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Suicide Risk and Self-Harm Among Bariatric Surgery Candidates: A Cross-Sectional Study

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ABSTRACT

Background: This cross-sectional study examined the frequency of lifetime suicidal ideation, suicide attempts, and nonsuicidal self-injury (NSSI), and factors associated with lifetime suicidal ideation among candidates for bariatric surgery.

Methods: Seventy consecutive adults referred for psychiatric evaluation before a planned bariatric procedure underwent a DSM-5-based unstructured clinical interview and completed standardized measures of suicide-related behaviors, depressive and anxiety symptoms, eating behavior, and self-injury. Group comparisons and exploratory multivariable logistic regression analyses were performed.

Results: Lifetime suicidal ideation was reported by 22 participants (31.4%), and 11 (15.7%) reported a history of NSSI. Psychiatric disorders were identified in 21 participants (30.0%). In the exploratory multivariable model, unemployment (odds ratio [OR], 6.17; 95% CI, 1.63–23.38), medical comorbidity (OR, 3.41; 95% CI, 1.03–11.30), and emotional eating (OR per unit increase, 1.73; 95% CI, 1.04–2.87) remained associated with lifetime suicidal ideation.

Conclusion: Lifetime suicidal ideation, NSSI, and psychiatric morbidity were common in this single-center sample. Unemployment, medical comorbidity, and emotional eating were associated with lifetime suicidal ideation in an exploratory model. These findings support comprehensive psychiatric assessment before bariatric surgery and require confirmation in larger prospective studies.

Keywords: bariatric surgery; obesity; suicide risk; self-harm; psychiatric evaluation

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INTRODUCTION

Obesity is a major global public health challenge.[1] Although lifestyle modification and pharmacological treatment remain first-line approaches, their long-term effectiveness may be limited. Bariatric surgery is an established treatment for severe obesity, generally defined as body mass index (BMI) ≥40 kg/m^2 or ≥35 kg/m^2 with obesity-related comorbidities.[2] Bariatric surgery candidates constitute a clinically distinct subgroup with high rates of psychiatric morbidity.[3,4] Evidence suggests a bidirectional relationship between obesity and mental health: obesity may worsen psychiatric symptoms, while conditions such as depression and disordered eating may contribute to metabolic dysregulation and further weight gain.[5-7]

A meta-analysis of 65,363 patients found that depression was present in 19% of bariatric surgery candidates, followed by binge-eating disorder (17%), anxiety disorders (12%), and suicidal ideation or behavior (9%).[3] Longitudinal studies have also reported an elevated rate of suicide and self-harm after bariatric surgery.[4,8,9] Proposed explanations include postoperative changes in coping, alcohol use, and body-image expectations.[10,11] Preoperative psychopathology appears to be an important correlate of postoperative self-harm and suicide, particularly when mood and eating disorders remain untreated.[4,12,13] In a nationwide cohort, most postoperative self-harm events occurred among patients with a documented preoperative psychiatric history.[14] Nevertheless, psychiatric assessment practices vary considerably across bariatric centers.[15]

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Preoperative psychiatric assessments often focus on identifying patients with active substance use, uncontrolled psychosis, or other clear contraindications. However, less overt concerns, including non-suicidal self-injury (NSSI), emotion-regulation difficulties, and subthreshold eating pathology, may receive less attention. Lifetime NSSI rates of up to 54% have been reported in bariatric surgery candidates, with behaviors including cutting, burning, and repetitive skin-picking.[16,17] Lifetime suicidal ideation and prior suicide attempts have also been reported in this population.[18] These rates may exceed those observed in the general population and in some other medically vulnerable groups.[19,20] Socioeconomic disadvantage, unemployment, and physical comorbidity may be relevant associated factors.[21-24]

An umbrella review found that bariatric surgery may be followed by improvement in anxiety, depression, and eating-disorder symptoms, while suicide and self-harm may remain important concerns.[25] A recent meta-analysis likewise reported a higher risk of suicide after metabolic bariatric surgery than among matched individuals with obesity who did not undergo surgery.[26] These findings suggest that bariatric surgery may be followed by improvement in some areas of obesity-related psychopathology, while the risk of suicide and self-harm may remain elevated. They support careful mental health assessment before surgery and continued follow-up after the procedure.

