

## User Embrace and Bonding at a Care Service for Patients with Eating Disorders

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**Abstract:** User embrace and bonding are technical and political devices that aim to guarantee qualified health care. This study aimed to assess user embrace and bonding among professionals and users at a multidisciplinary care service for people diagnosed with eating disorders. Through fourth-generation evaluation, 16 users and seven professionals were interviewed. Results were grouped in three thematic units: posture, technique and access. Data analysis, based on the dimensions mentioned, disclosed some elements that are necessary to establish user embrace and bonding: service comprehensiveness, intersectoriality, interdisciplinarity, professional training and humanization of care. It was concluded that, from the perspective of users and professionals, the service aims to offer user-centered care through procedures that prioritize the human dimension of the people who receive care, with considerable effectiveness in its actions, despite some limitations and shortages.

**Keywords:** therapeutic alliance, process assessment (health care), anorexia nervosa, bulimia, mental health services

## Acolhimento e Vínculo em um Serviço de Assistência a Portadores de Transtornos Alimentares<sup>1</sup>

**Resumo:** Acolhimento e vínculo são dispositivos técnicos e políticos que visam a garantir uma assistência qualificada em saúde. Este estudo teve por objetivo avaliar o acolhimento e o vínculo entre profissionais e usuários de um serviço de assistência multidisciplinar para pessoas diagnosticadas com transtornos alimentares. Foram entrevistados 16 usuários e sete profissionais. Foi utilizada avaliação qualitativa de quarta geração. Os resultados foram agrupados em três unidades temáticas: postura, técnica e acesso. A análise dos dados, a partir das dimensões mencionadas, evidenciou alguns elementos necessários para que o acolhimento e o vínculo no serviço se estabelecessem: integralidade no serviço, intersectorialidade, interdisciplinaridade, formação profissional e humanização da assistência. Concluiu-se que, na perspectiva de usuários e profissionais, o serviço busca oferecer um atendimento usuário-centrado por meio de procedimentos que priorizam a dimensão humana do sujeito atendido, com considerável efetividade em suas ações, apesar de algumas limitações e deficiências.

**Palavras-chave:** aliança terapêutica, avaliação de processos (cuidados de saúde), anorexia nervosa, bulimia, serviços de saúde mental

## Acogimiento y Vínculo en Grupo de Apoyo para Pacientes con Trastornos de la Conducta Alimentaria

**Resumen:** El acogimiento y el vínculo son dispositivos técnicos y políticos que visan garantizar atención calificada en salud. El estudio evaluó el acogimiento y el vínculo entre profesionales y usuarios de un grupo de atención en trastorno alimentario. Por medio de evaluación cualitativa de cuarta generación, basada en el constructivismo, fueron entrevistados 16 usuarios y siete profesionales del grupo. Los resultados fueron agrupados en tres unidades temáticas: postura, técnica y acceso. Los datos, analizados y sistematizados a partir de esas dimensiones, mostraron algunos elementos necesarios para el establecimiento del acogimiento y del vínculo en el servicio: integralidad en el servicio, intersectorialidad, interdisciplinaridad, formación profesional y humanización de la atención. Se concluye que el grupo puede ser considerado un servicio que busca una atención usuario-centrado, con considerable efectividad en sus acciones y con procedimientos que priorizan la dimensión humana del sujeto atendido, a pesar de algunas limitaciones y deficiencias.

**Palabras-Clave:** alianza terapéutica, evaluación de proceso (atención de salud), anorexia nervosa, bulimia, servicios de salud mental

Eating disorders (EDs) are behavioral syndromes that, according to the fourth revised edition of the *Diagnostic*

*and statistical manual of mental disorders* (DSM-IV-TR), include two main nosologic entities: Anorexia Nervosa (AN) and Bulimia Nervosa (BN) (American Psychiatric Association [APA], 2003).

EDs are conditions characterized by aspects like: morbid fear of gaining weight, exaggerated concern with body weight and shape, voluntary reduction of food consumption

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with progressive weight loss, massive food intake followed by vomiting and abuse of laxatives and/or diuretics (Fava & Peres, 2011).

According to the DSM-IV-TR, the diagnostic criteria for AN are: weight loss and refusal to maintain one's body weight within or above the minimum appropriate to one's age and height; morbid fear of gaining weight, even when underweight; body image disorder; and amenorrhea in post-menarche women (absence of at least three consecutive menstrual cycles).

