Original Article

VALENT Protocol: a proposal for a humanized nutritional care line for patients with anorexia nervosa in a hospital setting

Protocolo VALENT: uma proposta de linha de cuidado nutricional humanizada para pacientes com anorexia nervosa em ambiente hospitalar

DOI: 10.37111/braspenj.2025.40.2.18-en

Aline Ramalho dos Santos[1]
Marisa Chiconelli Bailer[2]
Maria Fernanda Jensen Kok[3]

ABSTRACT

Introduction: Anorexia nervosa is associated with malnutrition, requiring hospitalization in more severe cases. Treatment is based on nutritional therapy and interprofessional teamwork. There are few studies that guide this line of care in the hospital setting. Therefore, the aim was to propose a nutritional care protocol for teenagers diagnosed with anorexia nervosa, undergoing hospital treatment, considering nutritional strategies in a private hospital in São Paulo, Brazil. **Methods:** To construct the therapeutic plan, discussions were held with the team at 2 levels: in-hospital (with the care team) and hybrid (with a specialized team responsible for monitoring after hospital discharge). Benchmarking with reference centers and a literature review on the PUBMED, Scielo, and Lilacs platforms were considered. In the practical context, a face-to-face visit was made to the hospital kitchen with those responsible for implementing the home food menu. **Results:** The VALENT protocol was established in 4 phases. Phase 1 contained: early admission; calculation of nutritional intake; anthropometric assessment; standardization of weightings; investigation of nutritional deficiencies; structuring of a multidisciplinary team. Phase 2 contained: definition of weekly interdisciplinary meetings; weighing flow; weekly anthropometry; daily visit with a nutrologist. Phase 3 was done with the progression of nutritional supply every 3 days. Phase 4 executed the structure of dehospitalization. **Conclusion:** The structure of personalized and replicable care plans associating literature, practical action and reference centers is essential for excellence in care. Interprofessional discussions associating levels of care optimize alignment of long-term conducts, especially from a behavioral point of view.

Keywords:
Anorexia nervosa. Nutrition therapy. Hospitals. Evidence-based practice.

RESUMO

Introdução: A anorexia nervosa associa-se com desnutrição, sendo necessário a internação hospitalar em casos mais graves. O tratamento deve ser fundamentado na terapia nutricional e exercício interprofissional das equipes. Todavia, há poucos estudos que norteiem essa linha de cuidado no âmbito hospitalar. Assim, objetivou-se propor um protocolo de cuidado nutricional para adolescentes com diagnóstico de anorexia nervosa, em tratamento hospitalar, considerando as estratégias nutricionais adotadas em um hospital privado de São Paulo. **Método:** Para a construção do plano terapêutico, foram realizadas discussões com a equipe em 2 níveis: intra-hospitalar (com a equipe assistencial) e híbrido (com equipe especializada responsável pelo acompanhamento após a alta hospitalar). Considerou-se o benchmarking com centros de referência e revisão de literatura nas plataformas PUBMED, Scielo e Lilacs. No contexto prático, foi realizada visita presencial à cozinha do hospital com os responsáveis pela implementação do cardápio domiciliar. **Resultados:** O protocolo VALENT foi estabelecido em 4 fases. A Fase 1 incluiu: admissão precoce; cálculo da ingestão nutricional; avaliação antropométrica; padronização das pesagens; investigação de deficiências nutricionais; estruturação de equipe multidisciplinar. A Fase 2 incluiu: definição de reuniões interdisciplinares semanais; fluxo de pesagens; antropometria semanal; consulta diária com nutrólogo. A Fase 3 se resumiu a progressão da oferta nutricional a cada 3 dias. A Fase 4 foi composta pela estruturação da desospitalização. **Conclusões:** A estruturação de planos de cuidado personalizados e replicáveis, associando literatura, ações práticas e centros de referência é essencial para a excelência assistencial. Discussões interprofissionais associando níveis de cuidado otimizam o alinhamento de condutas de longo prazo, especialmente do ponto de vista comportamental.