In Türkiye, where obesity rates have increased substantially, data on psychiatric morbidity among bariatric surgery candidates remain limited.[27] Most available evidence comes from Western populations, which may limit generalizability to sociocultural distinct settings. In addition, the absence of standardized national protocols for preoperative psychiatric assessment has contributed to variation in clinical practice.[15] Cultural factors, including mental health stigma, family dynamics, and gender roles, may influence disclosure of suicidal thoughts and help-seeking behavior.[28,29]

MAIN POINTS

- Lifetime suicidal ideation was reported by 31.4% of participants, and 15.7% reported a history of non-suicidal self-injury.
- Unemployment, medical comorbidity, and emotional eating were associated with lifetime suicidal ideation in an exploratory multivariable model.
- Psychiatric disorders were identified in 30.0% of candidates during the preoperative assessment.
- These findings support comprehensive assessment of lifetime suicidality, self-harm, psychiatric disorders, and eating-related difficulties before bariatric surgery.

This study examined the frequency and correlates of suicide-related behaviors and self-harm in a Turkish cohort referred for bariatric surgery. Using DSM-5 diagnostic criteria and validated assessment instruments, the study had two objectives:

1. To estimate the frequency of lifetime suicidal ideation, suicide attempts, and NSSI among candidates for bariatric surgery.

2. To examine sociodemographic, medical, and psychological variables associated with lifetime suicidal ideation.

The study was intended to provide descriptive and exploratory evidence that may inform psychiatric assessment before bariatric surgery. Because of its cross-sectional design, it was not designed to evaluate the effect of psychiatric screening on later morbidity or intervention outcomes.

MATERIALS AND METHODS

Study Design and Participants

This cross-sectional descriptive study was conducted at Düzce University Faculty of Medicine between September 14, 2020, and May 31, 2021. The study population comprised consecutive patients referred by the obesity center for psychiatric evaluation before a planned bariatric surgery. Inclusion criteria were: (1) age 18 years or older; (2) eligibility for bariatric surgery (BMI ≥40 kg/m^2 or ≥35 kg/m^2 with an obesity-related comorbidity); (3) ability to understand and complete the study measures; and (4) provision of written informed consent. Exclusion criteria were active psychosis, severe cognitive impairment, or inability to communicate in Turkish. During the study period, 71 patients were assessed for eligibility; one was excluded because of a language barrier, resulting in a final sample of 70 participants. Of the 70 participants, 69 were subsequently scheduled for bariatric surgery, while one was scheduled for intragastric botulinum toxin injection. One participant with mild intellectual disability was included, as it did not affect decision-making capacity.Participant selection and inclusion are summarized in Figure 1.

Ethical Approval

The study protocol was approved by Düzce University Non-Interventional Health Research Ethics Committee (Approval No. 2020/200; September 7, 2020). All participants provided written informed consent after receiving detailed information about the study purpose and procedures. The study was conducted in accordance with the Declaration of Helsinki.

Assessment Tools

Clinical Psychiatric Evaluation

A DSM-5-based, unstructured clinical diagnostic interview was conducted by a board-certified psychiatrist.[30] The evaluation included:

