# Beyond BMI: Psychiatric Drivers of Obesity in the Ambulatory Setting

*Depression, Binge Eating, and Clinical Decision-Making in Ambulatory Care*

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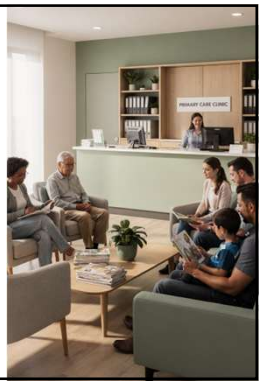

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## Disclosures

Dr. Glenn is a paid consultant and speaker for **Alkermes** and **Bristol Myers Squibb**. The content of this presentation is not influenced by these affiliations. Clinical recommendations are based on current evidence and are independent of industry relationships.

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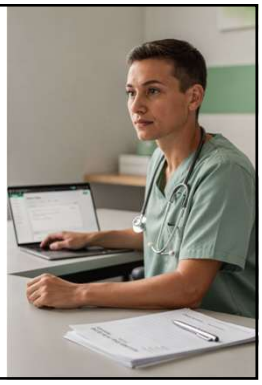
## Learning Objectives

By the end of this session, participants will be able to:

1. **Bidirectional Relationship**
   Identify the bidirectional relationship between depression and obesity
2. **BED vs. Emotional Eating**
   Differentiate binge eating disorder from emotional eating
3. **Pharmacologic Strategies**
   Apply evidence-based strategies including antidepressants and GLP-1 receptor agonists
4. **Screening & Stigma**
   Implement screening tools and communication strategies that address weight stigma



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SECTION 1 OF 4

# Learning Objective 1

Identify the bidirectional relationship between depression and obesity

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## Case: Ms. L

**42-year-old woman** presenting to primary care for follow-up of weight gain and fatigue

### Medical History

- BMI: **36 kg/m²**
- Prediabetes — A1c **6.1%**
- Hypertension
- GERD

### In Her Own Words

Works full time, cares for two children. High stress, limited exercise. Multiple diet attempts with weight regain. Expresses **shame about eating behaviors.** Denies purging.

### Psychiatric History

- Prior depressive episode in her early 30s
- Current: low mood, low motivation, poor sleep
- **PHQ-9: 14 (moderate depression)**

### Current Medications

- Sertraline 100 mg daily (~1 year)
- Lisinopril · Omeprazole

> *"I'm **exhausted all the time.**"*

> *"I've gained about **30 pounds** in the past two years."*

> *"At night I eat even when **I'm not hungry.**"*

> *"Once I start eating, **I can't stop.**"*

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## What Is the Primary Driver of Ms. L's Weight Gain?

A
Lifestyle factors alone

B
Depression contributing to weight gain

C
Possible binge eating disorder

D
Antidepressant-related weight effects

E ✓
**Likely multifactorial**

In clinical practice, obesity and psychiatric illness rarely have a single cause. Accurate case formulation requires evaluating mood, behavior, medications, and social context simultaneously.

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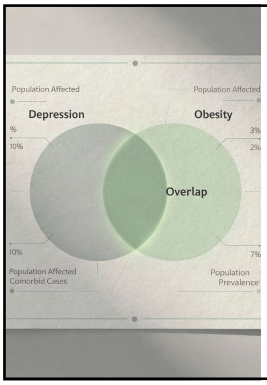


## Epidemiology: Depression & Obesity

**55%**

Increased risk of depression in people with obesity

**71%**

Increased risk of obesity in people with depression

**32%**

Higher CV mortality when both conditions co-occur

- The relationship is bidirectional — each condition amplifies the other.

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## Why Depression and Obesity Intersect

**Reward Pathways**
Dopamine dysregulation

**HPA Axis**
Chronic stress and cortisol

**Sleep Disruption**
Bidirectional metabolic effects

**Systemic Inflammation**
Shared inflammatory markers

**Psychotropic Medications**
Weight-promoting effects

**These mechanisms are mutually reinforcing — disruption in one pathway often worsens others, perpetuating both mood and metabolic dysfunction.**

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SECTION 1 · CLINICAL IMPLICATIONS

## Why Untreated Depression Undermines Metabolic Care

**Adherence Suffers**
Depression erodes motivation, self-efficacy, and follow-through with lifestyle interventions and medication regimens.

**Poorer Weight Loss Outcomes**
Baseline depression predicts attenuated response to both behavioral and pharmacologic weight loss treatments.

**Metabolic Care Is Impaired**
Untreated mood disorders worsen glycemic control, blood pressure management, and long-term cardiometabolic risk.

