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EDITORIAL

Implications of new diagnostic criteria for obesity on mental health comorbidities

Implicancias de los nuevos criterios diagnósticos de obesidad sobre las comorbilidades en salud mental

Julio Torales[1,2,3], Marcelo O´Higgins[1], Tomás Caycho-Rodríguez[4], Antonio Ventriglio[5], João Mauricio Castaldelli-Maia[6], Iván Barrios[3,7]

[1] Universidad Nacional de Asunción, Facultad de Ciencias Médicas, Grupo de Investigación sobre Epidemiología de los Trastornos Mentales, Psicopatología y Neurociencias, San Lorenzo, Paraguay.
[2] Vicerrectoría de Investigación y Postgrado, Universidad de Los Lagos, Osorno, Chile.
[3] Universidad Sudamericana, Facultad de Ciencias de la Salud, Pedro Juan Caballero, Paraguay.
[4] Universidad Científica del Sur, Lima, Perú.
[5] University of Foggia, Department of Clinical and Experimental Medicine, Foggia, Italy.
[6] University of São Paulo, Department of Psychiatry, São Paulo, SP, Brazil.
[7] Universidad Nacional de Asunción, Facultad de Ciencias Médicas, Filial Santa Rosa del Aguaray, Cátedra de Metodología de la Investigación, Santa Rosa del Aguaray, Paraguay.

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Corresponding author
Iván Barrios
Universidad Nacional de Asunción, Paraguay
jbarrios@fcmuna.edu.py

Responsible Editor
Iván Barrios, PhD
Universidad Nacional de Asunción, San Lorenzo, Paraguay.

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INTRODUCTION: FROM BODY MASS INDEX TO CLINICAL OBESITY

A recent report published by *The Lancet Diabetes & Endocrinology* Commission entitled *Definition and diagnostic criteria of clinical obesity* (2025) represents a major conceptual shift in how obesity is defined and understood. Moving beyond the long-standing reliance on body mass index (BMI), the Commission proposes a framework that conceptualizes obesity as a multifactorial, chronic, and systemic disease, emphasizing its functional, metabolic, and organ-specific consequences rather than body size alone (1). This reconceptualization has profound implications not only for medical practice but also for mental health research and care.

For decades, BMI has served as the primary diagnostic proxy for obesity despite well-documented limitations. BMI does not capture body composition, fat distribution, metabolic heterogeneity, or psychosocial burden. Individuals with elevated BMI may present preserved physical and mental functioning, whereas others with lower BMI values may experience marked psychological distress and functional impairment related to adiposity. Consequently, the exclusive use of BMI has often obscured clinically meaningful subgroups and contributed to both underdiagnosis and overmedicalization.

By prioritizing disease impact over numerical thresholds, the concept of “clinical obesity” allows for a more nuanced understanding of obesity and its associated comorbidities. Importantly, this shift provides a valuable opportunity to integrate mental health more explicitly into obesity assessment and management, acknowledging that psychological distress may be both a consequence and a constituent dimension of the disease.

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MENTAL HEALTH COMORBIDITIES UNDER THE NEW DIAGNOSTIC FRAMEWORK

The association between obesity and mental disorders has been consistently demonstrated across epidemiological studies and clinical populations. Depression and anxiety disorders, in particular, are more prevalent among individuals with obesity, although effect sizes vary and bidirectionality is common (2,3). Longitudinal evidence suggests that obesity increases the risk of subsequent depression, while depression may also predict future weight gain and obesity (4,5).

Crucially, these associations are not adequately explained by BMI alone. Psychological burden appears to be more strongly linked to functional impairment, chronic stress, comorbid medical conditions, and social marginalization than to body size per se. The new diagnostic framework, by emphasizing functional and systemic consequences, allows clinicians to identify individuals at heightened risk of mental health comorbidities even when BMI-based classifications would suggest otherwise.

The introduction of the concept of “preclinical obesity” is particularly relevant from a mental health perspective. Individuals with excess adiposity but without overt organ dysfunction may nonetheless experience early psychological symptoms, internalized stigma, emotional dysregulation, and maladaptive coping strategies. Identifying these individuals creates opportunities for early, preventive interventions that may mitigate both mental and physical disease progression.

From a behavioral perspective, emotional eating and maladaptive coping strategies represent important pathways through which psychological distress may contribute to obesity onset and progression. These patterns are particularly relevant within the framework of clinical and preclinical obesity, as they often precede overt metabolic dysfunction and are closely associated with anxiety and depressive symptoms (6).