Unitermos:
Anorexia nervosa. Terapia nutricional. Hospitais. Prática baseada em evidências.

Address for correspondence:
Aline Ramalho dos Santos
Rua Alameda Barros, 145 – Santa Cecília – São Paulo, SP, Brasil – CEP 01232-001
E-mail: alineramal@hotmail.com

Submission:
October 27th 2025

Accepted for publication:
December 8th 2025

Date of publication:
January 10th 2026

1. Nutricionista Coordenadora de Nutrição do Hospital PUC-Campinas, Residência em Oncologia Pediátrica pela UNIFESP, Especialização em Oncologia Multiprofissional pelo Instituto de Ensino e Pesquisa do Hospital Sírio Libanês, Especialização em Gestão em Saúde pelo Centro Universitário São Camilo, Especialização em Gestão da Qualidade e Segurança dos Alimentos pela UNICAMP, Mestranda em Ensino em Ciências da Saúde pela UNIFESP, São Paulo, SP, Brasil.
2. Nutricionista Coordenadora da Nutrição do Hospital Samaritano Higienópolis, Graduada em Nutrição pelo Centro Universitário São Camilo, Pós-graduada em Nutrição Clínica pelo GANEP, em Nutrição em Gerontologia pelo Hospital das Clínicas, MBA em Gestão de Serviços de Saúde pela Uninove e em Nutrição em Pediatria pelo PGPN, Docente do Ganep Educação, São Paulo, SP, Brasil.
3. Nutricionista Supervisora de Nutrição Clínica do Hospital Samaritano Higienópolis, Graduada pelo Centro Universitário São Camilo, Especialista em Nutrição em Pediatria pelo Instituto da Criança da USP, Especialista em Nutrição em Cardiologia pela SOCESP, São Paulo, SP, Brasil.

INTRODUCTION

Anorexia nervosa (AN) is an eating disorder with multifactorial etiology, characterized by severe dietary restriction, distorted body image, and an intense fear of weight gain. In severe cases, the clinical picture progresses to profound malnutrition, electrolyte disturbances, cardiac alterations, and imminent risk of death, requiring hospitalization for intensive clinical management[1]. Hospitalization generally occurs when there is weight loss greater than 25% of ideal body weight, bradycardia (<40 bpm), hypotension, severe hypokalemia, or failure to respond to outpatient treatment[2].

The hospital environment represents a crucial space for clinical stabilization and the beginning of nutritional rehabilitation. Nutritional intervention must be carefully planned to avoid complications such as refeeding syndrome, requiring close monitoring of electrolytes, liver and kidney function, and inflammatory markers[3]. The eating plan needs to be individualized, with a gradual progression of calories and a focus on protein-calorie adequacy, always in coordination with the multidisciplinary team, including psychiatrists, psychologists, and clinicians[4].

The role of the hospital nutritionist is crucial, both in prescribing dietary guidelines and monitoring nutritional status and providing nutritional education. The complexity of care requires an empathetic, evidence-based approach that considers the patient's clinical, emotional, and social aspects. The goal is to restore nutritional status, promote treatment adherence, and prevent relapses after hospital discharge[5]. Populational base studies demonstrate that, in Latin America, the prevalence of AN in the general population is around 0.1%. Although this rate seems to be lower than what is usually found for other eating disorders, the heterogeneity among studies indicates the necessity of continuous investigation and local scientific report[6].

In Brazil, the official database of hospitalization (DATASUS) registers hospitalizations due to mental disorders, even though it regularly groups different diagnoses. A study between 2008 and 2017 identified 152,465 hospitalizations in this age group while grouping several different psychiatric diagnoses, demonstrating the psychic suffering in this population and the necessity of deepening hospitalization mapping of eating disorders, including AN[7].

Thus, it is necessary to create a proposal for an in-hospital care line for pediatric patients diagnosed with AN and disseminate nutritional strategies adopted in a private hospital and contribute to better care practices for this public.