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# Learning Objective 2

Differentiate binge eating disorder from emotional eating

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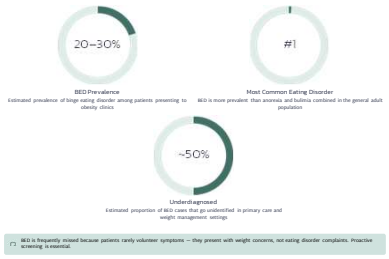
## BED in Obesity Clinics: A Hidden Diagnosis




BED is frequently missed because patients rarely volunteer symptoms — they present with weight concerns, not eating disorder complaints. Proactive screening is essential.

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## Diagnostic Features of Binge Eating Disorder

| DSM-5 Feature | BED |
|---|---|
| Loss of control during eating | ✅ Required |
| Consuming a large amount of food | ✅ Required |
| Marked distress afterward | ✅ Required |
| Frequency | ≥1x/week × 3 months |
| Compensatory behaviors (purging) | ❌ Absent |

### Key Diagnostic Clarification

The **absence of compensatory behaviors** distinguishes BED from bulimia nervosa. Patients often present with shame, secrecy, and weight gain rather than an explicit complaint about disordered eating.

At least **3 of 5 associated features** must be present: eating rapidly, eating until uncomfortably full, eating when not hungry, eating alone due to embarrassment, or feeling disgusted/depressed afterward.

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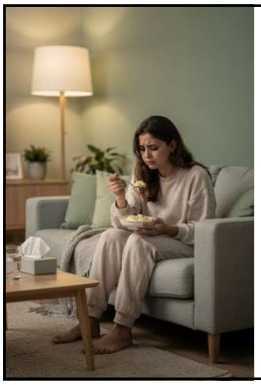

## Understanding Emotional Eating

| Definition | Common Triggers |
|---|---|
| Eating in response to emotional cues (stress, sadness, boredom) rather than physical hunger. | Stress, anxiety, loneliness, sadness, boredom, anger, fatigue. |

**Behavioral Patterns**

Often involves highly palatable, calorie-dense foods; can be habitual.

While common, emotional eating can contribute to weight gain and exacerbate mood symptoms. It's distinct from Binge Eating Disorder, which involves specific diagnostic criteria.

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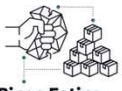
## Emotional Eating vs. Binge Eating Disorder

**Emotional Eating**

STRESS/MOOD TRIGGERED.

VARIABLE AMOUNTS.

NO LOSS OF CONTROL.



**Binge Eating Disorder (BED)**

LOSS OF CONTROL DEFINING FEATURE.

OBJECTIVELY LARGE AMOUNT.

CLINICALLY SIGNIFICANT DISTRESS.

**Clinical Distinction**

Emotional eating is common and dimensional — it exists on a spectrum. BED is a discrete DSM-5 diagnosis defined by **loss of control, episode recurrence, and clinically significant distress.**

Many patients with BED describe emotional eating as a trigger, but the two are not equivalent. Accurate differentiation guides treatment selection.

**Comorbidities**

The most common **psychiatric comorbidities** include major depressive disorders, anxiety disorders, substance use disorders, ADHD, borderline personality disorder, and PTSD.

The most common **medical comorbidities** include obesity, type 2 diabetes, hypertension, elevated cholesterol and triglycerides.

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## 3 Screening Questions PCPs Can Use

1. Loss of Control
   "Do you ever feel **unable to stop eating** once you start?"
2. Volume
   "Do you eat **large amounts of food** even when not physically hungry?"
3. Distress
   "Do you feel **distressed or ashamed** about your eating episodes afterward?"

Positive responses to all three warrant formal assessment. Consider the BEDS-7 or EDE-Q for structured follow-up screening.

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## BEDS-7 Questionnaire: Screening for Binge Eating Disorder

| Question | Never or Rarely | Sometimes | Often | Always |
|---|---|---|---|---|
| How often do you eat much more rapidly than normal? | | | | |
| How often do you eat until you feel uncomfortably full? | | | | |
| How often do you eat large amounts of food even when not physically hungry? | | | | |
| How often do you feel unable to stop eating once you start? | | | | |
| How often do you eat alone because you are embarrassed by how much you are eating? | | | | |
| How often do you feel disgusted with yourself, depressed, or very guilty afterward? | | | | |
| How often have these eating episodes occurred (on average) over the last 3 months? | | | | |

This self-report questionnaire can help identify potential binge eating disorder. A score of 3 or more "often" or "always" responses warrants further clinical assessment.

