Nazorat guruhida esa xavotir, depressiv simptomlar va tana obrazi buzilishlari ko‘rsatkichlari kuzatuv davri davomida izchil pasayib bordi. Xulosa: Aniqlangan tavsifiy natijalar bariatrik operatsiyadan keyingi psixologik ko‘rsatkichlar dinamikasi ikki guruhda turlicha kechganini ko‘rsatadi. Ushbu natijalar operatsiyadan keyingi erta davrdan so‘ng ham psixologik kuzatuvni davom ettirish muhimligini ta’kidlaydi. Kuzatilgan farqlarning statistik ahamiyatini aniqlash uchun validatsiyalangan longitudinal statistik usullar asosida qo‘shimcha tahlil o‘tkazish zarur.

Kalit so‘zlar: bariatrik jarrohlik; xavotir; depressiya; ovqatlanish xulq-atvori; tana obrazi; operatsiyadan keyingi kuzatuv.

INTRODUCTION

The factors contributing to the development of obesity usually act in combination; however, excessive caloric intake coupled with a sedentary lifestyle in genetically predisposed individuals is considered the primary cause. The pathogenesis of obesity is fundamentally characterized by an imbalance between energy intake and energy expenditure [10;11]. Recently, substantial evidence has accumulated indicating that body weight variability is associated with gene-environment interactions, including individual variability related to epigenetic factors. Furthermore, non-genetic factors, such as dietary patterns, physical exercise, and other weight-loss interventions, induce dynamic changes in epigenetic marks that regulate gene activity [9]. At present, the causes of syndromic and non-syndromic monogenic obesity are relatively well understood. Syndromic obesity arises from genetic defects or chromosomal abnormalities involving multiple genes and may be inherited in an autosomal or X-linked manner [3;12].

Among the best-known forms of syndromic obesity are Prader-Willi syndrome and Bardet-Biedl syndrome [5], as well as congenital leptin deficiency syndrome. These conditions may manifest at an early age and be accompanied by hyperphagia resulting from dysfunction of the central nervous system [2]. In 2001, six genes associated with monogenic obesity in humans had been identified, whereas no variants associated with polygenic obesity had yet been identified. By 2008, advances in this field had led to the identification of eight genes associated with monogenic obesity and four genes associated with polygenic obesity (FTO, PCSK1, MC4R, CTNNBL1). A study conducted by Hélène Choquet [6] revealed partially overlapping genetic contributions to monogenic and polygenic obesity. Currently, four genes (MC4R, PCSK1, POMC, and BDNF) are considered to contribute to both monogenic and polygenic forms of obesity, and this list may expand further in the coming years [12]. Leptin, produced by adipocytes, and insulin, secreted by pancreatic β-cells, are currently regarded as key anorexigenic hormones. Although leptin and insulin utilize distinct signaling pathways, their mechanisms of body weight regulation act in concert. Recent studies have demonstrated that insulin potentiates leptin-induced signaling pathways. Therefore, a deeper understanding of the interactions between leptin and insulin in the central nervous system is essential for elucidating the physiological and pathophysiological processes associated with their actions [6].

LITERATURE REVIEW

Bariatric surgery is widely used in the treatment of severe obesity and has demonstrated beneficial effects on body weight, physical health, and psychological well-being. Nevertheless, postoperative psychological changes are complex and vary among individuals. Although many patients experience improvements in anxiety and depressive symptoms, some continue to experience psychological difficulties or exhibit a recurrence of symptoms during follow-up. A systematic review and meta-analysis by Budin et al. [1] highlighted the importance of evaluating depressive symptoms at different stages after bariatric surgery. Previous research has also reported a considerable prevalence of mental health conditions among patients undergoing bariatric procedures [2]. Eating behavior is another important aspect of postoperative adaptation. Bariatric surgery alters eating patterns, food intake, and the relationship between emotions and eating. Wong et al. [7], in a systematic review and meta-analysis, found that emotional eating generally decreases after surgery, particularly during the first postoperative year.