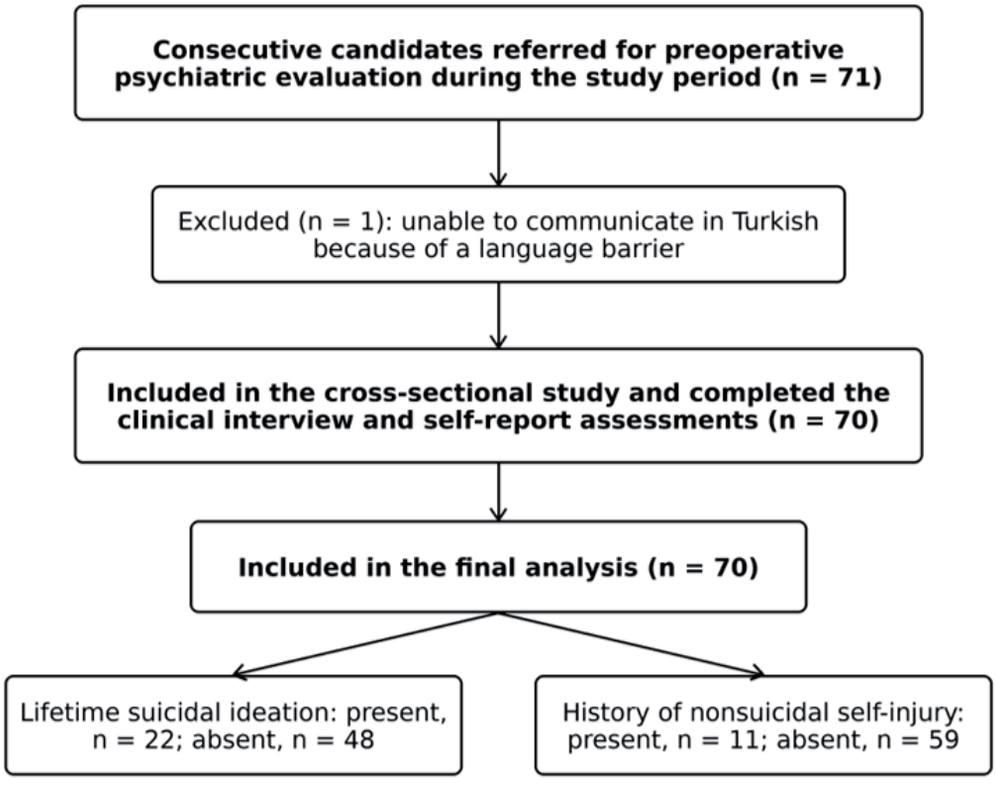

Figure 1. Participant flow diagram. Seventy-one consecutive candidates were assessed during the study period. One patient was excluded because of a language barrier. The final cross-sectional analysis included 70 participants. Outcome classifications were not mutually exclusive.

• Lifetime and current psychiatric disorders (e.g., depressive disorders, anxiety disorders, obsessive-compulsive disorder, substance use disorders).

• History of suicidal ideation, suicide attempts, and non-suicidal self-injury (ISAS).

• Medical comorbidities: Medical comorbidity was coded as present when at least one documented chronic medical condition, including diabetes, hypertension, cardiovascular disease, or another physician-diagnosed chronic condition, was recorded.

Sociodemographic and Clinical Data Form

A researcher-developed form collected:

• Sociodemographics: Age, gender, marital status, education level, occupation, monthly income, residence (urban/rural), cohabitation status. Participants self-reported their income level on a 5-point scale (1=Very Insufficient to 5=Very Good). Based on these responses, Socioeconomic Status was trichotomized: scores of 1–2 were defined as 'Low' 3 as 'Middle', and 4-5 as 'High'.

• Medical and surgical history: Chronic diseases, medications, previous surgeries.

• Health behaviors: Smoking, alcohol consumption, substance use, physical activity frequency.

• Trauma and Self-Harm History: Childhood trauma, adverse life events, lifetime suicide attempts, and self-harm behaviors were assessed using study-specific, non-standardized self-report items, rather than a validated scale.

Columbia Suicide Severity Rating Scale (C-SSRS)

The Columbia-Suicide Severity Rating Scale (C-SSRS) Baseline Version, adapted into Turkish by Kılınçaslan et al. from the original version developed by Posner et al., was used to assess lifetime suicidal ideation and suicide attempts. The validity and reliability of this Turkish version were established by Kılınçaslan et al. (2019) in an adolescent sample.[31]

• Suicidal Ideation: Severity graded 1–5 (1 = passive death wish; 5 = active planning with intent). Lifetime suicidal ideation was classified as present when the participant endorsed any C-SSRS lifetime suicidal ideation category from 1 to 5.