One of the diagnostic criteria of BN relates to recurrent episodes of binge eating, followed by compensatory behaviors to avoid weight gain. Compensatory behaviors are: self-induced vomiting; abuse of laxatives, diuretics, enemas and other drugs; and excessive fasting and exercising. To diagnose BN, binge eating and compensatory behaviors need to take place twice a week during at least three months (APA, 2003). Other characteristics of this psychopathological condition are excessive concern with body shape and weight, distorted physical self-perception and difficulties to identify and deal with one's own emotions (Rosa & Santos, 2011).

EDs are considered a severe psychopathology, and mortality rates due to AN reach 5% when associated with late diagnosis and treatment (Schmidt & Mata, 2008). The origin of EDs is multi-factorial, as it can emerge from a relation between biopsychosocial and historical-cultural variables (Andrade & Santos, 2009; Rosen, 2010).

The technical-scientific concepts of "user embracement" and "bonding" are targets of the Unified Health System (SUS). They are aimed at providing a user-centered service that offers quality in the primary, secondary and tertiary health care networks, solutions to users' demands and comprehensive care to the population. In primary health care, user embracement can be grouped in three dimensions: "posture", "technique" and "access" (Silva Júnior & Mascarenhas, 2004).

Posture presupposes health professionals and the team's attitude of receiving, listening and treating users and their demands in a humane manner. Posture is also observed and necessary in health team professionals' mutual relations and among the hierarchical levels of service management. Through qualified listening and a productive dialogue, the team can establish relations that stimulate professionals and users' participation and autonomy (Silva Júnior & Mascarenhas, 2004).

Technique applied to health services equips the production of procedures and organization actions. The recovery and enhancement of teams' technical knowledge permit qualifying different health professionals' care interventions. Access, then, can be understood as the dimension that describes the potential or actual entry of a given population group into a health service delivery system. Therefore, it represents the difficulties and facilities to obtain the desired treatment and is intrinsically related to the supply

characteristics and availability of service resources (Silva Júnior & Mascarenhas, 2004).

According to Campos and Amaral (2007), the bond between professionals and patients enhances the efficacy of health actions and favors user participation during service delivery. When seeking to produce a healthy bond between professional and patient, users' autonomy and citizenship are stimulated, as subjects who participate and interfere in their own treatment. According to Silva Júnior and Mascarenhas (2004), bonding comprises three dimensions: "affection", "therapeutic relation" and "continuity". When bonding is considered as affection, it refers to the subjective domain of professionals who like their profession and take interest in the patients as persons.

The professional-patient relations, imbued with a therapeutic nature, presuppose an attitude of care, involvement and accountability, of both professionals and users, towards treatment and serious care. Continuity, within the bonding concept, is closely linked with the professional accountability sphere. It implies that health professionals guarantee the routes that are to be followed to solve the patient's problem, without any bureaucratic transfer to another decision entity or care level (Merhy et al., 1997).

The SUS makes efforts to construct healthy bonds between health professionals and service users, with a view to promising user embracement and high-quality treatment. Nevertheless, difficulties are observed in the relations between AN/BN patients and health professionals because of patients' refusal to submit to treatment (Campbell & Aulísio, 2012).

Health professionals who relate to patients with AN and BN need to be able to bear attacks on their self-esteem, mistrust, sudden worsening in pathological conditions and ED patients little cooperation with treatment (Chandler, 1998). The technical rationality implicit in professional education, in combination with the patient's resistance against treatment, is another factor that can hamper bonding between professionals and users. The technical rationality, by eliminating the subjective elements of the work process, affects the quality of health care, devitalizing the relation between professionals and users (Monteiro & Figueiredo, 2009).

Health professionals' bonding with patients diagnosed with EDs is complex and require comprehension and empathy skills from professionals. Patients need to be heard with attention and interest, without condemnations or critical judgments. Thus, professionals can establish communication, informing patients about their physical condition, the implications of this condition and the possible prognosis. In the same sense, families also need a guaranteed space where they are heard (Souza & Santos, 2012; Souza, Santos, & Scorsolini-Comin, 2009).

