

A LOOK AT NURSING MANAGEMENT OF MAJOR EATING DISORDERS IN ADOLESCENTS IN PRIMARY HEALTH CARE: A NARRATIVE LITERATURE REVIEW

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Abstract: Adolescence is a stage of human development marked by intense biopsychosocial changes, which may increase vulnerability to mental health problems, including eating disorders. In the context of Primary Health Care, these conditions require early, continuous, and coordinated interventions that consider the territory, the family, and the adolescent's individual characteristics. This study aims to describe, based on the scientific literature, the psychosocial nursing management of eating disorders, with emphasis on Anorexia Nervosa and Bulimia Nervosa among adolescents within Primary Health Care in Brazil. This is a descriptive and reflective narrative literature review, conducted using the Virtual Health Library (VHL), as well as books, technical manuals, and legislation related to mental health, psychiatry, primary health care, and nursing practice. The findings indicate that nurses in Primary Health Care play a strategic role in the early identification, welcoming, and longitudinal follow-up of adolescents with eating disorders, being a central and essential professional in this process. Nursing management should involve physical and mental assessment, mental status examination, and, when necessary, the request for laboratory tests according to Ministry of Health or institutional protocols, in addition to qualified listening, health education, articulation with the psychosocial care network, and shared care with the Primary Health Care team. It is concluded that nursing management of eating disorders during adolescence requires a comprehensive, humanized, and territory-based approach, grounded in bonding, continuity of care, and network articulation. At the same time, gaps in the national scientific production regarding the role of nurses in this field are recognized, reinforcing the

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need for investments in research and continuing education.

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INTRODUCTION

Adolescence is recognized as a phase of human development marked by intense physical, cognitive, emotional, and social transformations. The World Health Organization (WHO) defines adolescence as the period between 10 and 19 years of age, highlighting that experiences and behaviors established during this phase exert a significant influence on health throughout life (WHO, 2023).

Similarly, the United Nations Children's Fund (UNICEF, 2022) emphasizes that, although adolescence represents a stage of opportunity, it is also a period of greater vulnerability, especially in contexts of social inequality, which demands public policies and intersectoral actions aimed at promoting health and comprehensive protection. In Brazil, the Statute of the Child and Adolescent (ECA, 1990) defines adolescence as the age range between 12 and 18 years of age, which, in exceptional situations, may extend up to 21 years of age.

Adolescence is a phase with several biopsychosocial transformations, which increase vulnerability to health-related risk behaviors. This vulnerability may be related to both social aspects and the characteristics of this developmental phase, such as the search for new experiences (Silva et al., 2022).

Currently, the dictatorship of thinness, the cult of the perfect body, is generally accompanied by examples of individual success, influencing mainly young people and adolescents with the idea of perfection, leaving them increasingly vulnerable to the emergence of these disorders (Ferreira, 2018). In this context, adolescence develops in a society that values thin, defined, and idealized body standards, widely disseminated through social media.

Continuous exposure to edited images, filters, and unattainable body types fosters constant comparisons, intensifies body dissatisfaction and appearance-related anxiety, and reinforces



discriminatory practices such as fatphobia and the overvaluation of aesthetics at the expense of health. In this context, adolescents become particularly susceptible to developing eating disorders (EDs), since the construction of identity and self-image occurs intensely during this period of the life cycle.

Body dissatisfaction associated with the internalization of unrealistic aesthetic standards can promote inadequate eating behaviors, constituting important risk factors for eating disorders.

According to Carmo, Pereira, Cândido (2014), eating disorders (ED) are psychiatric illnesses characterized by severe alterations in eating behavior that mostly affect female adolescents and young adults, and can lead to biological and psychological harm, as well as increased morbidity and mortality. These conditions involve complex changes in the relationship with the body, weight, and food, going beyond isolated food choices and constituting significant harm to mental health, especially during adolescence.

In the context of the Unified Health System (SUS), Primary Health Care (PHC) is defined as a set of individual, family, and collective actions that encompass health promotion, disease prevention, diagnosis, treatment, rehabilitation, harm reduction, palliative care, and health surveillance, developed by multidisciplinary teams in defined territories, with sanitary responsibility over the assigned population (Brazil, 2017).

Furthermore, according to Brasil (2013), Primary Health Care (PHC) is responsible for identifying and monitoring mental health problems that manifest in the daily demands of healthcare, including psychological distress and conditions that affect the relationship with the body and food. In the Brazilian context, PHC professionals are encouraged to work in an integrated manner, considering the unique characteristics of each territory and population, and to promote welcoming, therapeutic bonding, and continuous care at the community level.

Thus, as the main gateway to the SUS (Brazilian Public Health System) and coordinator of care within the Health Care Network, Primary Health Care plays a strategic role in the early identification and continuous monitoring of mental health needs, including eating disorders in adolescence, through relationship building, qualified listening, and network coordination.