METHODS

This was a descriptive qualitative study composed of 3 stages: (1) narrative literature review; (2) benchmarking with reference centers for eating disorders; and (3) construction of a care protocol based on technical meetings and multiprofessional consensus.

For the construction of the care pathway, a narrative bibliographic review on the topic was carried out, using the PubMed, SciELO, and Lilacs databases, in addition to books and websites of scientific institutes related to the theme. Controlled descriptors (DeCS/MeSH) and keywords combined with Boolean operators were used: "anorexia nervosa" AND "adolescent", "eating disorders" AND "hospitalization", "multidisciplinary care" AND "adolescent health". Papers published in English, Portuguese, and Spanish between 2015 and 2025 were included. Duplicate studies, articles without full text available, and reviews without practical relevance to the hospital environment were excluded.

Data from these articles gave rise to the general guidelines for nutritional management, metabolic safety recommendations, parameters for caloric progression, and multiprofessional strategies adopted in the protocol. To compare care practices and identify critical elements for the construction of a replicable nutritional protocol, benchmarking was conducted with two centers specialized in the treatment of anorexia nervosa in adolescents, both located in the city of São Paulo, SP, Brazil, which have multiprofessional teams and availability to participate voluntarily in this process, seeking to recognize standards of excellence, identify already consolidated strategies, and understand care flows that could be adapted to the non-specialized hospital context. An in-person technical visit was carried out through professional observation, with an average duration of 5 hours, and notes were recorded in a structured field diary regarding nutritional decision criteria, care flow, interface between the clinical team and kitchen team, behavioral strategies used, and nutritional monitoring methods. Discussions were held with a specialist nutritionist and psychiatrist from each of the 2 centers, remotely, through online platforms, with a total duration of approximately 10 hours. Simultaneously, intra-hospital meetings took place in person with the nursing, nutrition, psychology, clinical nutrition, and psychiatry teams.

Data analysis was conducted through methodological triangulation, integrating direct observations from technical visits, content from remote discussions, and bibliographic references, determining comparative matrices on care strategies, nutritional conduct, recommendations applicable to the hospital context, and gaps identified in practice.

After reading all the materials and completion of the benchmarking process, the VALENT protocol was developed,

proposing care guidelines for adolescents diagnosed with AN undergoing hospital treatment.

The construction of this protocol was also based on periodic technical meetings with the medical team (pediatrics, clinical nutrition, and psychiatry) and the multidisciplinary team (nursing, psychology, nutrition), in two modalities: intra-hospital with the institution's care team and in hybrid form with a specialized team responsible for follow-up after hospital discharge.

For the development of the visual guidance of food preparations, the most representative food items of the therapeutic menu of adolescents treated at the institution were initially identified. Subsequently, the lead clinical nutritionist for the cases individually determined, together with the patient, family, and kitchen staff, the standardization of utensils, type of cooking, preparation method, presentation form, standard portion in grams, and photographic visualization of the equivalence of this portion, variable according to the individuality of each patient, therefore developed at each new admission; generating internal reproducibility and alignment with the nutritional rehabilitation plan.

Technical standardization involved weighing each item on a calibrated digital scale, prepared by pre-designated and instructed cooks, using previously standardized utensils, photographic control by the production nutritionist including post-preparation portion weight and final meal assembly for validation of compliance with nutritional planning by the lead nutritionist.

The photographic stage occurred at previously standardized angles to capture different views, with continuous artificial lighting and respecting a fixed distance of approximately 30 cm between the camera and the food. For photographs, a smartphone with a high-resolution sensor was used. To allow accurate interpretation of real size, some scale elements were included: an oval ceramic plate positioned below the food, a dessert spoon positioned laterally, and small, medium, and large ceramic ramekins. All photographs received a technical caption containing the name of the preparation ready for consumption and the weight of this item, composing a bank of standardized and reproducible images.

Technical validation of portioning comprised conformity between the photograph and the real weight of the portion, clarity in the visual interpretation of volumes, and coherence of the material with the individual nutritional plan for caloric and nutritional progression.