Although empathetic and comprehensive postures are necessary for the relation, the exhaustion and stress patients' resistance against treatment causes arouse professionals' defense mechanisms, such as the fragmentation of the

relationship between professional and patient, depersonalization, categorization and denial of the individual's importance, distancing and denial of feeling. Thus, professionals who attend to patients with EDs adhere to a discourse about the patients that is anchored in representations of lack of control, body image distortion, destructive and manipulative behavior, need, low frustration threshold and need to attract attention (Grando & Rolim, 2006).

In view of difficulties to establish a more consolidated bond between AN/BN patients and health professionals (Peres & Santos, 2011; Snell, Crowe & Jordan, 2010) and the health policy in force, which stimulates actions in which user embrace and bonding between community and service are put in practice, this study was aimed at assessing user embrace and bonding between professionals and users at a multidisciplinary care service for patients diagnosed with EDs, at a general hospital.

## Method

### Participants

The 25 professionals who were active at the service and 30 service users were recruited to participate in this research. Based on this recruitment, the stakeholders present at the service were defined who, according to Guba and Lincoln (1989), are the potential agents, victims or beneficiaries of the service. The agents are the people involved in the production and implementation of the service. Beneficiaries are all people who are somehow favored as a result of the service. Victims are people whom the service somehow impairs.

According to these criteria, the beneficiaries/victims were defined as AN and BN patients under treatment for at least one year. The stakeholder group corresponded to professionals working in the multiprofessional team of the care group under investigation. Based on the adopted method, participants under the age of 13 years were excluded, considering that they did not have the level of abstract thinking needed to participate in the adopted fourth-generation evaluation process. Mentally disabled persons with severe functional impairment, psychotic patients and other delusional personalities were also excluded. Constructions are considered delusional when they do not emerge from an interaction, but merely from the constructor's own mind (Guba & Lincoln, 1989). Hence, at the end of this selection, 16 users and seven service professionals remained who participated in the study.

### Instruments

For the purpose of this research, Guba and Lincoln's hermeneutic-dialectic circle was used (1989). According to those authors, the application of the method starts when the researcher chooses a respondent (R1) because of his/her position and distinguished function in the situation assessed. An open interview is held with R1 to determine the research

focus. The researcher "filters" the concepts, ideas, values, problems and questions that emerged in this interview, who analyzes it and issues a construction (C1). In the subsequent interview with respondent (R2), room is given for him/her to talk openly about the research situation, after with the researcher presents C1 through the interview with R1. Thus, R2 can confront his/her impressions with those issued in C1. In the interview with respondent 3 (R3), who will talk first about the proposed theme, after the open conversation, constructions C1 and C2 will be confronted. This process takes place in the other interviews.

### Procedure

**Data collection.** After the research received Institutional Review Board approval, the researcher started her observation in the service to get accustomed to the organizational dynamics and activities offered. After this phase, the interviews with the interest groups started through Guba and Lincoln's hermeneutic-dialectic cycle (1989). The interest group beneficiaries/victims was the first to be interviewed. When the hermeneutic-dialectic cycle was established, two questions were asked: (1) "How do you consider the way the hospital attends to and welcomes service users?" and (2) "How do you assess the relation between the professionals and hospital patients?". After completing the hermeneutic-dialectic cycle with the patient group, the same procedure was applied to the group of professionals (stakeholder interest group).

**Data analysis.** For data analysis, thematic units were used to group the constructions of meaning deriving from Guba and Lincoln's hermeneutic-dialectic cycle. According to Minayo (2010), thematic units are groups of elements, ideas or expressions around a concept, which are used to establish classifications. Thus, the evaluator looked for thematic units that would group and summarize the data that emerged in the interviews with the interest groups, in order to articulate the data with the theoretical frameworks and answer the study questions based on the proposed objectives.

### Ethical Considerations

The study received approval from the Institutional Review Board for Research Involving Human Beings at the University of São Paulo at Ribeirão Preto Medical School *Hospital das Clínicas* (Process 2077/2008), 2020 and participants agreed to participate by signing the Informed Consent Term.

## Results

The results found were distributed in three thematic units: posture, technique and access. The most relevant data with regard to posture (first thematic unit) show that the user-user relation can negatively influence treatment, due to conversations about diet changes and use of purgatives,

which take place among users while awaiting consultations. When directed in a psychological support group for patients held at the service, however, the relation among users showed to be an important resource for coping with ED, in accordance with Report 1.