The nurse's role is supported by Law No. 7,498/1986, which regulates the professional practice of nursing, as well as its regulatory decree, ensuring that nurses have competencies related to comprehensive care, health education, prevention of illnesses, and monitoring of individuals, families, and communities (COFEN, 1986).

In this sense, the nurse's role in mental health care finds legal support in COFEN Resolution No. 678/2021, which approves and regulates the performance of the nursing team in mental health and psychiatric nursing. The document recognizes the nurse's role in promoting mental health, providing support, active listening, identifying psychological distress, and developing educational and comprehensive care actions (COFEN, 2021). These responsibilities legitimize the nursing practice in managing eating disorders in primary health care, strengthening practices focused on prevention, continuous care, and coordination with the Health Care Network.

Within the context of Primary Health Care, nurses play a central and multifaceted role in the management of eating disorders, acting as educators, caregivers, and care coordinators. Their strategic role contributes to the early identification of signs and symptoms, qualified reception, and longitudinal follow-up of adolescents, favoring timely interventions and positively impacting the quality of life of this population (Cardoso, Andrade, Marques, 2024).

Nurses face significant challenges in caring for people with mental disorders, related to the complexity of cases, the stigma associated with psychological distress, and adherence to treatment. In this context, continuing health education in primary health care is fundamental to improving clinical management and strengthening interpersonal skills, based on welcoming, active listening, and health education, contributing to the construction of comprehensive, humanized, and effective care, focused on the user and their family (Silva, Nasi, Fiorini, 2025).

Given that adolescence is a period of high vulnerability to the development of eating disorders, which have significant repercussions for physical, mental, and social health, primary health care assumes a strategic role as the gateway to the Brazilian Unified Health System (SUS) and a privileged space for early identification, longitudinal follow-up, and coordination of care.



Given this scenario, the present article aims to analyze, through a narrative literature review, the nursing management of eating disorders, with an emphasis on Anorexia and Bulimia Nervosa in adolescents within the context of Primary Health Care, due to the scarcity of scientific publications that specifically address this issue.

METHODOLOGY

This is a narrative literature review (NLR) of a descriptive and reflective nature, aiming to analyze nursing management of the main eating disorders in adolescents within Primary Health Care (PHC). The choice of this type of review is based on the possibility of integrating different scientific productions, allowing for a broad, critical, and contextualized analysis of care practices developed at this level of care (Ogassavara et al., 2023).

The search for scientific articles was conducted between September and December 2025 in the Virtual Health Library (VHL), using the Health Sciences Descriptors (DeCS): “eating disorders”, “nursing”, “primary health care”, “adolescents”, and “psychosocial management”, combined using the Boolean operators AND and OR. Books, technical manuals, protocols, and normative documents were selected from the researcher’s personal physical and virtual collection, composed of recognized works in the areas of mental health, primary health care, and mental health and psychiatric nursing.

Publications from 2010 to 2025 in Portuguese and English that addressed or were related to the role of nurses in managing eating disorders in primary health care (PHC) were included. Although eating disorders encompass a broad range of clinical conditions, this review focused on anorexia nervosa and bulimia nervosa due to their higher prevalence in adolescence and clinical relevance in this context. Duplicate studies, studies without full text access, or studies without a direct relationship to the topic were excluded.

The analysis of the materials was qualitative and thematic, resulting in the organization of the content into three categories: (1) Adolescence and eating behavior: a biopsychosocial reflection, (2)



Eating disorders in adolescence: conceptual and clinical aspects, (3) Nursing management in primary health care for eating disorders in adolescence.

Since this research was based on secondary and publicly available sources, there was no need to submit it to the Research Ethics Committee (CEP) in accordance with CNS Resolutions No. 466/2012 and No. 510/2016.

RESULTS AND DISCUSSION

Adolescence and eating behavior: a biopsychosocial reflection

Adolescence is a phase of the life cycle that demands attention, as it is a period marked by discoveries, comparisons, heightened emotions, and personal and family conflicts. These experiences can increase vulnerability to psychological distress and contribute to the development of mental disorders, including eating disorders.

From this perspective, puberty can be considered a transitional milestone between childhood and adolescence. Within this developmental period, puberty is characterized by well-defined biological changes that are linked to a continuous process of psychosocial development, in which emotional, cognitive, and relational aspects are under construction (Itiba, 2010).

These transformations typical of adolescence directly impact the individual's relationship with their body, health, and eating habits, making eating behavior a sensitive field of biological, emotional, and social expression during this period of life.

According to Devine, Hill, and Gallagher (2023), these transformations typical of adolescence mean that eating behavior becomes influenced by multiple factors that go beyond nutritional knowledge, reflecting interactions between individual, social, and contextual dimensions.

Body image dissatisfaction and its associated challenges have been linked to poorer health outcomes among adolescents in various contexts, including disordered eating behaviors, symptoms of depression, and anxiety. Despite the importance of these findings, the most recent estimates on the



prevalence of these problems, as well as on positive eating attitudes and behaviors such as intuitive eating and body appreciation, remain outdated in many contexts, limiting current understanding of the extent and nuances of these experiences among adolescents (Babbott, Consedine, Roberts, 2023).

