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Difficulties and challenges of Brazilian psychiatrists regarding eating disorders care: a qualitative study

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Abstract

Objective

To explore the perceptions of Brazilian psychiatrists regarding the challenges of eating disorders (ED) care in Brazil, based on their clinical experiences.

Method

This is a qualitative, descriptive and exploratory study. Data were collected through an online survey, distributed to Brazilian psychiatrists. There were 191 valid responses to an open-ended question, asking for comments about their experiences in caring for ED patients. Transcriptions were submitted to lexical analysis using the Alceste 2012 software.

Results

The sample was predominant women (67,53%); 30–59 years-old (79,58%); from Southeast region (56,02%). There were two thematic axes: (I) lack of experience with ED and the need to refer to ED specialists, and (II) barriers and limitations in treating ED patients, divided into two classes (a) insufficient training and unavailability of a multidisciplinary team, and (b) patient's low adherence and lack of family support.

Discussion

These results highlighted the main difficulties and challenges faced by Brazilian psychiatrists in their routine clinical practice regarding ED care. It reflects the need to develop and implement some strategies aiming the clinical training on the management of ED, the expansion of multidisciplinary teams´ availability, and the psychoeducation for patients and their families, to improve treatment adherence.

Plain English summary

Eating disorders (EDs) are complex psychiatric conditions that require specialized, multidisciplinary care. This study investigated the main challenges faced by Brazilian psychiatrists in the management of patients with EDs. The findings revealed that the most frequently reported barriers were limited clinical experience with EDs and insufficient training during medical education, often resulting in referrals to specialized services. Additional challenges included the lack of access to multidisciplinary teams, poor patient adherence to treatment, and limited family involvement. These findings highlight important gaps in the provision of ED care in Brazil and emphasize the need for targeted strategies to improve professional training, expand access to specialized multidisciplinary services, and strengthen family engagement throughout treatment.

1. Introduction

Eating disorders (ED) are a global mental health concern, particularly among young people and gender/sexual minorities.[1] Global estimates indicate that 13.6% of individuals are affected by an ED, with a prevalence of 9% among females and 4.7% among males. This burden is associated with an estimated loss of approximately 3.3 million disability-adjusted life years (DALYs) worldwide.[2,3] Furthermore, ED prevalence has increased considerably over the past two decades, worsening even further since the COVID-19 pandemic.[4,5]

Several studies have identified key obstacles to accessing and engaging with ED treatment, as well as potential facilitators.[6–10] Authors consistently divide them into individual barriers (feelings like shame and/or personal beliefs that minimize the severity of ED conditions) and process or systemic barriers (difficulties in access and availability of treatment - financial limitations, lack of knowledge about treatment or lack of available and efficient treatments.[11,12]

Researchers have increasingly focused on the perceptions of healthcare professionals in delivering ED care.[13,14] In fact, a recent systematic review of qualitative studies brought up important themes: 1) challenging experiences in providing ED care due to complex and multifactorial characteristics of ED and the difficulty of communicating with patients; 2) ability to work with specialized multidisciplinary health teams, with constant need to be flexible and have clinical discussions; 3) malleability necessary to deal with patients' and family members' ambivalences towards ED.[15]

In Brazil, the provision of ED care remains uneven and inadequately structured.[16,17] There are no dedicated public policies specifically targeting patients with ED in Brazil and their assistance is poorly systematized.[18] A survey that evaluated the provision of ED services in Brazil demonstrated that there are few specialized units and that these are basically concentrated in university or educational institutions and in large urban centers.[19] Although ED treatment is covered by Brazil's public mental healthcare network, called "Rede de Atenção Psicossocial (RAPS)", one of many services of our "Sistema Único de Saúde" (SUS), we are faced with a scenario of great scarcity in this area. [20] In addition, reports pointed out that only part of those affected by severe mental health disorders receive proper treatment in Brazil.[21]

To address the limited information on psychiatrists' perspectives on ED care in Brazil, the ED Committee of the Brazilian Psychiatric Association (ABP) conducted a cross-sectional study to assess Brazilian psychiatrist´s knowledge and self-reported confidence in diagnosing and treating ED. The quantitative findings revealed significant gaps in both areas, raising serious concerns about the potential impact on the quality of care for individuals with ED in Brazil.[22]

As an extension of prior quantitative research, our study adopts a qualitative approach to delve into Brazilian psychiatrists' perceptions of ED care in our country. This study offers a unique contribution by

focusing on the specific perspective of psychiatrists – who typically coordinate patient management – within the Brazilian context, a Latin American country where scientific data on ED care remains scarce.

2. Methods

2.1 Study Design and Participants

This is a qualitative, descriptive and exploratory study conducted by the ED Committee of ABP. The research is part of a broader investigation[22] and aimed to explore psychiatrists' perspectives on the challenges of caring for individuals with ED in Brazil. Data were collected through an online survey (see Supplementary Material), which was distributed, by an email distribution list, to all psychiatrists affiliated to ABP. A total of 259 professionals completed the questionnaire. The instrument comprised sections on participants' sociodemographic information, multiple-choice questions regarding ED diagnosis and treatment, based on standard clinical guidelines, and an open-ended question soliciting personal comments on their experiences providing care to ED patients.