Regarding the behavioral aspect, given that the accuracy of numerical values in the identification of meals ready for consumption and in hospital discharge materials could trigger anxiety due to visual stimuli, it was recommended that the printed and digital material be used only by those responsible for meal preparation, being made available to the adolescent in treatment only after approval by the psychology and psychiatry teams, varying according to individual assessment.

Approximately 15 days before hospital discharge, those responsible for meal preparation for each patient were referred to the kitchen of Hospital Samaritano Higienópolis for practical education and reinforcement of the dietary plan guidelines. At hospital discharge, the illustrative educational resource is delivered to these family members so that they may use it as a guide for the portioning process in the home environment, updated according to the current dietary plan.

RESULTS

The care pathway established in this study is called the "Valent Protocol", originating from the acronym "Vigilância e atenção lineares à evolução nutricional e terapêutica" (Portuguese for "Linear surveillance and attention to nutritional and therapeutic evolution") and from the name of the first patient with anorexia nervosa treated by the lead author of this study, representing a structured clinical protocol that follows the patient throughout hospitalization, with a focus on monitoring, safety, and rehabilitation, establishing a technical and humanistic perspective. In addition, the word "valente" (Portuguese for courageous) conveys the importance of courage, so it is essential for this treatment.

Regarding the review, the initial search resulted in the identification of 134 potentially relevant articles. After the removal of duplicates across databases (27 duplicate articles), 107 studies remained for screening. The title and abstract screening stage led to the exclusion of 68 articles for the following reasons: exclusively outpatient or psychotherapeutic focus (n=41); studies related to anorexia nervosa in adults (n=15); absence of a nutritional or hospital approach (n=12). Thirty-nine articles were selected for full-text reading. During full reading, 23 studies were excluded because they did not present data applicable to the hospital environment (n=14); presented only expert opinion without relation to nutritional care (n=5); or lacked a clear methodology or applicability to the Brazilian context (n=4). Thus, 16 articles comprised the final synthesis and supported the construction of the four phases of the VALENT protocol, of which 10 (62.5%) were international (USA, Australia, United Kingdom, Canada) and 6 (37.5%) were national studies, including reviews, clinical protocols, and institutional reports related to the management of anorexia nervosa and nutritional therapy in adolescents.

The integration of these findings helped to create the four phases of the VALENT protocol, presented in Figure 1 and addressing the following topics: nutritional admission and alignment of periodic returns; process of assessing nutritional status and food intake; structuring care discussions with the