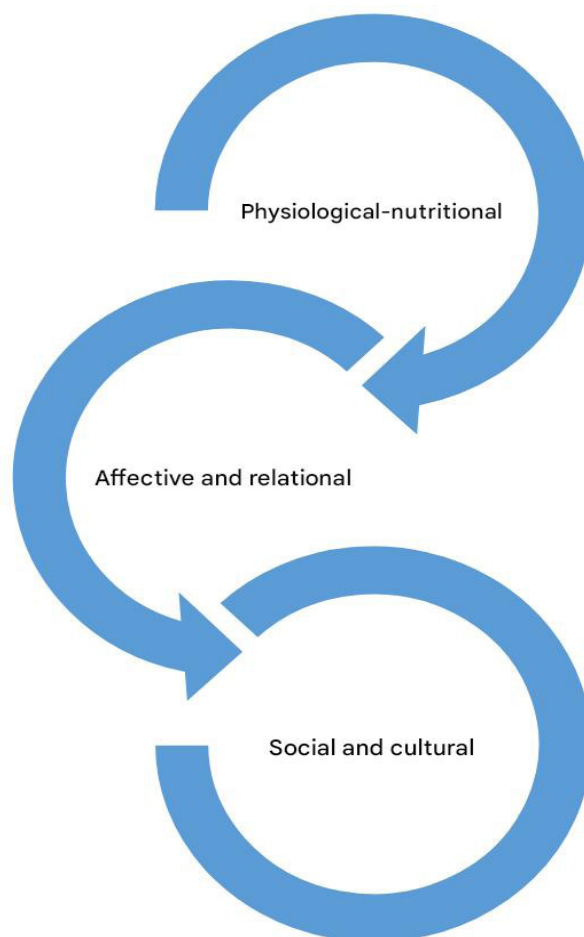
Eating behavior, although it may seem like a common aspect of everyday life, is a complex human phenomenon of central importance both in societies and in people's subjective experience (Dalgarrondo, 2019).

However, eating behavior is a rather broad term that encompasses various decisions about what to eat, when to eat, and how much to eat. Therefore, understanding eating behavior is important, since food choices have significant implications for the individual and society (Emilien, Hollis, 2017).

Given this complexity, eating behavior can be understood from three fundamental dimensions, as observed in flowchart 1, which are interrelated and influence food choices throughout life, allowing for an integrated view of the phenomenon.



Image 1 - Basic dimensions of eating behavior



Source: Adapted from Bernard, Trouvé (1976); Rossi (2014).

From the perspective of the flowchart presented and considering the adolescent phase, eating behavior in adolescents cannot be understood in a restricted or fragmented way, limited to a single determinant, as it is a multifaceted phenomenon in which different dimensions are dynamically articulated at this time and throughout the individual's life.

According to Bernad, Trouvé (1976) and Rossi (2014), the physiological-nutritional dimension refers to the metabolic, endocrine and neurobiological mechanisms responsible for regulating hunger, satiety and the satisfaction of nutritional needs.



While the affective-relational dimension encompasses the links between food, pleasure, and satisfaction, recognizing that the act of eating goes beyond biological function, evidence indicates that family practices of body objectification negatively influence adolescents' body perception and eating behavior, associating with greater body dissatisfaction, lower self-esteem, and disordered eating patterns, such as bulimic symptoms and less adherence to intuitive eating (Tanguay et al., 2025).

In turn, the social and cultural dimension refers to the norms, values, and practices historically constructed around food, configuring itself as a socially shared behavior influenced by family, cultural, and peer group contexts, aspects that take on special relevance in adolescence due to the search for belonging and social recognition.

Body transformations and the construction of body image play a central role in the subjective experience during adolescence, as this is a period in which the body becomes the object of constant evaluation, both by the adolescent themselves and by the social environment, which can intensify feelings of dissatisfaction, comparison, and inadequacy.

During adolescence, individuals can become especially sensitive to tensions and conflicts present in their social and family context, internalizing dysfunctional aspects of their environment. In this scenario, self-criticism and dissatisfaction with weight are frequent, which can result in changes in body image perception and a progressive withdrawal from social activities. Furthermore, the recurrent adoption of restrictive diets is observed, which tend to be maintained even in the face of significant weight loss, potentially leading to disproportionate weight for height and risky eating behaviors (Araújo, 2016).

The experiences lived through at this time can have repercussions throughout the course of life, significantly influencing eating patterns, mental health, and overall well-being. Therefore, understanding eating behavior at this stage must consider the centrality of body image, social relationships, and the developmental context (Neumark-Sztainer et al., 2018).

Within the context of social relationships experienced during adolescence, experiences of symbolic violence, such as bullying, also exert a significant influence on eating behavior. Evidence



points to an association between experiencing bullying and the occurrence of eating disorders among adolescents (Santos et al., 2023).