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## BED Treatment Overview

1

First-Line Psychotherapy

**CBT** is the gold-standard treatment for BED — targets distorted cognitions and behavioral patterns

2

FDA-Approved Pharmacotherapy

**Lisdexamfetamine (Vyvanse)** — only FDA-approved medication for moderate-to-severe BED

3

Other Medications Studied

**Topiramate** and **naltrexone/bupropion** have evidence for binge reduction and weight management

4

GLP-1 Considerations

Emerging data suggest appetite suppression may reduce binge frequency — screen for BED **before** initiating

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SECTION 3 OF 4

## Learning Objective 3

Apply pharmacologic strategies including antidepressants and GLP-1 receptor agonists

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## Antidepressants & Weight: What to Expect

| Medication | Weight Effect | Notes |
|---|---|---|
| Bupropion | ↓ Neutral/Loss | Preferred in obesity |
| Fluoxetine | ↔ Variable | Short-term loss possible |
| Sertraline | ↔ Variable | Gain with long-term use |
| Escitalopram | ↑ Modest gain | Monitor over time |
| Paroxetine | ↑↑ Gain risk | Avoid when possible |
| Mirtazapine | ↑↑ Gain | Significant appetite increase |

Clinical Pearl

When depression and obesity coexist, antidepressant selection should be **weight-intentional.** Bupropion is the only antidepressant with consistent evidence for modest weight loss.

Long-term SSRI use — including sertraline — is associated with progressive weight gain that may not be apparent in the first year of treatment.

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## Psychiatric Medications That Promote Weight Gain

Antipsychotics
- Olanzapine — highest risk
- Quetiapine — moderate risk
- Clozapine — significant gain
- Aripiprazole — lower risk
- Lurasidone — relatively neutral

Mood Stabilizers
- Valproate — significant weight gain
- Lithium — modest gain, edema
- Lamotrigine — relatively neutral
- Topiramate — weight loss effect

Antidepressants
- Mirtazapine — appetite ↑↑
- Paroxetine — metabolic risk
- TCAs — significant gain
- MAOIs — variable, monitor

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## GLP-1 Receptor Agonists & Mental Health

What Clinicians Need to Know
- **Appetite suppression** may secondarily reduce binge frequency — but this is not a substitute for BED treatment
- **Emerging psychiatric signal:** FDA label includes language on suicidality monitoring; evidence is mixed but warrants vigilance
- **Mood changes during rapid weight loss** can occur — screen for emerging depressive symptoms at follow-up visits
- GLP-1s do not treat underlying psychiatric drivers — **integrate with behavioral support**
- Screen for active BED and mood disorders **before** initiating weight loss pharmacotherapy

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## Emerging GLP-1 RA Research in Psychiatry

Beyond weight management, GLP-1 receptor agonists are being investigated for their potential impact on various psychiatric conditions, opening new avenues for treatment.

**Mood & Anxiety Effects**

Preclinical and early human studies suggest GLP-1 RAs may exhibit mood-stabilizing and anxiolytic properties, influencing brain circuits involved in emotional regulation. (Smith et al., J Clin Psychiatry, 2023)

**Substance Use Reduction**

Growing evidence indicates GLP-1 RAs could reduce cravings and modify reward pathways, showing promise in treating substance use disorders, particularly alcohol and nicotine. (Jones & Brown, Addiction, 2024)

**Neuroprotective Potential**

Research is exploring GLP-1 RAs' neuroprotective effects and potential to improve cognitive function in models of neurodegenerative diseases like Alzheimer's and Parkinson's. (Garcia et al., Neurosci Rev, 2023)

These findings highlight a rapidly evolving field, but more extensive human trials are needed to confirm efficacy and establish clinical guidelines.

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## Other FDA-Approved Obesity Medications & Mental Health

Phentermine
A short-term stimulant for appetite suppression. Can cause anxiety, insomnia, agitation, and elevated heart rate/blood pressure. Use with caution in patients with anxiety disorders or substance use history.

Naltrexone/Bupropion (Contrave)
Combines an opioid antagonist (naltrexone) and an antidepressant (bupropion). Bupropion may improve mood in some but carries a black box warning for suicidal thoughts. Common side effects include nausea and headache.

Phentermine/Topiramate (Qsymia)
A combination of appetite suppressant and anti-seizure medication. Topiramate can cause cognitive side effects (e.g., word-finding difficulty, memory issues), anxiety, and depression. Titrate slowly and monitor mental status carefully.

Careful consideration of potential psychiatric side effects is crucial when selecting pharmacotherapy for obesity, especially in patients with co-occurring mental health conditions.