SHARED BIOLOGICAL AND PSYCHOSOCIAL MECHANISMS

Obesity and mental disorders share several biological pathways that extend beyond behavioral explanations. Chronic low-grade inflammation, dysregulation of the hypothalamic–pituitary–adrenal axis, insulin resistance, and alterations in neuroendocrine signaling have all been implicated in both obesity and mood disorders (7,8). These mechanisms contribute to fatigue, cognitive impairment, sleep disturbances, and emotional dysregulation, reinforcing a bidirectional relationship between metabolic and mental health conditions.

Beyond inflammatory and neuroendocrine pathways, chronic psychosocial stress has been identified as a central mechanism linking obesity and mental disorders. Stress-related processes influence eating behavior, metabolic regulation, and emotional functioning, contributing to a self-perpetuating cycle between psychological distress and adiposity, even in the absence of overt metabolic complications (9).

Psychosocial mechanisms are equally central. Individuals with obesity are frequently exposed to weight-based discrimination in healthcare settings, workplaces, educational environments, and interpersonal relationships. This persistent exposure to stigma acts as a chronic stressor and is associated with depression, anxiety, disordered eating, and avoidance of medical care (10,11). Importantly, stigma-related harm occurs independently of BMI and is often driven by social perceptions rather than objective health status.

WEIGHT STIGMA, DIAGNOSTIC LABELS, AND PSYCHOLOGICAL BURDEN

Weight stigma remains one of the most prevalent and socially tolerated forms of discrimination. Extensive research has shown that weight stigma exacerbates psychological distress, undermines self-esteem, and negatively affects treatment adherence and health behaviors (12). In this context, redefining obesity as a multifactorial disease rather than a personal failure has the potential to reduce blame-based narratives and foster more compassionate care.

However, diagnostic labels themselves can carry psychological consequences. The implementation of the "clinical obesity" diagnosis must therefore be accompanied by careful, patient-centered communication to avoid unintended effects such as increased anxiety or identity-based distress. Mental health professionals play a crucial role in supporting individuals as they interpret and integrate diagnostic information, particularly in societies where weight-related stigma is deeply entrenched.

IMPLICATIONS FOR CLINICAL PRACTICE AND INTEGRATED CARE

The adoption of the new diagnostic criteria encourages a shift toward integrated, person-centered care models that address both physical and mental health dimensions of obesity. Rather than focusing exclusively on weight loss, treatment goals can be reframed to prioritize functional improvement, psychological well-being, and quality of life.

Integrated care models combining medical, nutritional, and psychological interventions have demonstrated superior outcomes compared with isolated approaches (13). Routine screening for depression, anxiety, stress, and disordered eating should become standard practice in obesity care, particularly for individuals meeting criteria for clinical obesity or exhibiting early functional impairment. Conversely, mental health services should consider obesity-related factors that may influence symptom presentation, pharmacological choices, and treatment response.

The concept of preclinical obesity further underscores the importance of early intervention. Psychosocial support, lifestyle counseling, and stigma-sensitive care at this stage may prevent the progression of both metabolic and mental health complications, aligning with preventive psychiatry and stepped-care models (14).

PUBLIC HEALTH AND POLICY IMPLICATIONS

Beyond individual clinical practice, the new diagnostic framework has important public health implications. Recognizing obesity as a systemic disease may facilitate more equitable allocation of healthcare resources, including funding for mental health services tailored to this population. It also aligns with precision medicine approaches, emphasizing individualized assessment rather than one-size-fits-all interventions (15).

Public health strategies informed by this framework can more effectively address upstream determinants of both obesity and mental disorders, such as socioeconomic inequality, food insecurity, urban environments, and access to care. Integrating mental health promotion into obesity prevention programs may reduce long-term disease burden and improve population-level outcomes.

FUTURE DIRECTIONS AND RESEARCH PRIORITIES

The implementation of the new diagnostic criteria raises several research questions. Longitudinal studies are needed to assess how classifications of clinical and preclinical obesity predict mental health trajectories, treatment outcomes, and quality of life. Cross-cultural validation is also essential, as experiences of obesity, stigma, and mental illness vary substantially across sociocultural contexts.