In light of the discussions presented, it becomes necessary and fundamental to consider the adolescent in their uniqueness, recognizing their particularities, emotions, and feelings specific to this stage of development, attributing value and voice to them in processes related to health care. Understanding eating behavior in adolescence requires a broader perspective, sensitive to the physiological, affective, and sociocultural dimensions that permeate this stage of life.

Eating disorders in adolescence: conceptual and clinical aspects

Adolescence represents a phase of high vulnerability to mental health, in which bodily, emotional, and social changes can trigger different manifestations of psychological distress. In this context, mental disorders, especially eating disorders, emerge not only as diagnostic categories, but as expressions of complex processes that permeate identity construction, the relationship with the body, and social bonds.

According to the APA (2023), eating disorders are characterized by a persistent disturbance in eating or eating-related behavior, resulting in altered food consumption or absorption, which significantly compromises the individual's physical health or psychosocial functioning.

Eating disorders (EDs) have a complex and multifactorial etiology, not yet fully understood, resulting from the interaction between biological, psychological, social, environmental, and cultural factors. A higher incidence of these conditions is observed in sociocultural contexts that overvalue thinness as an ideal of beauty, success, and social acceptance, a phenomenon frequently described as body worship (Rathke; Barros, 2014).

According to Araújo (2016):

“Oral disorders can originate from various causes, such as: a history of obesity, humiliation, and associated social failures. Children and adolescents de-



monstrate negative attitudes and conceptions towards obesity; in some cases, obesity can be an escape valve for certain psychological maladjustments, seeking to resolve frustrations and obtain immediate gratification, creating only another problem.”

These disorders have a multifactorial etiology, being determined by a diversity of biological, genetic, psychological, sociocultural, and family factors that interact with each other to produce and perpetuate the disease. In addition to presenting complications in various body systems, more recent studies are relating body dissatisfaction and eating disorders to immune system dysfunction and the triggering of an inflammatory response (Carmo, Pereira, Cândido, 2014).

Reflecting on psychodynamic theories, the development of an eating disorder is based on an unsatisfied feeling of separation-individuation. When situations arise that threaten the vulnerable ego, feelings of lack of control over one’s own body (self) emerge. Behaviors associated with food and food intake generate feelings of control over one’s own life (Towsend, Morgan, 2021).

In this context, the high prevalence, clinical severity, and significant mortality rates related to eating disorders, as well as the increase in their rates worldwide, highlight the need to improve diagnostic criteria and develop more precise instruments capable of promoting early identification and the implementation of timely and effective interventions (Bertoletti; Antunes, 2023).

According to Ferreira (2018), anorexia and bulimia nervosa are eating disorders that are growing worldwide every day and result not from just one, but from a multitude of factors that influence their appearance in the individual. From a psychopathological point of view, the intense fear of gaining weight is a central element in eating disorders, manifesting itself in different ways depending on the clinical picture. In anorexia nervosa, this fear leads to food refusal even when hungry, differentiating it from other conditions associated with weight loss. In bulimia nervosa, the fear of obesity is momentarily relieved by episodes of binge eating followed by compensatory behaviors, while in binge eating disorder these episodes occur without purging practices (Rathke; Barros, 2014).



According to Sadock, Sadock, Ruiz (2017, p. 509), the expression anorexia nervosa is derived from the Greek term for “loss of appetite” and a Latin word implying nervous origin. It is characterized by a distorted body image and intense food restriction, which can result in significant weight loss (Sgarbim et al., 2023).

According to APA (2023), AN has three essential characteristics: (A) persistent restriction of caloric intake, (B) intense fear of gaining weight or becoming fat or persistent behavior that interferes with weight gain, and (C) disturbance in the perception of one’s own weight or shape, in addition to being classified into two important subtypes as shown in the image below.

Table 1 -Subtypes of Anorexia Nervosa (AN)

Restrictive Anorexia Nervosa (AN)	Anorexia Nervosa (AN) Purgative
Weight loss occurs primarily through diet, fasting, and/or excessive exercise, combined with progressive food restriction and the exclusion of food groups.	It presents occasional episodes of excessive food intake, especially of foods rich in carbohydrates and lipids, followed by the use of compensatory behaviors such as laxatives, diuretics, enemas, and induced vomiting for weight loss.

Regarding the clinical picture, AN usually begins with progressive dietary restrictions, such as the exclusion of foods considered high in calories, often justified by the pursuit of a “healthy” diet. Over time, there is a reduction in the quantity and variety of food, accompanied by weight loss or failure to achieve the expected weight gain, which can progress to malnutrition (Appolinario, 2022).

People with anorexia nervosa (AN) have high rates of psychiatric comorbidities, such as depression, obsessive-compulsive disorder (OCD), personality disorders, as well as possible problems related to the use of psychoactive substances (Carvalho, Gonçalves, Araújo, 2025).