However, individual differences persist, and emotional, external, and restrained eating behaviors may follow different trajectories. Therefore, assessing these dimensions can help identify patients who experience difficulties adapting their eating behavior after surgery. Body image is also an important component of psychological recovery. Although substantial weight loss may improve satisfaction with physical appearance, some patients continue to experience body dissatisfaction or difficulties adapting to changes in their bodies. Ivezaj and Grilo [4] emphasized the complexity of body image following bariatric surgery and the variability of psychological outcomes among patients. These findings suggest that weight reduction alone does not necessarily ensure complete psychological adaptation. The relationship between anxiety, depressive symptoms, eating behavior, and body image highlights the need for comprehensive psychological assessment after bariatric surgery. Evaluating these parameters at multiple postoperative time points may help identify different patterns of psychological adaptation and determine which patients may require additional support [6]. The present study therefore examines changes in anxiety, depressive symptoms, eating behavior, and body image at 3, 6, and 12 months after bariatric surgery. By comparing the trajectories observed in the two study groups, the study aims to characterize differences in postoperative psychological adaptation and provide a basis for improving psychological monitoring during follow-up.

RESEARCH METHODOLOGY

The study included 124 patients who underwent bariatric surgery at the multidisciplinary clinic “Medbar,” Tashkent State Medical University, Uzbekistan. The study population was divided into two groups: a main group comprising 70 patients and a control group comprising 54 patients. Psychological assessments were conducted at 3, 6, and 12 months after surgery to evaluate postoperative changes in anxiety and depressive symptoms, eating behavior patterns, and body image disturbance. The assessment was based on standardized psychological questionnaires, including the Hospital Anxiety and Depression Scale (HADS), the Dutch Eating Behavior Questionnaire (DEBQ), and the Body Image Disturbance Questionnaire (BIDQ). These instruments were used to characterize changes in psychological indicators throughout the follow-up period and to compare the observed patterns between the two groups. The study design enabled the examination of both early postoperative changes and the subsequent course of psychological symptoms over 12 months. The criteria used to allocate patients to the main and control groups must be specified according to the original study protocol and documented research records. These criteria should not be inferred retrospectively from the observed psychological outcomes, as doing so could introduce classification bias and affect the interpretation of between-group differences.

Anxiety and depressive symptoms were assessed using the Hospital Anxiety and Depression Scale (HADS), with the anxiety subscale (HADS-A) used to evaluate anxiety symptoms and the depression subscale (HADS-D) used to assess depressive symptoms [1]. The use of these two subscales allowed the separate examination of anxiety- and depression-related symptom patterns during the postoperative follow-up period. Eating behavior was evaluated using the Dutch Eating Behavior Questionnaire (DEBQ), which includes three subscales: emotional eating, restrained eating, and external eating [2]. These subscales were considered separately to characterize different patterns of eating behavior and examine how they changed at 3, 6, and 12 months after surgery. Body image disturbance was assessed using the Body Image Disturbance Questionnaire (BIDQ) [3], which was used to evaluate concerns and dissatisfaction related to body image. The results obtained from these instruments were analyzed across the follow-up time points to describe postoperative changes in psychological symptoms, eating behavior, and body image in the study groups. This article focuses primarily on the descriptive analysis of changes in reported mean scores across the postoperative follow-up period, with assessments conducted at 3, 6, and 12 months after bariatric surgery. The analysis considers the observed patterns in anxiety and depressive symptoms, eating behavior, and body image disturbance in both study groups. Values are presented as reported in the original study tables, without introducing additional calculations or modifying the reported results. This approach allows the temporal patterns of psychological indicators to be described and provides a basis for identifying potential differences in postoperative psychological adaptation between the main and control groups.

However, the findings should be interpreted in the context of the available data. The source material provided for this draft does not include complete patient-level observations or a fully verified longitudinal statistical model. Consequently, no additional p-values, confidence intervals, standardized effect sizes, or conclusions regarding a statistically significant group-by-time interaction have been calculated or reported. Although changes in mean scores may suggest improvements or fluctuations in particular psychological indicators, descriptive differences alone cannot establish statistical significance or confirm that the observed changes differ significantly between groups. Before drawing inferential conclusions, the original dataset and SPSS output should be reviewed to verify the sample sizes at each follow-up point, the statistical methods applied, and the assumptions underlying the selected analyses. Any additional statistical results should be incorporated only after this verification, ensuring that the final conclusions accurately reflect the available evidence and avoid overstating the findings.