Report 1: [...] *the group is a mirror, you see? It also serves for you to get to know the patients and see each person's reality of life. This reality of life, you can also see what you gained, what you didn't have. That helps you with your treatment.* (User 13)

Regarding the relation among professionals, the posture revealed that these stakeholders communicate well among themselves, which facilitates teamwork and the production of problem-solving actions in response to users' demands. Nevertheless, difficulties are observed in the hospital team's communication and relation with some professional, with are more oriented towards a biomedical care view, and which therefore often show to be inapt for the required interdisciplinary work process, as observed in Report 2.

Report 2: [...] *I think that dietician and psychologist get along better. I think we are more open to psychologists. Sometimes with doctors, I think it's a bit more difficult, also because of the look. I think we try to adopt a more comprehensive, not just organic look.* (Professional 7)

The posture involved in the relation between professional and users seems to take an empathetic form with rooms for negotiation and dialogue, disclosing the requisites of affection and therapeutic relationship, necessary to establish a consolidated bond. Shortages in some professionals' academic background, however, highly restricted to a biomedical conception of health and inapt to address patients' mental and social dimensions, hamper the accomplishment of professional-user bonding. Also, as perceived, bonding between professionals and users at this service takes place slowly and gradually, as room needs to be created to contain recently hospitalized patients' anguish, fears and doubts.

The reliability network between professionals and users develops gradually, which allows the latter to stop boycotting treatment or "infringing on" the bond established with professionals. When considering the perceived weakness in bonding, however, the turnover revealed at the service, as part of a teaching institution, with trainees and residents who will soon close off their education phase, hampers users' bonding with treatment. Also, the constitution of the professional team, with most professionals acting on a voluntary base, further raises the limits for users' bonding with the service, in accordance with Report 3.

Report 3: [...] *because they've got a lot of limitations here [...] most of this voluntary staff [...] so they do what they can [...] that does not discredit the group, I think it works well, but it could get better.* (User 8)

Concerning the technique (second thematic unit), often, the team puts a functional burden on the dietician. Despite

the team's attempt to establish interdisciplinary work, including the distribution of roles and functions related to each professional's core competences, the dietician assumes the role of guaranteeing that the team receives information which goes beyond his/her competency or, for example, attending patients in mental areas that do not suit his/her educational background. In accordance with Report 4, in the attempt to attend to this functional burden, the team delivers joint care, involving more than one professional specialty, which has greatly contributed to enrich and qualify care, as both professionals' knowledge adds up.

Report 4: [...] *joint care helps a lot with a view to integration among the professionals, that one knows what the other is doing, saying. For the patient that's good, because he perceives that the team has worked together.* (Professional 2)

Also with regard to the technique, in its organization, the service uses the advantage of being articulated with a general hospital to guarantee benefits to users, like multiprofessional care through examinations, hospitalizations and treatment free of charge, as indicated in Report 5.

Report 5: [...] *now, one think which I think makes a difference, even with regard to other services without a medical, nutrologist part, is the difficulty to request exams, the difficulty to hospitalize this patient sometimes [...] and here [...] they are forwarded by the SUS and do everything here through the hospital, the hospitalization... nothing for the patient, no cost.* (Professional 7)

The service's intersectoral articulation also extends to other institutions and organizations, including schools, the press and primary health care services. This fact permits the organization of prevention, promotion and knowledge dissemination activities to society (symposia, mini-courses or lectures about EDs and healthy eating) and the achievement of an even higher care quality level and range. Care delivery could be better qualified, however, if the team articulated, for example, with dental treatment services or family therapy, with a view to guaranteeing support to people diagnosed with EDs in areas that are still wanting.

Regarding access (third thematic unit), it was observed that, out of 16 users interviewed, 11 lived in neighboring cities to the city where the service is located. The mean travel time between the user's home and the service was 45 minutes. The maximum amount spent on food, transportation and accommodation was R\$90 upon every return appointment. Based on these data, users' access to the service depends on a certain structure that permits these users' transportation and entry quality. The service already possesses some structure, as eight out of 11 users who live in the region of the city where the service is located use free transportation, offered by the municipal government in their city of origin, to visit the service. Large amounts spent on food and accommodation, however, suggest the need to create food aids, rest places or partnerships between the service and hotels and pensions, in order to facilitate these users' access.

Another characteristic present at the service that hampers users' access is space. A limited number of rooms are available at the service, some of which are inappropriate and offer little comfort to respond to the patients' demands. This problem seems to have been reduced, however, through a change made in the course of this study. This change guarantee some larger and more appropriate rooms and spaces for care, as illustrated by Report 6.