• Nonsuicidal Self-Injury: The clinical interview and Inventory of Statements About Self-Injury (ISAS) were used to identify a lifetime history of NSSI; the C-SSRS was not used as the primary NSSI classification instrument.

Inventory of Statements About Self-Injury (ISAS)

The Turkish adaptation of the Inventory of Statements About Self-Injury was used to assess 12 NSSI behaviors, including self-cutting, self-hitting, and hair-pulling, together with their functional correlates.[32]

Beck Depression Inventory (BDI)

A 21-item self-report scale measuring depressive symptom severity (range: 0–63). The Turkish version, validated by Hisli, uses a cutoff score of ≥17 for clinical depression.[33]

Beck Anxiety Inventory (BAI)

A 21-item scale assessing anxiety symptom severity (range: 0–63). The Turkish adaptation by Ulusoy et al.[34] demonstrated high reliability (Cronbach's α = 0.93).

Dutch Eating Behavior Questionnaire (DEBQ)

This 33-item questionnaire evaluated three eating behavior domains: emotional eating, external eating, and restrained eating. The Turkish validation by Bozan et al.[35] showed good internal consistency (α = 0.81–0.94).

Eating Disorder Examination Questionnaire (EDE-Q)

A 28-item scale assessing eating pathology across four subscales: restraint, eating concern, weight concern, and shape concern. The Turkish version, validated by Yucel et al.[36], uses a global score range of 0–6. For descriptive reporting, "binge-eating symptoms present" was based on recurrent binge-eating symptoms documented during the DSM-5-based clinical interview and did not denote a separate DSM-5 diagnosis unless full diagnostic criteria were met.

Night Eating Questionnaire (NEQ)

A 14-item scale screening for night eating syndrome, validated in Turkish by Atasoy et al.[37] with a cutoff score of ≥18.

Statistical Analysis

Data were analyzed using IBM SPSS Statistics, version 25.0 (IBM Corp, Armonk, NY, USA). Continuous variables are presented as mean ± standard deviation or median (interquartile range), as appropriate, and categorical variables as number and percentage. Participants were grouped according to lifetime suicidal ideation (present, n = 22; absent, n = 48) and NSSI history (present, n = 11; absent, n = 59). Distributional assumptions were examined using the Kolmogorov-Smirnov and Shapiro-Wilk tests and visual inspection of histograms and Q–Q plots.

Continuous variables were compared using the Mann-Whitney U test when nonparametric analysis was indicated. Categorical variables were compared using Pearson chi-square, Fisher exact, or Fisher-Freeman-Halton tests, as appropriate, with Bonferroni-adjusted post hoc comparisons when required.

No formal a priori sample-size calculation was performed because all consecutive eligible patients evaluated during the predefined recruitment period were included. Six variables associated with lifetime suicidal ideation in univariable analyses—unemployment, medical comorbidity, BDI score, EDE-Q global score, DEBQ emotional-eating score, and NEQ morning-anorexia score—were entered into an exploratory backward Wald logistic regression model. Because only 22 participants reported lifetime suicidal ideation, the initial model had a low event-to-predictor ratio and was vulnerable to overfitting, unstable variable selection, and inflated effect estimates.[38] Odds ratios (ORs) and 95% confidence intervals (CIs) are therefore reported as hypothesis-generating associations rather than validated predictors. The univariable analyses were exploratory, and no global multiplicity adjustment was applied; the corresponding P values should be interpreted as nominal. There were no missing data for variables included in the descriptive and regression analyses. Model classification accuracy was not used as evidence of predictive performance.