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## Medication Strategy Pearls

**Depression + Obesity**

Consider **bupropion** as a first-line antidepressant when depression and obesity coexist — the only antidepressant with weight-loss benefit.

**Screen Before Prescribing**

Assess for **active BED** before initiating any weight loss pharmacotherapy. Unrecognized BED may not respond — and may worsen — without targeted treatment.

**Monitor Mood During Weight Loss**

Rapid weight loss with GLP-1s or surgery can precipitate or unmask **depressive symptoms.** Build psychiatric check-ins into follow-up cadence.

**Avoid High-Risk Combinations**

When possible, avoid pairing **weight-promoting psychotropics** (olanzapine, valproate, mirtazapine) with patients already carrying metabolic risk.

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# Learning Objective 4

Implement screening and communication strategies addressing weight stigma

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## Weight Stigma in Healthcare: The Evidence

**Patient Avoidance**

Stigmatizing experiences lead patients to **delay or avoid care**, including preventive visits and weight management follow-up.

**Physiologic Stress Response**

Perceived weight stigma activates the HPA axis, **elevating cortisol** — directly worsening insulin resistance and driving further weight gain.

**Treatment Disengagement**

Patients who experience stigma from providers are significantly **less likely to adhere** to treatment plans, return for follow-up, or engage in lifestyle programs.

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## Language That Reduces Stigma

Person-first, non-judgmental language shapes patient trust and engagement. Small word choices carry real clinical consequences.

| ❌ Instead of This | ✅ Use This Instead |
|---|---|
| "Obese patient" | "Patient with obesity" |
| "Noncompliant" | "Struggling with treatment plan" |
| "She failed diet therapy" | "Has not yet responded to diet therapy" |
| "Morbidly obese" | "Patient with severe obesity" |
| "Just needs to lose weight" | "Managing a complex metabolic condition" |

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## Practical Screening in Primary Care


Integration Tips

- Embed **PHQ-9 and GAD-7** in rooming workflows for all obesity visits — not just psychiatric referrals
- Use the **3 BED screening questions** whenever a patient reports nighttime eating, loss of control, or shame around food
- Document eating behavior and mood screening as part of the **obesity visit note template**
- Brief screens take under **2 minutes** and substantially improve diagnostic yield

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## Introducing "Treating Obesity First"

The Obesity Medicine Association is launching a new initiative designed to fundamentally shift the clinical conversation around obesity, empowering clinicians with innovative tools and comprehensive resources.

**OMAr: AI Patient Simulator**

Practice sensitive and effective patient conversations in a safe, AI-powered environment.

**Clinical Resource Hub**

Access a comprehensive suite of evidence-based guidelines, clinical tools, and educational materials.

**CME Opportunities**

Stay at the forefront of obesity medicine with accredited continuing medical education programs.

Explore these resources and join the movement at: treatingobesityfirst.org

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## Returning to Ms. L — What Would You Do?

Recall the Clinical Picture

- PHQ-9: 14 — moderate depression, undertreated on sertraline 100 mg
- Reports loss of control eating, nighttime eating, shame
- 30 lb weight gain over 2 years
- High stress, limited coping resources

Consider: Is her current antidepressant contributing to weight gain? Does she meet criteria for BED? What would you add, change, or screen for next?

Discussion: What Would You Do Now?

- → Re-evaluate adequacy of depression treatment — consider switching or augmenting sertraline
- → Formally screen for BED using the 3-question tool or structured instrument
- → Assess whether bupropion is appropriate as a weight-conscious antidepressant alternative
- → Refer to psychology/CBT if BED is confirmed

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## Clinical Pearls: Summary

01

**Screen Mood at Every Obesity Visit**

Use PHQ-9 routinely — depression is prevalent, underdetected, and treatable.

02

**Screen for BED Before Pharmacotherapy**

Undiagnosed BED changes the treatment approach — do not initiate weight loss medications without ruling it out.

03

**Choose Weight-Conscious Antidepressants**

Be intentional: prefer bupropion, avoid paroxetine and mirtazapine when metabolic risk is present.

04

**Monitor Psychiatric Symptoms During Weight Loss**

GLP-1s and aggressive therapy can unmask mood symptoms — build check-ins into follow-up.


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> "Treating obesity requires addressing both metabolism *and* the brain."

Effective obesity care in the ambulatory setting demands integration of psychiatric screening, weight-conscious prescribing, and stigma-aware communication. Neither metabolic nor mental health goals are achievable in isolation.

## Thank You — Questions Welcome

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