Report 6: [...] *but now we got more rooms. As from next month, we will have more rooms. I think the physical space will get better.* (Professional 3)

## Discussion

According to the results, the service under analysis is guided by the principle of care comprehensiveness, as its actions are focused on health promotion, protection and recovery (Ministério da Saúde, 2006). The service does not only offer knowledge dissemination, prevention, promotion and rehabilitation activities, but also multidisciplinary care, attending to patients in their mental, organic and social dimensions. Therefore, it attempts to guarantee health care from the simplest to the most complex levels, from curative to preventive care, as well as the biopsychosocial understanding of the users attended, immersed in their groups (Ministério da Saúde, 1993).

Despite some aspects to improve, like articulation with other services that could qualify care even further, the service aims to put in practice the technical-scientific concept of intersectoral articulation established in SUS guidelines. Therefore, it aims to recognize and seek partnerships external to the unit and the health sector, with a view to completing service gaps and offer better user embracement (Burlandy, 2009). Hence, by joining efforts with hospitals, schools and the press to organize events, the service reinforces the need to establish intersectoral networks. Through intersectoral articulation, mini-courses, symposia and weeks are held to raise awareness about EDs and healthy eating. In isolation, it would become unfeasible to solve the multiple dimensions of the problems involved in care. Thus, intersectoral actions structure joint work, with a view to the effectiveness and ability to solve health demands (Magalhães & Bodstein, 2009).

Interdisciplinarity is also a fundamental technical-scientific principle to put the proposals and guidelines of the SUS in practice, by seeking to humanize care and welcome users (Linard, Castro & Cruz, 2011). This health care concept departs from the premise of collective teamwork, in which professional acts so as to offer their maximum potential in the care process and integrative different subjects and knowledge areas in putting treatment in practice. At the service, however, some factors hinder the concretization of better interdisciplinary work. The first bottleneck is the functional burden placed on a sole professional category: the dietician. The team seems to face difficulties to outline this professional's field and core competence and responsibility,

leading to disorganization and confusion about the team and the patients attended.

Campos and Amaral (2007) define core competence and professional responsibility as each professional's specific set of knowledge and responsibilities and competency and professional accountability area towards the knowledge and common or shared responsibilities of different team professionals or specialties. To enable professionals to offer their maximum interdisciplinary team potential, the core competency and responsibility of each professionals working in team needs to be outlined. This exercise already seems to be practiced in the service when, during joint care, two professional modalities are integrated and complementary knowledge is applied in clinical practice. This integration permits the construction of an expanded clinic, with a view to promoting the emerge of new and/or the re-signification of existing knowledge (Favoreto, 2005). Thus, interdisciplinary work takes form through the concretization of spaces for reflection and dialogue among different professional knowledge areas.

Getting to know and informing the interdisciplinary team about each professional's knowledge and responsibilities, which the team is already starting to do during joint care, permits guaranteeing users' perception of an interdisciplinary team where, in each professional category, the help and care can be requested which this category is most able to offer. Thus, users will be able to make the best of each professional's potential and obtain a more qualified and harmonious care.

Another aspect that hampers the establishment of more consolidated interdisciplinary work is some professionals' biomedical conception of health care. This fact limits the articulation among different knowledge areas and the overcoming of team fragmentation, with a view to the construction of more appropriate routes for emerging needs (Silva Júnior & Mascarenhas, 2004).

The importance of appropriate professional education is highlighted, so as to instruct future professionals towards a broad health perspective, within a holistic view of the being. Broad education and training, which considers users' social, biological and mental aspects, can lead to the improvement of interdisciplinary work, access, the problem-solving ability of service actions and service quality (Motta, Caldas & Assis, 2008).

Health care quality is fundamental in the SUS proposals, with the Family Health Strategy (FHS) as the most concrete strategy. The FHS intends to guarantee new meanings for the figure of the subject who receives care and take into account intersubjectivity in the preventive and/or curative actions health team members accomplish (Favoreto, 2005). Considering intersubjectivity means guaranteeing a "clinic of the subject", in which clients can gain an active role in treatment (Campos, 2007). Nevertheless, although most team professionals manifest affection and the therapeutic relationship as necessary for bonding in their actions,

some professionals' education, predominantly based on the organic model, limited the development of the interpersonal professional-patient relation in some situations. On behalf of a strictly organic cure, professionals who are fans of the organic model pass over the mental and social dimensions of the individuals they deliver care to (Martins et al., 2011).