The term bulimia nervosa derives from the terms for “hunger of The word “bulimia nervosa” comes from the Greek word for “ox” and the Latin word for “nervous involvement.” For some patients, bulimia nervosa may represent a failed attempt at anorexia nervosa, sharing the goal of becoming very thin, but occurring in people with less capacity to maintain prolonged semi-starvation or extreme hunger, such as those with classic restrictive anorexia nervosa (Sadock, Sadock, Ruiz, 2017).

Bulimia nervosa, on the other hand, involves recurrent episodes of excessive food intake in a short period of time, followed by the adoption of inappropriate compensatory behaviors to avoid weight gain, such as self-induced vomiting and the use of laxatives and diuretics (Sgarbim et al., 2023).

According to the APA (2023, p. 388), there are three essential aspects in bulimia nervosa: (A) recurrent episodes of binge eating, (B) recurrent inappropriate compensatory behaviors to prevent weight gain, (C) binge eating and inappropriate compensatory behaviors must occur on average at least once a week for three months, (D) self-evaluation unduly influenced by body shape and weight, to qualify for the diagnosis.

According to Appolinario (2022), the clinical picture is marked by episodes of binge eating, characterized by excessive food intake associated with a feeling of loss of control. These episodes usually occur after periods of food restriction or in situations of emotional dysregulation, frequently involving foods rich in carbohydrates and fats. They generally occur covertly and are accompanied by intense feelings of guilt, shame, and psychological suffering. People with bulimia nervosa (BM) have a higher frequency of psychiatric comorbidities, such as bipolar and depressive disorders, and anxiety disorders may also be present (APA, 2023).

Nursing Management in Primary Health Care for Eating Disorders in Adolescence

The management of eating disorders (EDs) in adolescence requires a multidisciplinary and coordinated approach, involving different areas of health, due to the clinical complexity of these conditions, demanding the integrated action of professionals such as psychiatrists, nutritionists, nurses



and therapists, as well as other specialists as needed (Carmo, Pereira, Cândido, 2014).

This highlights the need for a structured primary health care system capable of organizing care and improving care practices in the face of the complexity of eating disorders in adolescence, emphasizing the role of the nurse as a strategic professional in this process, especially in coordinating care, providing support, listening attentively, and offering longitudinal follow-up for adolescents and their families.

It is also considered that adolescents with eating disorders often initially seek out healthcare professionals who are not specialists in mental health, motivated by nonspecific emotional, physical, or behavioral complaints. This makes it essential that all professionals involved in healthcare, including those in primary care, nutritionists, and physical education teachers, are trained to recognize warning signs and make timely referrals to specialized services, thus promoting early intervention and reducing complications (Muzy, Carvalho, 2025).

In this sense, the National Policy for Comprehensive Healthcare for Adolescents and Young People (PNAISAJ) recognizes adolescence as a strategic period for mental health interventions, emphasizing the strengthening of healthy social and emotional behaviors and the early identification of risk situations (Brazil, 2010). This guideline reinforces the understanding of eating disorders as biopsychosocial phenomena, demanding preventive, educational, and care actions within the scope of primary care, in accordance with the principles of comprehensive and territorial care.

Given this scenario, in the context of primary health care, nurses have legal support to request complementary examinations in adolescence, as established by Law No. 7,498/1986, provided that this practice is included in protocols, public health programs, and institutional routines. This attribution strengthens the professional autonomy of nurses and contributes to the early identification of problems, clinical monitoring, and longitudinal follow-up of adolescents with eating disorders, promoting comprehensive and effective care.

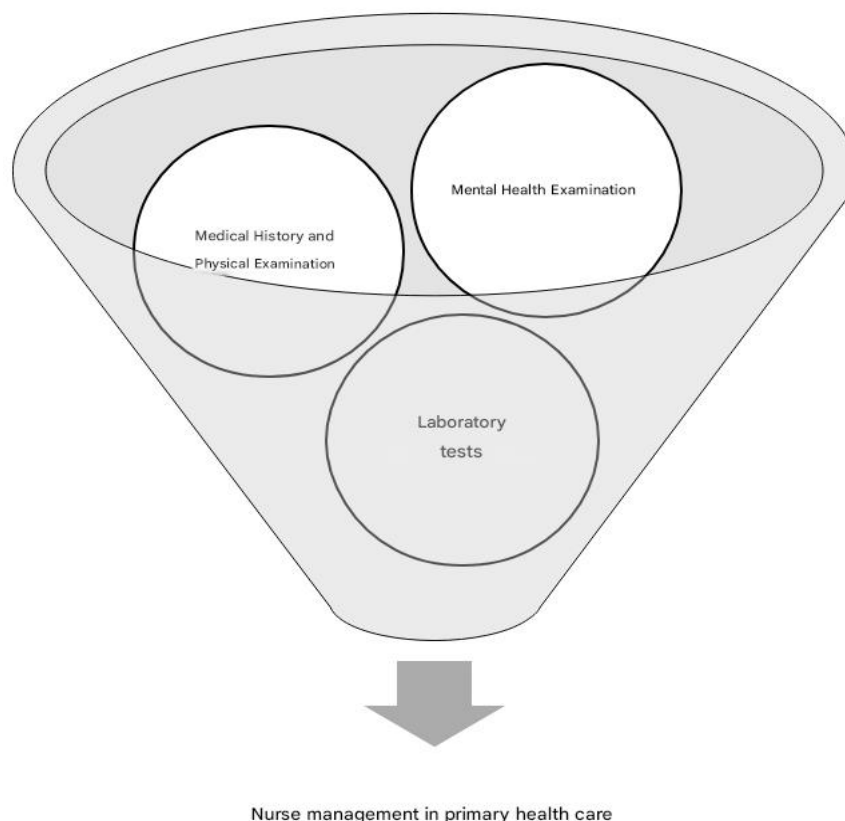
Therefore, nursing management of eating disorders in adolescence requires an integrated clinical approach, including physical and mental assessment of the adolescent, a psychiatric