RESULTS

Sociodemographic and Clinical Characteristics

A total of 70 participants were included in the study. The mean age was 35.4 ± 10.2 years, 68.6% of participants were female, and the mean BMI was 44.7 ± 6.1 kg/m^2. Sociodemographic and clinical characteristics are summarized in Table 1.

Psychiatric disorders were identified in 21 participants (30.0%); the diagnostic distribution is presented in Table 2.

Suicidal Ideation and Attempts

Lifetime suicidal ideation was reported by 22 participants (31.4%). No participant endorsed current active suicidal ideation at the time of the preoperative assessment.

Two participants (2.9%) reported a lifetime suicide attempt. Both attempts involved medication overdose and had occurred several years before the evaluation; these cases are described only descriptively because of the very small number.

Inventory of Statements About Self-Injury (ISAS)

A history of NSSI was reported by 11 participants (15.7%; Table 2).

Factors Associated With Lifetime Suicidal Ideation

Shapiro–Wilk test results indicated that the distributions of age, body mass index (BMI), Beck Depression Inventory (BDI) total score, Eating Disorder Examination Questionnaire (EDE-Q) global score, Dutch Eating Behavior Questionnaire (DEBQ) emotional eating subscale score, and Night Eating Questionnaire (NEQ) morning anorexia subscale score deviated significantly from normality in at least one of the

Table 1. *Sociodemographic and Clinical Characteristics of Participants*

Variable	Value, n (%) or mean ± SD
Planned Intervention	Sleeve gastrectomy (62), Gastric bypass (3), Revision surgery (4), Intragastric botulinum toxin injection (1)
Gender	Male (22, 31.4%), Female (48, 68.6%)
Residence	Rural (11, 15.7%), Urban (59, 84.3%)
Marital Status	Single (22, 31.4%), Married (43, 61.4%), Widowed (2, 2.9%), Other or not reported (3, 4.3%)
Age	35.4 ± 10.2 years (range: 19–58)
Education	11.2 ± 3.1 years (range: 5–18)
BMI	44.7 ± 6.1 kg/m² (range: 35.2–63.4)
Regular Physical Activity	No (47, 67.1%), Yes (23, 32.9%)
Socioeconomic Status	Low (9, 12.9%), Middle (35, 50.0%), High (26, 37.1%)
Employment Status	Employed (30, 42.9%), Unemployed (33, 47.1%), Retired (7, 10.0%)
Family Psychiatric History	Yes (16, 22.9%), No (54, 77.1%)
Medical Comorbidities	Yes (29, 41.4%), No (41, 58.6%)
Adverse Life Events	Yes (50, 71.4%), No (20, 28.6%)

BMI, body mass index. The available dataset did not permit further disaggregation of the "other or not reported" marital-status category.

Table 2. *Psychiatric Diagnoses and Behavioral Characteristics*

Variable	Value, n (%)
Primary Psychiatric Diagnosis	None (49, 70.0%), Major depression (6, 8.6%), Anxiety disorders (6, 8.6%), OCD (4, 5.7%), Bipolar disorder (1, 1.4%), Alcohol use disorder (1, 1.4%), ADHD (1, 1.4%), Mild intellectual disability (1, 1.4%), Adjustment disorder (1, 1.4%)
Lifetime Suicidal Ideation (C-SSRS)	Present (22, 31.4%), Absent (48, 68.6%)
Suicide Attempt History	Present (2, 2.9%), Absent (68, 97.1%)
ISAS	Present (11, 15.7%), Absent (59, 84.3%)
Screening and Symptom Measures	BDI ≥17 (22, 31.4%), BAI ≥16 (27, 38.6%), binge-eating symptoms present (23, 32.9%), NEQ ≥18 (40, 57.1%)

OCD, obsessive-compulsive disorder; ADHD, attention-deficit/hyperactivity disorder; C-SSRS, Columbia-Suicide Severity Rating Scale; BDI, Beck Depression Inventory; BAI, Beck Anxiety Inventory; NEQ, Night Eating Questionnaire; ISAS, Inventory of Statements About Self-Injury; "Binge-eating symptoms present" was based on recurrent symptoms documented during the DSM-5-based clinical interview and was not treated as a separate diagnosis unless full criteria were met.

lifetime suicidal ideation groups ($P < .05$ for each). Consequently, these continuous variables were compared using the Mann–Whitney U test and are presented as median (interquartile range).