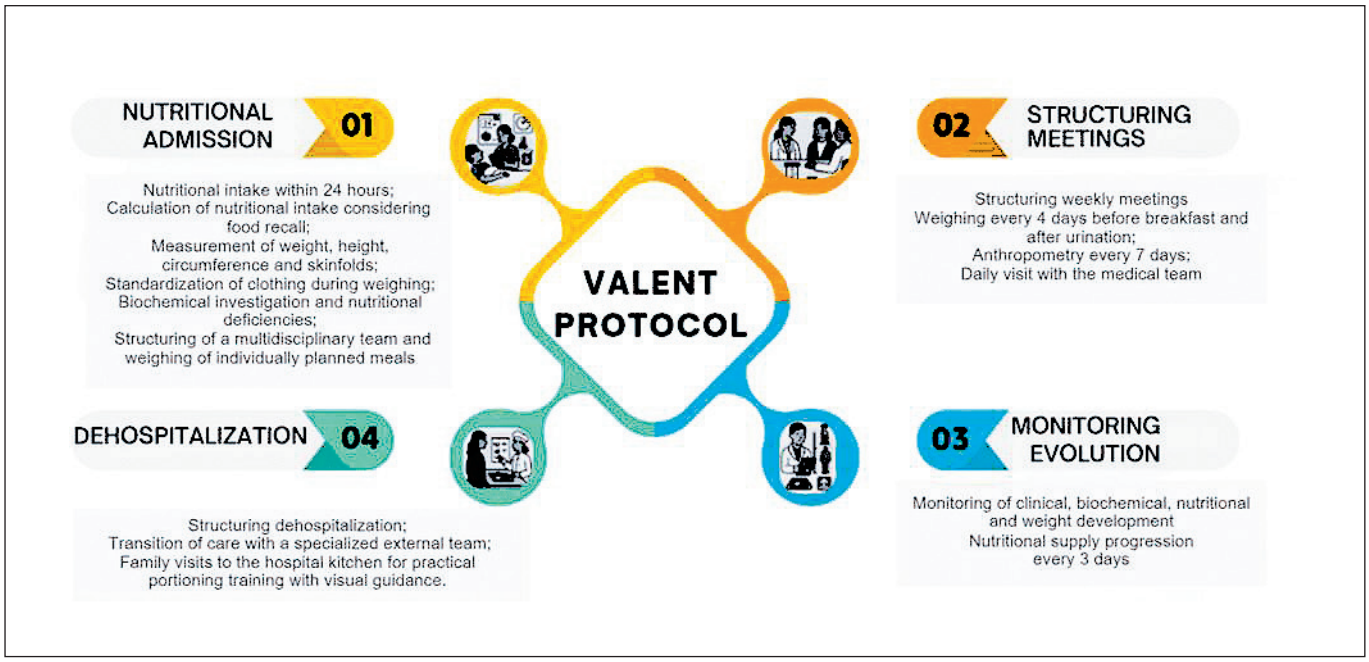

Figure 1 - *Proposal of 4 phases for the in-hospital care line for teenagers with anorexia nervosa.*

medical and multidisciplinary team on a periodic basis; standardization of clothing and speech; strategies for progression of nutritional supply; structuring the dehospitalization process and transition of care.

At all stages, the importance of effective communication between all professionals and family members is reinforced, aligning the care dimension and nutritional strategies. A detailed description of each phase of this protocol is provided below.

Phase 1

This phase begins with early nutritional admission, within 24 hours of admission, investigating behavioral aspects, usual diet, and family context. Furthermore, nutritional intake is calculated to estimate average caloric and protein intake, serving as the starting point for initiating nutritional therapy and establishing nutritional goals. An anthropometric nutritional assessment is performed considering current weight, height, usual weight, percentage of weight loss, arm circumference, triceps skinfold thickness, and calf circumference. Standardized clothing is determined for weighing in to reduce the optimistic bias of weight gain due to patient manipulation (excessive clothing and high water intake prior to weighing may be evidenced). A multidisciplinary referral team should be identified at this stage. Guidance for the clinical nutrition team and the food and beverage unit, including waitresses, cooks, production nutritionists, and head chef, should begin with an understanding of the complexity of the diagnosis and the importance of each professional for excellent care and ensuring adequate nutritional provision.

Phase 2

At this stage, the structure of weekly interdisciplinary meetings is strengthened, considering nutritional (anthropometry, dietary intake, biochemical tests, gastrointestinal tolerance) and behavioral developments. Weighing is performed every four days, before breakfast and after urination, to reduce the optimistic bias of positive progress, emphasizing the importance of not allowing the patient with an eating disorder to see the weight measured on the scale. Anthropometry is performed weekly. There should be special care not to reveal objective data to the patient at this time. Follow-up visits should be periodic and are recommended in conjunction with a multidisciplinary team and medical team, especially nutritionists and psychiatrists, to reduce episodes of manipulation and contribute to timely alignment and clarification.

Phase 3

This is a fundamental and longer stage, which includes the progression of nutritional intake every three days and the assessment of the acceptance process. Oral supplementation strategies are explored at this stage, and enteral nutritional therapy may also be considered, depending on each case.