examination, and monitoring through laboratory tests. These elements guide the early identification of problems, the planning of interventions, and the longitudinal follow-up of care.

For this to happen, it is essential to establish a solid therapeutic relationship between the nurse and the patient, starting with a comprehensive assessment that involves physical examination and the identification of nursing diagnoses, because it is from this process that the nurse, together with the patient and their family, develops a care plan according to the identified needs (Ferreira, Viana, Silva, 2024).

Image 2 –Components in the Management of Eating Disorders in Adolescents in Primary Health Care.



Source: Own work (2025).



In the context of routine consultations, especially during the initial assessment, nurses can use screening tools and specific questionnaires aimed at identifying eating disorders, such as the SCOFF (Sick, Control, One Stone, Fat, Food Questionnaire), which assesses signs suggestive of anorexia nervosa and bulimia nervosa, among other protocols appropriate for Primary Health Care (Teixeira et al., 2021).

The SCOFF is not a diagnostic tool and should not be used as a substitute for a complete clinical evaluation; however, based on the findings of the initial screening, it becomes possible to make timely referrals of adolescents for multidisciplinary follow-up, favoring the early initiation of care and the reduction of possible complications (Lima, 2012).

Table 3 –SCOFF Instrument Questions

Nº	QUESTIONS	SIM	NO
1	Do you induce vomiting because you feel uncomfortably full?		
2	Are you worried that you've lost control over how much you eat?		
3	Have you recently lost more than 6 kg in a 3-month period?		
4	Do you believe you are fat even when others say you are too thin?		
5	Would you say that food dominates your life?		

Interpretation after the instrument has been applied by healthcare professionals, whether or not they are specialists in mental health, within the context of primary health care.

- 1 point: low risk (initial suspicion of a possible eating disorder);
- 2 points: moderate risk (likely ongoing eating disorder);
- > 3 points: high risk (high potential for serious eating disorder).

The use of standardized instruments, validated internationally or nationally, is fundamental for assessment and management by nurses in primary health care. In addition, Gurgel et al. (2023) emphasize that the initial assessment of adolescents suspected of having eating disorders should be based on a detailed medical history, including current, minimum, maximum, and desired weight, as



well as, in the case of girls, the age of menarche and menstrual pattern.

According to the author cited earlier, dietary patterns should be investigated, including restrictions, fasting, preferences, and peculiar behaviors, as well as the frequency of episodes of overeating, vomiting, and the abusive use of anorexigenics, diuretics, laxatives, or other medications. The assessment should also encompass body image distortion, the adolescent's level of understanding of the harms associated with the disorder, physical exercise patterns, and a complete physical examination, providing information to support the planning of multidisciplinary care.

Regarding the assessment of nutritional status, Carvalho (2025) emphasizes that the nurse should measure weight and height, using the Body Mass Index (BMI) as one of the main indicators for comparison with reference standards for age and sex, enabling the monitoring of the degree of malnutrition and the clinical evolution of the adolescent throughout the follow-up.

In addition to clinical aspects, the adolescent's life history is a central element in nursing assessment, since family, school, and social experiences can directly influence eating behavior and mental health.

Investigating situations of bullying, family conflicts, patterns of aesthetic pressure, family history of mental disorders, and recent stressful events contributes to understanding eating disorders in their biopsychosocial dimension, favoring individualized interventions that are sensitive to the adolescent's life, as observed below.

Table 4 –Aspects and considerations in Nursing Assessment

$$\text{BMI} = \frac{\text{Weight (Kg)}}{\text{Height}^2 \text{ (mts)}}$$

Source: Adapted from: Marclona, Castro (2013).