ANALYSIS AND RESULTS

The descriptive analysis of anxiety and depressive symptoms revealed different patterns of change between the main and control groups during the 12-month postoperative follow-up. In the main group, the mean HADS-A score decreased from 13.8 at 3 months to 10.5 at 6 months, indicating an improvement in reported anxiety symptoms during the intermediate follow-up period. However, at 12 months, the mean score increased to 12.4, suggesting a partial return toward the higher level observed at 3 months. A similar pattern was observed for depressive symptoms. The mean HADS-D score decreased from 11.9 at 3 months to 10.2 at 6 months, followed by an increase to 11.0 at 12 months. These findings descriptively indicate that the initial reduction in anxiety and depressive symptoms was not fully maintained throughout the entire observation period in the main group. In contrast, the control group demonstrated a continuous decline in both HADS subscale scores. The mean HADS-A score decreased from 6.3 at 3 months to 4.1 at 6 months and further to 1.8 at 12 months. Similarly, the mean HADS-D score declined from 4.5 at 3 months to 2.4 at 6 months and 1.6 at

12 months. This pattern reflects a progressive reduction in reported anxiety and depressive symptoms over the follow-up period. Although the descriptive trajectories differed between the groups, the statistical significance of these differences cannot be established from the mean scores alone and requires confirmation using the original longitudinal data and appropriate statistical tests.

Changes in eating behavior also demonstrated distinct descriptive trajectories in the two groups. In the main group, emotional eating decreased from a mean score of 3.10 at 3 months to 2.11 at 6 months, followed by an increase to 3.52 at 12 months. This pattern suggests that the initial reduction in emotional eating was followed by a recurrence of higher scores during the later postoperative period. Such a pattern may warrant further investigation in relation to patients' psychological adaptation after surgery; however, the available descriptive data do not establish the underlying causes of this change.

Restrained eating in the main group showed a different trajectory, with mean scores of 4.80, 4.64, and 3.34 at 3, 6, and 12 months, respectively. The gradual decline indicates a reduction in reported restrained eating across the follow-up period. External eating decreased from 3.50 at 3 months to 2.38 at 6 months, before increasing moderately to 2.69 at 12 months. Thus, emotional and external eating showed increases in mean scores between the 6- and 12-month assessments, whereas restrained eating continued to decline. In the control group, all three DEBQ subscales demonstrated a progressive downward pattern. Emotional eating scores decreased from 2.40 at 3 months to 2.22 at 6 months and 1.95 at 12 months. Restrained eating declined from 3.95 to 3.52 and then to 2.87, while external eating decreased from 3.05 to 2.74 and 2.37 over the same period. These descriptive findings indicate that the mean scores for all three eating behavior dimensions decreased throughout follow-up in the control group. Compared with the main group, the control group did not show an increase in emotional or external eating scores between 6 and 12 months. Nevertheless, determining whether these differences represent statistically significant changes requires further analysis of the original data. The longitudinal descriptive pattern of body image disturbance, assessed using the BIDQ, also differed between the two groups. In the main group, the mean BIDQ score decreased from 3.7 at 3 months to 3.2 at 6 months, indicating a reduction in reported body image concerns during the first part of the follow-up period. At 12 months, however, the mean score increased to 4.0, exceeding the values recorded at both earlier assessments. This change suggests that the initial improvement in body image-related concerns was not sustained throughout the entire observation period.

In the control group, BIDQ scores showed a consistent downward trend, decreasing from 2.8 at 3 months to 2.3 at 6 months and 1.9 at 12 months. This pattern indicates a progressive reduction in reported body image disturbance over the 12-month follow-up. The contrasting trajectories suggest that changes in body image-related concerns may vary among patients following bariatric surgery. In particular, the increase in the main group's mean BIDQ score between 6 and 12 months highlights the importance of assessing psychological outcomes beyond the early postoperative period. Overall, the descriptive findings indicate that the main group experienced fluctuations in several psychological indicators, including anxiety, depressive symptoms, emotional eating, external eating, and body image disturbance. In contrast, the control group showed a consistent downward pattern across the reported measures, while restrained eating decreased in both groups. These observations support the importance of longitudinal psychological assessment following bariatric surgery. However, they should be interpreted as descriptive patterns rather than evidence of statistically significant between-group differences or confirmed psychological relapse. Further interpretation depends on verification of the group allocation criteria and the results of appropriate longitudinal statistical analyses.