Phase 4

This crucial stage begins the structuring of dehospitalization based on the observation of positive and sustained progress within the hospital setting. The transition of care to a specialized external team, with the inclusion of an outpatient nutritionist (while still in the hospital) fosters bonding and facilitates nutritional negotiations. The practical guidance process

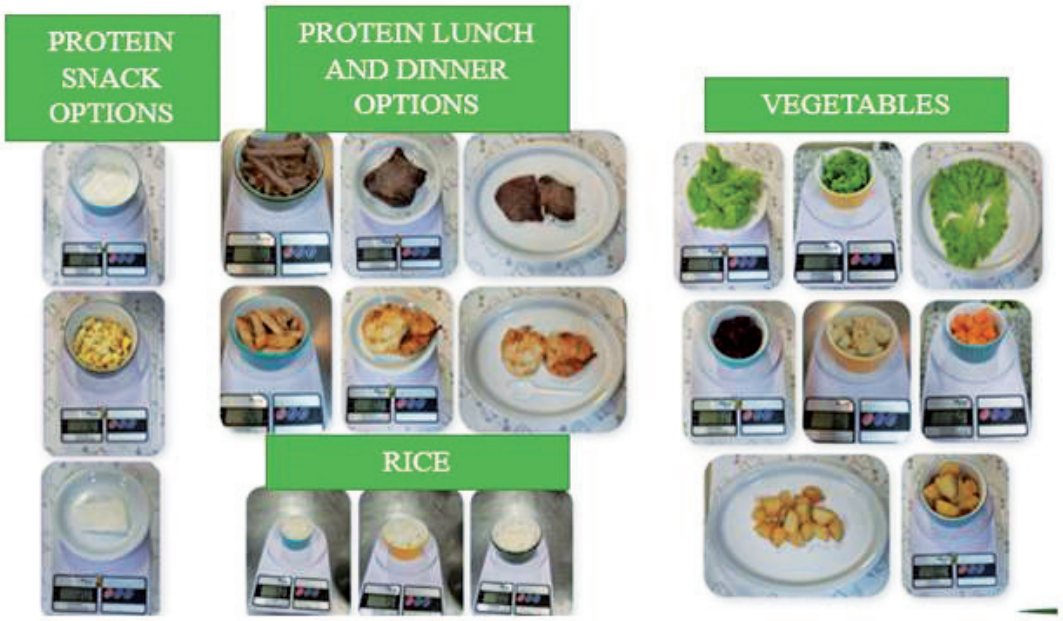

Figure 2 - *Partial demonstration of the method of illustrated nutritional guidance developed at the institution.*

begins with family visits to the hospital kitchen, contributing to early clarification and the physical and digital provision of illustrated nutritional guidance, as illustrated in Figure 2.

DISCUSSION

The proposal for a phased hospital-based nutritional care plan for adolescents diagnosed with anorexia nervosa has the potential to represent a breakthrough in the organization of care for this population. The phased approach allows for progressive and individualized treatment, respecting the clinical, emotional, and social needs of patients. The literature indicates that the hospital approach to eating disorders in adolescents should be intensive, multidimensional, and evidence-based[8,9], and the model proposed here aligns with these recommendations by integrating clinical assessment, nutritional strategies, behavioral aspects, and ongoing family involvement.

In Phase 1, the emphasis on early nutritional admission within 24 hours of admission is in line with international protocols that reinforce the importance of initial nutritional assessment for preventing clinical complications and establishing safe therapeutic goals[10]. Detailed and standardized anthropometric assessment, with control for variables that can be manipulated by patients (such as clothing and water intake) contributes to greater data accuracy and reliability and is a recommended practice in specialized centers[11]. The early integration of the multidisciplinary team and the involvement of professionals from the food and nutrition unit (FNU) reflect systemic care, in which each link in the food production and supply chain is made aware of the impact of their work on patient recovery. This strategy is supported by the literature on hospital food safety and patient-centered care[12].

Phase 2, by emphasizing weekly interdisciplinary meetings and integrated analysis of clinical, behavioral, and nutritional markers, reinforces the need for coordinated and collaborative care, a central feature of mental health and eating disorder care models[13]. Strict monitoring of weight measurements (while avoiding disclosure of results to patients) is a practice advocated by experts to prevent negative reinforcement of dysfunctional behaviors[14]. Including family members in meetings led by multiple professionals helps increase treatment adherence and reduces manipulative behaviors, fostering an environment of greater trust and transparency, which are key factors for therapeutic success[15].