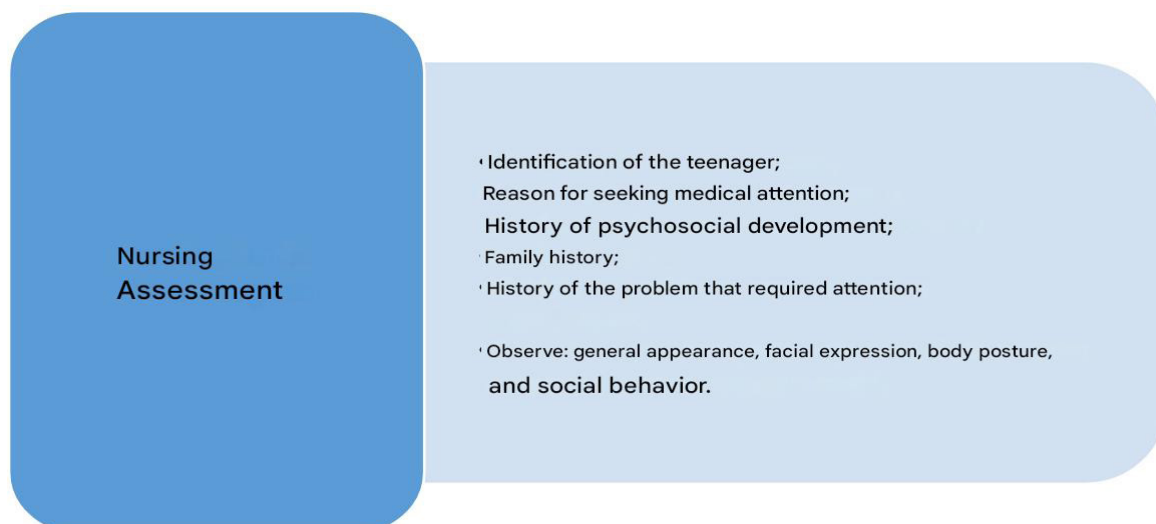
The mental examination, therefore, consists of an analysis that is carried out using information



collected in the interview/history, associated with verbal expression and observation of behavior, taking as a reference the sociocultural and family reality of the person being evaluated, as well as the characteristics of the health care service. The ten psychic functions are evaluated throughout the interview and, at the end of the examination, the findings identified in each of them are described (Marcolan, Castro, 2013).

Nursing assessment in the care of adolescents with eating disorders should encompass not only physical and nutritional aspects, but also the emotional and behavioral components involved in the illness, considering the psychological nature of these conditions.

Table 5 –Aspects and/or mental functions observed in the mental status examination.



Source: Adapted from: Marclona, Castro (2013); Sadock; Sadock; Ruiz (2017)

It is necessary for the nurse to integrate the mental status examination of the adolescent with eating disorders, whether anorexia nervosa or biochemical bipolar disorder, during their assessment, as it is an important component for identifying nursing problems, constructing nursing diagnoses (ND), and consequently, short-, medium-, and long-term nursing interventions.

In the management of eating disorders, biochemical tests play a complementary role to



clinical evaluation, allowing the identification of organic repercussions resulting from food restriction, purging, or binge eating, considering the request and evaluation of complete blood count, blood glucose levels, lipid profile, electrolytes, renal function, hepatic function, hormone levels, electrocardiogram (ECG), and urine tests.

Electrolyte imbalances, metabolic disorders, anemia, hypoglycemia, and hormonal changes are frequent findings, especially in more severe cases. Although the request and interpretation of these tests are shared with the medical team, it is the nurse's responsibility to monitor the results, track risk signs, and coordinate care, ensuring continuity of care and the adolescent's safety in primary health care.

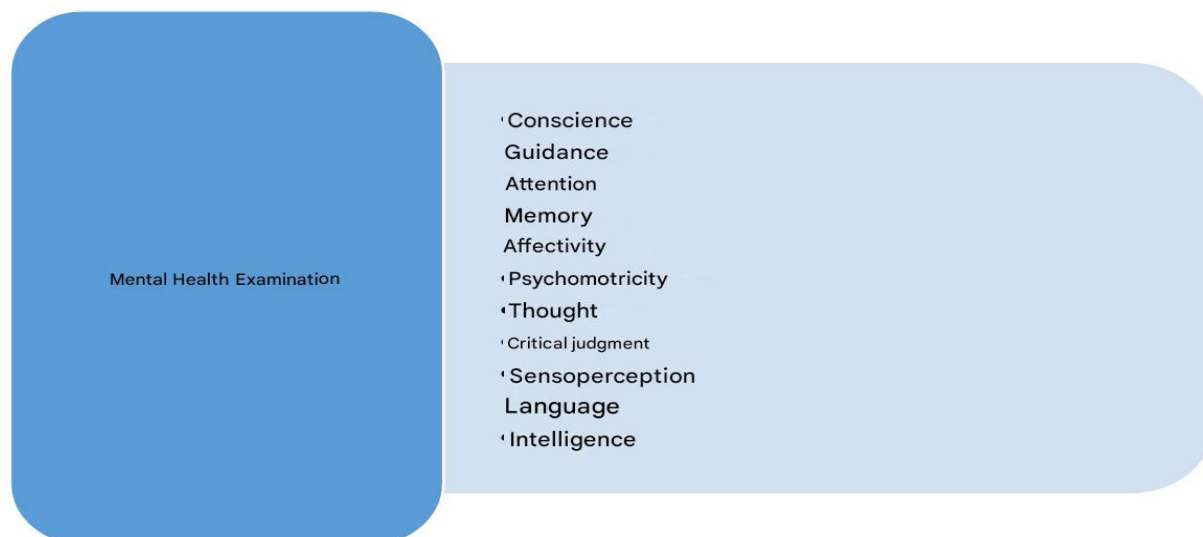
According to Pinto et al. (2023), nurses need to be able to guide and conduct high-quality and efficient clinical follow-up for patients and their families, focusing on establishing bonds of trust, emotional support, and guidance on the pathology and its physical consequences.