Table 1.
HADS scores across postoperative follow-up

Measure / group	3 months	6 months	12 months
HADS-A, main group	13.8 ± 3.0	10.5 ± 2.8	12.4 ± 3.1
HADS-D, main group	11.9 ± 2.8	10.2 ± 2.5	11.0 ± 2.7
HADS-A, control group	6.3 ± 2.1	4.1 ± 1.9	1.8 ± 1.2
HADS-D, control group	4.5 ± 1.8	2.4 ± 1.5	1.6 ± 1.1

Table 2.
DEBQ and BIDQ scores across postoperative follow-up

Measure	Group	3 months	6 months	12 months
DEBQ emotional	Main	3.10	2.11	3.52
DEBQ emotional	Control	2.40	2.22	1.95
DEBQ restrained	Main	4.80	4.64	3.34
DEBQ restrained	Control	3.95	3.52	2.87
DEBQ external	Main	3.50	2.38	2.69
DEBQ external	Control	3.05	2.74	2.37
BIDQ	Main	3.7 ± 0.48	3.2 ± 0.58	4.0 ± 0.547
BIDQ	Cotrol	2.8 ± 0.52	2.3 ± 0.47	1.9 ± 0.42

The main finding is the difference in the descriptive time courses of psychological measures between the two groups. In the main group, anxiety and depressive symptom scores improved between months 3 and 6 but increased again by month 12. Emotional eating and body image disturbance showed a similar pattern of initial improvement followed by an increase at 12 months. In contrast, the control group showed progressive reductions in HADS and BIDQ scores, while all three DEBQ dimensions also declined throughout the reported follow-up period. These findings suggest that early postoperative improvement should not automatically be assumed to continue throughout the first year. Repeated assessment may be useful for identifying patients whose psychological symptoms or eating-related difficulties increase after an initial improvement. However, the present descriptive patterns cannot establish why the trajectories differed, nor do they demonstrate that changes in weight, expectations, or personality caused the observed psychological changes.

The clinical interpretation depends on the validity of the group definitions and the statistical comparison of changes over time. If the groups were defined using the same psychological outcomes subsequently compared in this article, this must be clearly disclosed because it could introduce circularity. A formal longitudinal analysis should be used to test group, time, and group-by-time effects before claiming that the trajectories differ statistically. The findings highlight the importance of maintaining psychological follow-up beyond the early postoperative period in patients undergoing bariatric surgery. Although some psychological indicators may improve during the initial months after surgery, the descriptive patterns observed in the main group suggest that these improvements may not be sustained uniformly over time. Therefore, psychological assessment should continue throughout the first postoperative year and, where clinically indicated, beyond this period. Follow-up assessments may include anxiety and depressive symptoms, eating behavior patterns, and concerns related to body image. Standardized instruments such as HADS, DEBQ, and BIDQ may help identify changes in these domains and facilitate the timely identification of patients who may require further evaluation. An increase in questionnaire scores should prompt an individualized clinical assessment that takes into account the patient's symptoms, functional status, medical condition, and psychosocial circumstances. Such changes should not automatically be interpreted as evidence of a psychiatric diagnosis or as an indication for a specific treatment without an appropriate clinical evaluation.

The present study was observational and focused on describing changes in psychological indicators over time. It did not evaluate the effectiveness of any specific psychological or psychiatric intervention. Consequently, the findings cannot establish which treatment approach is most effective for patients experiencing persistent or worsening psychological symptoms after bariatric surgery. Further prospective studies are needed to investigate the effectiveness of structured psychological follow-up, cognitive behavioral interventions, and other clinically appropriate treatment strategies in this population. This draft is based on summary values rather than a complete patient-level dataset. Some table values were supplied without standard deviations or p-values; therefore, these values have not been invented. The exact group-allocation criteria and the longitudinal statistical tests must be verified. Before submission, all means, measures of dispersion, time labels, and significance markers should be reconciled with the final SPSS output. The observational design of the study limits causal interpretation.

CONCLUSION

The main group showed an initial reduction followed by an increase at 12 months in anxiety, depressive symptoms, emotional eating, and body image disturbance scores. The control group showed continued reductions in anxiety, depressive symptoms, and body image disturbance, together with declining DEBQ scores. These descriptive trajectories highlight the importance of follow-up throughout the first postoperative year; however, formal longitudinal statistical testing is required before concluding that the group trajectories differ significantly.

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