Phase 3 represents the core of the nutritional rehabilitation process and must be conducted with caution and technical expertise. The gradual progression of food intake, with adjustments every 3 days, allows for the observation of tolerance and metabolic adaptation, mitigating the risk of refeeding syndrome, a potentially serious and often underestimated complication in the management of patients with severe malnutrition[10]. The use of oral supplementation and, in indicated cases, enteral nutritional therapy must be based

on well-defined protocols and conducted by a trained team. It is important to emphasize that the decision to use an enteral feeding tube should be carefully discussed with the patient and their guardians, reinforcing the therapeutic, non-punitive nature of the resource[6]. This respectful and technical approach has been highlighted as a differentiator in centers that achieve better clinical outcomes[16].

Phase 4, in turn, assumes a strategic role in planning hospital discharge and continuity of care. The early inclusion of an outpatient nutritionist during hospitalization represents an innovation that favors bonding, therapeutic continuity, and a safe transition. Studies show that adolescents with anorexia nervosa have high relapse rates when there is no structured outpatient follow-up and continuous family support[17]. Preparing the family through visits to the hospital kitchen, provision of illustrated educational materials, and practical guidance strengthens family involvement in care, which is a fundamental principle of family-centered treatment models[15].

Throughout all phases, effective communication between healthcare professionals and family members is a cross-cutting and essential axis. The literature recognizes that communication failures are among the main factors associated with treatment discontinuation, low engagement, and relapses in adolescents with eating disorders[13,18]. The proposed care pathway includes ongoing meetings, consultations, and guidance, fostering an environment of active listening, knowledge sharing, and shared responsibility among all involved.

CONCLUSION

Structuring a phased care pathway for adolescents with AN admitted to a hospital setting represents a promising, evidence-based strategy focused on the needs of the patient and their support network. Its implementation can improve nutritional care, promote better clinical outcomes, and contribute to the development of more humane and effective models for treating eating disorders in hospital settings.

Longitudinal studies with post-discharge follow-up are suggested to assess relapse rates and adherence to the eating plan after implementation of the structured care plan. Alternatively, multicenter studies can validate the care plan in different hospitals, aiming to adapt the model to the regional and infrastructure specificities of each service, strengthening the scientific basis of the proposed model, contributing to its dissemination in health services and the continuous improvement of nutritional care for eating disorders.

The implementation of the VALENT protocol represents an innovative and necessary strategy, given the clinical and emotional complexities of these patients. Thus, it encompasses early and systematic assessment, continuous monitoring, safe nutritional progression, integrated multidisciplinary work, and family involvement. These aspects align with the recommendations of scientific literature and the principles of person-centered care.

Cross-referencing scientific data, practical work, and referral centers is essential for optimizing therapy and nutritional recovery, positively impacting the quality of care and the safety of hospitalized patients. In the context of care transition, the integration of the medical team, the multidisciplinary team, and the external specialized team is a priority. This coordination between healthcare professionals and the active inclusion of the family are considered key elements for the success of the therapeutic plan, fostering bonding, trust, and continuity of care after hospital discharge, and optimizing alignment of short-, medium-, and long-term approaches.

There is a potential for replicability, guiding the development of institutional protocols, training teams, and qualifying general or non-specialized hospital services for eating disorders. It emphasizes the need for an ethical, empathetic, and evidence-based approach, always considering the psychological distress and challenges inherent to this condition.