Nursing aims to maximize clients' positive interaction with their environment, increase their level of happiness, and reinforce their degree of autonomy. Care for these patients is continuous; therefore, the nurse must understand the illness to educate the patient to understand themselves and emphasize the importance of family. in the process, since patient follow-up goes beyond hospitalization (Pinto et al. 2023).

From this perspective, the management of eating disorders in adolescence, within the scope of primary health care by nurses, is structured around three fundamental axes, as observed in the image below.



Image 3 –Nursing strategies in the management of eating disorders in adolescents.



Source: Adapted from Cardoso, Andrade, Marques (2024).

These elements complement each other and reinforce the nurse's role as a strategic professional in the prevention, comprehensive care, and promotion of the mental health of adolescents monitored by them in primary health care.

In this sense, nursing management takes place during physical and psychological assessments, in regular meetings during nursing consultations, home visits, or through operational groups developed within primary health care, with the inclusion of family members as a fundamental support network in this process.

According to Townsend and Morgan (2021), nursing interventions in the care of adolescents with eating disorders should be systematized, continuous, and focused on clinical safety, nutritional recovery, and emotional support. The nurse acts in monitoring physical status, preventing complications, providing support during meals, and mediating care with the multidisciplinary team, always considering the biological and psychosocial dimensions of the illness, and may consider the following nursing interventions:



- Monitor food intake, weight loss and gain, with daily weighing under standardized conditions;
- Regularly assess vital signs, paying attention to orthostatic hypotension and bradycardia;
- Observe hydration, skin turgor, and mucous membrane conditions;
- Accompany the patient during meals, offering support and establishing time limits;
- Perform postprandial surveillance to prevent purging behaviors;
- Maintain a detailed record of clinical and nutritional progress;
- Instruct the patient and family about the therapeutic plan, reinforcing adherence to treatment;
- Avoid focusing exclusively on food, prioritizing listening and addressing emotional aspects;
- Encourage the recognition of feelings and conflicts associated with eating behavior.

It is important for nurses to reflect on their competencies and skills in caring for adolescents with eating disorders within primary health care, knowing when to communicate with the team's physician and when to refer them to specialized care.

Given that a person suffering from severe eating disorders that put their life in danger, total lack of impulse control over food intake, persistent refusal to eat, presence of suicidal ideation or behavior, presence of delusional-hallucinatory ideation, weight below 75% of expected weight, and physical complications should be referred (Rathke, Barros, 2019).

Regarding eating disorders such as anorexia and bulimia nervosa, improvement and cure only occur when food and weight cease to be a constant concern in the lives of patients; and the contribution of the nursing professional is essential for the patient and their family to understand that human beings are more than just physical characteristics dictated by single standards, and that the



pursuit of a healthy life is what truly matters (Coras, Araújo, 2011).

It is clear that nurses play a crucial role in managing eating disorders in adolescents within primary health care. However, many times nurses working in this context develop barriers that need to be overcome to (re)build competencies and skills in the field of mental health, thus offering truly comprehensive and responsible care within the health care network.

FINAL CONSIDERATIONS

The findings of this narrative review show that eating disorders in adolescence constitute complex and multifactorial problems, strongly related to the biopsychosocial transformations inherent to this period of development, since the construction of identity, the relationship with the body, and the influence of sociocultural factors make adolescents particularly vulnerable.

In the context of Primary Health Care (PHC), its strategic role as the entry point to the Unified Health System (SUS) and a privileged space for welcoming, early identification, and longitudinal follow-up of adolescents with eating disorders stands out. In this scenario, the nurse assumes a central position in coordinating care, establishing the therapeutic bond, providing qualified listening, conducting comprehensive assessments, and coordinating with the psychosocial care network, contributing significantly to the comprehensiveness, continuity, and effectiveness of mental health care.

Despite the relevance of the nurse's role in this field, there is a significant gap in national scientific production regarding nursing management of eating disorders in adolescence, especially within the context of primary health care. This finding points to the need for investments in research, care protocols, and continuing education processes that strengthen evidence-based practices, contributing to the improvement of care, the reduction of stigma, and the promotion of mental health among adolescents in these communities.



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