Further research should explore how these criteria can be operationalized within mental health services and how interdisciplinary collaboration can be optimized. Incorporating patient-reported outcomes, particularly measures of psychological well-being and perceived stigma, will be critical to ensuring that the framework translates into meaningful improvements in care.

CONCLUSION

The updated diagnostic criteria for obesity represent a paradigm shift with substantial implications for mental health. By moving beyond BMI and emphasizing functional and systemic impact, the concept of clinical obesity offers a more nuanced and humane framework that aligns closely with contemporary models of integrated care. Its successful implementation will depend on interdisciplinary collaboration, stigma-sensitive practice, and a sustained commitment to patient-centered approaches. Bridging the gap between obesity management and mental health care is not only desirable but essential for improving outcomes for individuals living with obesity.

REFERENCES

1. Rubino F, Cummings DE, Eckel RH, Cohen RV, Wilding JPH, Brown WA, et al. Definition and diagnostic criteria of clinical obesity. Lancet Diabetes Endocrinol. 2025;13(3):221-262. https://doi.org/10.1016/S2213-8587(24)00316-4
2. Simon GE, Von Korff M, Saunders K, Miglioretti DL, Crane PK, van Belle G, Kessler RC. Association between obesity and psychiatric disorders in the US adult population. Arch Gen Psychiatry. 2006;63(7):824-30. https://doi.org/10.1001/archpsyc.63.7.824
3. Scott KM, Bruffaerts R, Simon GE, Alonso J, Angermeyer M, de Girolamo G, et al. Obesity and mental disorders in the general population: results from the world mental health surveys. Int J Obes (Lond). 2008;32(1):192-200. https://doi:org/10.1038/sj.ijo.0803701
4. Luppino FS, de Wit LM, Bouvy PF, Stijnen T, Cuijpers P, Penninx BW, et al. Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies. Arch Gen Psychiatry. 2010;67(3):220-9. https://doi.org/10.1001/archgenpsychiatry.2010.2
5. Faith MS, Butryn M, Wadden TA, Fabricatore A, Nguyen AM, Heymsfield SB. Evidence for prospective associations among depression and obesity in population-based studies. Obes Rev. 2011;12(5):e438-53. https://doi.org/10.1111/j.1467-789X.2010.00843.x
6. van Strien T. Causes of Emotional Eating and Matched Treatment of Obesity. Curr Diab Rep. 2018;18(6):35. https://doi.org/10.1007/s11892-018-1000-x
7. Milaneschi Y, Simmons WK, van Rossum EFC, Penninx BW. Depression and obesity: evidence of shared biological mechanisms. Mol Psychiatry. 2019;24(1):18-33. https://doi.org/10.1038/s41380-018-0017-5
8. Mansur RB, Brietzke E, McIntyre RS. Is there a "metabolic-mood syndrome"? A review of the relationship between obesity and mood disorders. Neurosci Biobehav Rev. 2015;52:89-104. https://doi.org/10.1016/j.neubiorev.2014.12.017
9. Tomiyama AJ. Stress and Obesity. Annu Rev Psychol. 2019;70:703-718. https://doi.org/10.1146/annurev-psych-010418-102936
10. Puhl RM, Heuer CA. The stigma of obesity: a review and update. Obesity (Silver Spring). 2009;17(5):941-64. https://doi.org/10.1038/oby.2008.636
11. Pearl RL. Weight bias and stigma: public health implications and structural solutions. Soc Issues Policy Rev.

2018;12(1):146–182. https://doi.org/10.1111/sipr.12043
12. Pearl RL, Puhl RM, Himmelstein MS, Pinto AM, Foster GD. Weight Stigma and Weight-Related Health: Associations of Self-Report Measures Among Adults in Weight Management. Ann Behav Med. 2020;54(11):904-914. https://doi.org/10.1093/abm/kaaa026
13. Sharma AM, Campbell-Scherer DL. Redefining obesity: Beyond the numbers. Obesity (Silver Spring). 2017;25(4):660-661. https://doi.org/10.1002/oby.21801
14. Bray GA, Heisel WE, Afshin A, Jensen MD, Dietz WH, Long M, et al. The Science of Obesity Management: An Endocrine Society Scientific Statement. Endocr Rev. 2018;39(2):79-132. https://doi.org/10.1210/er.2017-00253
15. Topol EJ. Individualized medicine from prewomb to tomb. Cell. 2014;157(1):241-53. https://doi.org/10.1016/j.cell.2014.02.012