2.2 Procedures

The questionnaire was adapted from a validated instrument on ED knowledge developed by Jones and Morgan (2013)[23], with formal authorization obtained from the original author. To address the study's qualitative objective, the following open-ended question was added: *"Please add any comment that you consider important about your experience in caring for patients with eating disorders."* The final instrument was formatted using Google Forms and subjected to a pilot test with six psychiatrists not specialized in EDs, allowing for subsequent adjustments. The survey was disseminated via email to all ABP members, accompanied by the Free and Informed Consent Form and a direct link to access the questionnaire. Data collection took place from June to August 2021.

2.3 Data analysis

Out of the 259 participants, 191 provided valid responses to the open-ended question. Responses that were blank or unrelated to the research objective (e.g., general remarks such as "Congratulations on the study" or "Thank you") were excluded from the corpus construction. The remaining 191 responses were exported to Excel and used to create the textual corpus, with each response constituting an Initial Context Unit (ICU), corresponding to one completed survey response.

The corpus was analyzed using ALCESTE 2012 software (Analyse Lexicale par Contexte d'un Ensemble de Segments de Texte), a textual data analysis tool that applies statistical and lexical methods to examine the structure and meaning of discourse.[24,25] The software performs a lexicographic and lexicometric analysis, organizing text segments into lexical classes based on co-occurring terms and semantic proximity. Through Descending Hierarchical Classification (DHC), the software generates dendrograms that visually represent these lexical classes and their relationships.

Each class is composed of Elementary Context Units (ECUs), representing the most statistically significant segments within the discourse. The analysis focused on the DHC dendrogram and the ECUs that comprise it. These classes were interpreted based on their most associated keywords (measured by Phi values) and the thematic content expressed in the ECUs. For analytical purposes, participant characteristics such as sex, age group, and geographic region were also considered to contextualize the findings.

3. Results

Among the 191 valid responses, the majority was composed by women (67.53%); in the age group of 30–59 years-old (79.58%); from the Southeast region (56,02%) – see Table 1.

Table 1
Sample description (N = 191)

Sex		**n**	**%**
	Female	**129**	**67.54**
	Male	62	32,46
Age group	≤ 29	14	7,33
	30–59	152	79.58
	≥ 60	25	13,09
Region	South	41	21,47
	Southeast	103	56,02
	Midwest	17	8,90
	North	4	2,09
	Northeast	25	13,09

After processing data, 917 distinct forms were analyzed, and then 108 relevant forms were generated by reduction process. The percentage of vocabulary richness was 93.35%, and the average number of words analyzed per ECU was 5.22. The corpus was subdivided into 210 ECUs, with 71% of ECUs classified and 29% was discarded.

The DHC dendrogram presented in Figure 1 illustrates the identification of three stable lexical classes, organized into two primary thematic axes: **Axis I – Lack of experience with ED patients and need to refer to specialists**, formed by **Class 1**, with 14% of the corpus (370 ECUs, 112 analyzable words); **Axis II – Barriers and limitations in treating ED patients**, divided into **Class 2 – Insufficient training and unavailability of a multidisciplinary team**, and **Class 3 – Patient's low adherence and lack of family support**, with the remaining 86% of the corpus. Class 2 contained the highest retention rate, with 75% of

the corpus (111 ECU, 28 analyzable words), and Class 3 had 11% of the corpus (16 ECU, 13 analyzable words). While sharing related lexicons, the distinct thematic focuses of Class 2 and Class 3 justified their separation into two classes within the same overarching axis. In turn, Class 1 had more evident oppositions of meaning in relation to the classes of axis 2, which justified its separation.

Axis I (Class 1): Lack of experience with ED patients and need to refer to specialists

This class describes the lack of clinical experience in ED care. We can observe that the psychiatrists in the sample are not used to receiving and accepting patients with this diagnosis, and they usually refer them to professionals who have more experience in treating ED. The results also pointed out that these psychiatrists prefer to avoid treating people with ED, by directing them to specialists or professionals with more experience instead of seeking for training and improving their skills to better serve these patients. The lexicon with the greatest statistical association with this class, as shown in Figure 1, is experi+ [experience, experienced]. This finding indicates that, for most respondents, previous experience is considered essential for providing ideal care to patients with ED. Therefore, they usually refer these patients to other clinicians, mainly ED specialists. This pattern reflects a broader issue in psychiatric practice where **experience is viewed as essential**for effective ED care, reinforcing the reliance on referral pathways.

P27: "**I have no experience** with these patients because **I have always referred** them to colleagues who are more specialized in the subject".

P65: "**I do not see them**; **I refer them to a specialist**".

P67: "**I do not see patients** whose main complaint is an eating disorder, **I refer them to a specialist** in the subject".

P90: "**I usually refer** them to colleagues".