No significant differences were observed between participants with and without lifetime suicidal ideation in terms of age, gender, BMI, marital status, or education ($P > .05$ for all). In univariable comparisons, participants with lifetime suicidal ideation had significantly higher scores on

the BDI (median 14 (IQR 16) vs. 8 (IQR 12); *P* = .033), EDE-Q global (2.6 (IQR 1.2) vs. 1.8 (IQR 1.4); *P* = .033), DEBQ emotional eating (3.2 (IQR 2) vs. 2.2 (IQR 2); *P* = .026), and NEQ morning anorexia (6 (IQR 3) vs. 4 (IQR 4); *P* = *.032) (Table 3)*. These variables were entered as candidate predictors into the exploratory multivariable logistic regression model (Table 3).

Exploratory Logistic Regression Analysis

In the exploratory backward Wald logistic regression model (likelihood-ratio x^2 = 18.07; *P* = .001; Nagelkerke R^2 = .32), unemployment, medical comorbidity, and emotional eating were retained as variables associated with lifetime suicidal ideation (Table 4). The estimates were imprecise, with wide 95% CIs, and the model was not internally or externally validated. These findings should not be interpreted as stable predictors or causal risk factors.

DISCUSSION

In this single-center cross-sectional study, lifetime suicidal ideation, NSSI, and psychiatric disorders were frequently reported among candidates for bariatric surgery. Unemployment, medical comorbidity, and emotional eating were associated with lifetime suicidal ideation in an exploratory multivariable analysis.[16-18,39] These findings add descriptive data from a Turkish clinical sample but do not establish causal or prospective risk relationships.

Although no participant endorsed current active suicidal ideation at the time of assessment, 31.4% reported lifetime suicidal ideation and 15.7% reported a history of NSSI. This difference illustrates the limitation of relying solely on the current mental-state examination and supports obtaining a comprehensive lifetime history of suicide-related thoughts and self-harm.

Emotional eating remained associated with lifetime suicidal ideation in the exploratory model. This finding may reflect a broader relationship between affect-regulation difficulties, eating behavior, and suicidality; however, the cross-sectional design does not establish directionality.[40,41] Unemployed participants had approximately six times the odds of lifetime suicidal ideation, but the confidence interval was wide, indicating substantial uncertainty. The association should therefore be interpreted as hypothesis-generating rather than predictive.[42,43]

Table 3. *Psychological Scale Scores According to Lifetime Suicidal Ideation Status*

Variable	Lifetime suicidal ideation present, n = 22 Median (IQR)	Lifetime suicidal ideation absent, n = 48 Median (IQR)	*P*
BDI score	14 (16)	8 (12)	.033
Global score of EDE-Q	2.6 (1.2)	1.8 (1.4)	.033
Emotional eating subscale score of DEBQ	3.2 (2)	2.2 (2)	.026
Morning anorexia subscale score of NEQ	6 (3)	4 (4)	.032

IQR, interquartile range; BDI, Beck Depression Inventory; EDE-Q, Eating Disorder Examination Questionnaire; DEBQ, Dutch Eating Behavior Questionnaire; NEQ, Night Eating Questionnaire.