The lack of continuity in the service hampers the dialogic clinic, based on the bond that emerges from the reflections and encounters between professional and user (Teixeira, 2003). The turnover of undergraduate and graduate students is present in the teaching hospital context and leads to a lack of continuity in bonding. Most team professionals' voluntary work reinforces the variation in professionals' entry and exit from the service and difficulties to establish bonds between professionals and users.

Bonding was also observed in the user-user relation. Due to the characteristic of EDs, diagnosed patients often display characteristics associated with personality disorders and impulsiveness, mood disorders and anxiety disorders. Besides organic and nutritional weakness, these are often patients who are already subject to intense social harm, including distancing from social network, ruptures and difficulties in relationships (Morais, 2006).

Finally, according to SUS policies, it is the duty of health services to guarantee easy access to users and a user-centered organization, which is directly linked with health service humanization (Ostermann & Souza, 2009). Therefore, appropriate training is fundamental, with a view to the development of qualified professional listening, responsible for offering users answers and solutions to their most urgent needs and demands (Solla, 2005). The service showed to be in constant need of improvement as, despite some shortages in the posture, technique and access dimensions, its aim is to attend to its users' demands and needs. One example was the change made, at the time the research was development, in the clinical care site, which moved towards a larger and broader space, or team professionals' continuous search for personal development and professional qualification. Therefore, according to the data analyzed, it can be affirmed that the service has tried to promote user-centered care, aiming for humanization in its care process.

### **Final Considerations**

From the perspective of the users and professionals who participated in this study, the ED care service under investigation works in compliance with SUS principles and guidelines, as it offers universal care, accessible to all users, and which everyone is entitled to. It establishes comprehensiveness, as a service articulated with other curative and preventive, individual and collective services, at all complexity levels. The service reveals a high level of hierarchization, as part of a large-scale referral and teaching hospital that attends to more than one city for complex cases. Thus, it is a service that also comprises equity, as it offers assistance to everyone, without prejudices or privileges of

any kind. In addition, it guarantees information to the people attended and dissemination of its service to the population.

Also, it can be affirmed that the service complies with the principles of "user embracement" and "bonding", in its attempts to articulate the different dimensions of user embracement (posture, technique and access) and bonding (affection, therapeutic relationship and continuity) in its care process, with a view to offering increasingly humanitarian and user-centered care.

Nevertheless, some factors were identified in this study that directly influence user embracement and bonding between professional and user. The need to take into account the concept of care comprehensiveness was perceived, with a view to offering comprehensive and problem-solving care. When based on this principle, the various care dimensions can be developed in care delivery, ranging from the preventive to the curative level, and in the biopsychosocial context.

It was also observed that, in the organizational dynamics of the care service, intersectoral and interdisciplinary actions are needed that guarantee resources, through a joint taskforce of entities, institutions, managers and professionals, with a view to solving or making feasible some user demands and needs which would not be attended through isolated actions in any other way. Intra and extra-professional team articulations, however, would not be, and often were not put in practice without qualified listening. Therefore, the importance of good education and professional qualification was evidenced, developing health agents towards an enhanced perception of health, within a processual understanding that comprises biopsychosocial factors.

Thus, by understanding the health-disease process as a phenomenon that involves biopsychosocial dimensions, and which therefore requires health promotion, prevention, cure and rehabilitation actions, professionals will be competent to offer qualified listening, which furthers interdisciplinary, intersectoral work and professionals' bonding with users and their respective communities. In possession of these principles, professionals can gain a professional posture that can promote care humanization. Also, in accordance with those ideas, public policies and health managers can again focus on the needs of care services for people diagnosed with EDs and guarantee stimuli and resources to expand and qualify treatment sites. A structure is expected that is capable of enhancing interventions that are problem solving, humanized and appropriate to the demands of this population.

In short, this study can offer support to devise health services, including those dealing with EDs, so as to get organized and structured in a way that is more in line with the SUS principles of problem solving, humanity and citizenship. In view of the small number of subjects investigated in the research universe, which limits the investigation and impedes a more comprehensive analysis, further studies should complement the identified findings to reach a richer understanding about care in the context of EDs.

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