REFERENCES

1. Nunes DCL, Ramos AL, Zilio FA, Souza EP, Souza PAESS, Mainente APB, et al. Anorexia nervosa: desafios no diagnóstico precoce, implicações clínicas de longo prazo e novas perspectivas terapêuticas. Braz J Implantol Health Sci. 2025;7(12):756-70.
2. Chakraborty K, Basu D. Management of anorexia and bulimia nervosa: An evidence-based review. Indian J Psychiatry. 2010;52(2):174-86.
3. Calcaterra V, Magenes VC, Fratangeli N, Nigro G, Fabiano V, Mendolicchio L, et al. Hypothalamic-pituitary-adrenal axis in anorexia nervosa; an underestimated endocrine dysfunction among adolescents. Front Pediatr. 2024;12:1415061.
4. Treasure J, Stein D, Maguire S. Has the time come for a staging model to map the course of eating disorders from high risk to severe enduring illness? An exploration of the evidence. Early Interv Psychiatry. 2015;9(3):173-84.
5. Norrington A, Stanley R, Tremlett M, Birrell G. Medical management of acute severe anorexia nervosa. Arch Dis Child Educ Pract Ed. 2012;97(2):48-54.
6. Kolar DR, Mejía Rodriguez DL, Chams MM, Hoek HW. Epidemiology of eating disorders in Latin America: a systematic review and meta-analysis. Curr Opin Psychiatry. 2016;29(6):363-71.
7. Baudinet J, Simic M. Adolescent eating disorder day programme treatment models and outcomes: a systematic scoping review. Front Psychiatry. 2021;12:652604.
8. Golden NH, Katzman DK, Sawyer SM, Ornstein RM, Rome ES, Garber AK, et al. Position paper of the society for adolescent health and medicine: medical management of restrictive eating disorders in adolescents and young adults. J Adolesc Health. 2015;56(1):121-5.
9. Collins K. Eating disorder clinical pathway (internet). Johns Hopkins All Children's Hospital, Saint Petersburg; 2025. Disponível em: https://www.hopkinsmedicine.org/-/media/files/allchildrens/clinical-pathways/eating-disorders-clinical-pathway-8202025revisions. Acesso em: 10/10/2025.
10. Michel D, Venta A. Eating disorders. In: Fonagy P, Sharp C, Fletcher JM, Venta A. Developmental Psychopathology. Wiley-Blackwell, Hoboken, 2021.

11. Amusquibar AMG. Interdisciplinary team for the treatment of eating disorders. Eat Weight Disord. 2000;5(1):223-7.
12. Dufour R, Novack K, Picard L, Chadi N, Booij L. The use of technology in the treatment of youth with eating disorders: a scoping review. J Eat Disord. 2022;10(1):182.
13. Amusquibar AMG. Interdisciplinary team for the treatment of eating disorders. Eat Weight Disord. 2000;5(4):223–7.
14. Grange DL, Lock J, Loeb K, Nicholls D. Academy for Eating Disorders position paper: the role of the family in eating disorders. Int J Eat Disord. 2010;43(1):1-5.
15. Lock J, Grange DL. Family-based treatment of eating disorders. Int J Eat Disord. 2005;37 Suppl:S64-7.
16. Madden S, Miskovic-Wheatley J, Wallis A, Kohn M, Lock J, Grange DL, et al. A randomized controlled trial of in-patient treatment for anorexia nervosa in medically unstable adolescents. Psychol Med. 2015;45(2):415-27.
17. Grange DL, Hughes EK, Court A, Yeo M, Crosby RD, Sawyer SM. Randomized clinical trial of parent-focused treatment and family-based treatment for adolescent anorexia nervosa. J Am Acad Child Adolesc Psychiatry. 2016;55(8): 683-92.
18. Hart LM, Granillo MT, Jorm AF, Paxton SJ. Unmet need for treatment in the eating disorders: a systematic review of eating disorder-specific treatment seeking among community cases. Clin Psychol Rev. 2011;31(5):727–35.

Study location: Hospital Samaritano Higienópolis, São Paulo, SP, Brasil.

Conflict of interest: The authors declare there are none. However, it is important to note that this work was presented at the XI Congresso Paulista de Nutrição, em São Paulo, on May 17th, 2025, orally, being awarded as Best Work in the Oral Presentation category. The first author received an award of professional distinction by the Regional Council of Nutrtion by this project's development.