Table 4. *Exploratory Logistic Regression Model for Lifetime Suicidal Ideation*

Variable	B	SE	Wald x^2	*P*	OR (95% CI)
Employment status (overall)			7.91	.019	
Unemployment	1.82	0.68	7.16	.007	6.17 (1.63-23.38)
Retired	0.23	1.30	0.03	.857	1.26 (0.10-16.09)
Medical comorbidity	1.23	0.61	4.07	.044	3.41 (1.03-11.30)
Emotional eating (DEBQ)	0.55	0.26	4.41	.036	1.73 (1.04-2.87)

B, unstandardized regression coefficient; CI, confidence interval; DEBQ, Dutch Eating Behavior Questionnaire; OR, odds ratio; SE, standard error. Reference categories were employed status for employment and absence of medical comorbidity. The model was exploratory and vulnerable to overfitting because it was based on 22 outcome events and six initial candidate variables.
Model fit: likelihood-ratio x^2 = 18.07, P = .001; Nagelkerke R^2 = .32; Hosmer-Lemeshow x^2 = 5.17, P = .740. Apparent classification accuracy was not interpreted as evidence of predictive performance.

The findings suggest that psychiatric assessment before bariatric surgery may benefit from including a lifetime history of suicidality and NSSI, together with assessment of current psychiatric symptoms, medical burden, and eating-related difficulties. The present study did not test whether screening or intervention reduces suicide risk or improves later outcomes.

The 31.4% prevalence of lifetime suicidal ideation was broadly consistent with estimates reported in some bariatric cohorts.[5,17,18,44,45] The NSSI prevalence in this study (15.7%) was lower than the 54% reported by Sansone et al.[16] The lower estimate may reflect differences in sample characteristics, measurement methods, or willingness to disclose self-injury across settings.

The lack of association between BMI and lifetime suicidal ideation contrasts with studies linking higher BMI to suicidality.[44,46-48] This may reflect the restricted BMI range in a sample with severe obesity. Medical comorbidity, but not BMI, was associated with lifetime suicidal ideation in the exploratory model (OR, 3.41; 95% CI, 1.03–11.30), aligning with evidence that chronic illness burden, not weight per se, is associated with suicidal behavior.[49,50]

Limitations and Methodological Considerations

The study has several limitations that should be acknowledged. First, the cross-sectional design prevents causal inferences, and longitudinal studies are necessary to examine post-surgical suicide risk trajectories over time. Second, the small sample size limits statistical power, particularly in detecting differences in rare outcomes such as suicide attempts. The multivariable findings for lifetime suicidal ideation are therefore exploratory and may be affected by overfitting. Only two participants reported a lifetime suicide attempt, precluding meaningful inferential analysis of this outcome. Third, despite the use of clinical interviews based on DSM-5 criteria, self-report measures may introduce bias due to socially desirable responding, potentially leading to underestimation of self-harm behaviors. Besides, although the C-SSRS Turkish version used in this study was adapted and validated in an adolescent sample by Kılınçaslan et al., its psychometric properties in adult bariatric surgery populations have not been specifically examined. Fourth, the absence of a control group consisting of non-surgical obese individuals makes it difficult to determine whether the observed risks are specific to bariatric surgery or related to obesity itself.

However, the study also has methodological strengths, including the use of DSM-5 diagnostic criteria and validated assessment tools such as the Columbia-Suicide Severity Rating Scale and Inventory of Statements About Self-Injury, which enhance diagnostic accuracy and help mitigate concerns regarding self-report limitations.

Conclusion

In this single-center cross-sectional sample, lifetime suicidal ideation, NSSI, and psychiatric morbidity were common among candidates for bariatric surgery. Unemployment, medical comorbidity, and emotional eating were associated with lifetime suicidal ideation in an exploratory model. These findings support comprehensive preoperative psychiatric assessment, including lifetime suicidality, self-harm, psychiatric symptoms, medical burden, and eating-related difficulties. Larger prospective studies are needed to confirm the observed associations and determine their relevance to postoperative outcomes.

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Ethics Committee Approval: The study protocol was approved by the Düzce University Non-Interventional Health Research Ethics Committee (Approval No. 2020/200; September 7, 2020), and the study was conducted in accordance with the Declaration of Helsinki.

Informed Consent: All participants provided written informed consent after receiving detailed information about the study purpose and procedures.

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Data Availability Statement: De-identified data that support the findings of this study may be available from the corresponding author upon reasonable request, subject to ethics committee and institutional approval.

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