P132: "I have **no experience**".

P162: "**I do not have much experience** with patients with eating disorders and **I usually refer** them to colleagues who do".

P172: "**I do not treat** patients with eating disorders".

Axis II: Barriers and limitations in treating ED patients

Classes 2 and 3 addressed the difficulties encountered in the clinical care of people with ED. While Class 2 placed the difficulties in political and institutional aspects, Class 3 explored the personified dimensions, represented by low patient adherence and family support. Therefore, what brought the classes together was the meaning of "difficulty" and what separated them was the locus where these difficulties were located.

Class 2: Insufficient training and unavailability of a multidisciplinary team

The lexicon most statistically associated with Class 2 is multidisciplinary+ [multidisciplinary, multidisciplinary]. Analysis of the ECUs within this class reveals that a multidisciplinary team, specialized knowledge, and professional training constitute the three pillars of effective ED care, and these deficiencies are configured as the great difficulty in the clinical care of people with this diagnosis.

P5: "The subject **is not widely available in our training**. There **is little availability of non-medical professionals specialized** in the area".

P8: "There is a **lack of specialized professionals** for **multidisciplinary work** in public health".

P21: "Other medical specialties with little **training, knowledge regarding eating disorders**".

P53: "**There is a lack of specialized professionals** in the area for **multidisciplinary care** other than psychiatrists".

P96: "A **multidisciplinary approach would be important**, something we cannot count on in small towns in the countryside, like mine. There is a **lack of training** for professionals in all specialties on the subject and a lack of political will to form teams in the public health service".

P106: "Working in the countryside with patients with eating disorders is difficult and lonely, there is a **lack of professionals prepared** to have a different vision for the treatment of these disorders".

P143: "In the public service where I work, **I try to work together** with the nutritionist and the psychology team, but as **there is no specific training for the team**, much of this management is insufficient, in my opinion".

Class 3: Patient's low adherence and lack of family support

In this class, the lexicon with the greatest statistical association is baix+ [low, low]. This lexicon, in conjunction with the corresponding ECUs, highlights low patient adherence to treatment and a lack of family support and understanding.

P16: "It is difficult to have **patient adherence** to treatment".

P58: "**Poor insight from patients and families** is one of the main difficulties in managing eating disorders".

P93: "The difficulty these patients encounter is **cultural and family support**".

P100: "Patients with **low adherence** to treatment".

P113: "In addition to diagnostic errors, there is **low family adherence** to support patients".

P126: “They are **difficult patients** with **little insight** about their pathology. **Families often do not see binge eating disorder in adolescents as a disease**”.

P151: “If the **family does not support**, treatment is very difficult”.

4. Discussion

Our findings underscore the multifaceted difficulties in clinical care for ED patients experienced by Brazilian psychiatrists. The analysis of their perceptions revealed a landscape defined by significant challenges, which we categorized into two main thematic axes. The first axis highlights a prevalent lack of clinical experience, which compels many psychiatrists to refer ED patients to more specialized colleagues, effectively creating a barrier to initial care. The second axis details the systemic and interpersonal barriers that persist even when care is initiated. These include important deficiencies in professional training and the conspicuous absence of functional multidisciplinary teams, alongside the profound challenges of low patient adherence to treatment and inadequate family support. Taken together, these results reveal a picture of the current difficult scenario of ED care in Brazil, where structural and interpersonal obstacles significantly compromise the delivery of effective care.

These findings show a remarkable convergence with the conclusions of a recent systematic review and meta-synthesis by Maia et al. (2023)[15], which investigated the perceptions of various health professionals providing care for anorexia and bulimia nervosa internationally. Their study identified key themes such as the hard relational experiences of professionals ("Going outside the comfort zone"), the need for multidisciplinary discussion and flexibility ("Reflecting on treatment"), and the challenge of managing family dynamics ("Dealing with ambivalences"). Our study’s findings on low patient adherence, the need for multidisciplinary teams, and the lack of family support align directly with these internationally recognized themes. While Maia et al. noted a lack of studies from Latin America in their review, our research helps fill this geographical gap, providing robust, initial evidence that these same challenges are acutely perceived by psychiatrists within the specific context of the Brazilian healthcare system.

First, we highlight the role of the lack of professional training in compromising the quality of ED care. The tendency among our respondents to refer patients with ED to other professionals, as identified in the Axis I (Class 1), appears to be a direct consequence of insufficient training and a resulting lack of confidence. This is not an isolated phenomenon; studies consistently show that even modest improvements in ED knowledge can significantly enhance healthcare providers' comfort and attitudes toward patients with ED, thereby improving clinical care.[26–28] The gap is so critical that leading researchers emphasize that expanding ED training, potentially via innovative digital tools, is essential to increase the reach of evidence-based therapies and reduce the treatment gap.[12] This reinforces that the lack of experience reported by Brazilian psychiatrists is not a personal failing but a systemic issue demanding urgent educational intervention.

Another significant challenge identified in our study is related to the need for ED multidisciplinary specialized teams to adopt evidence-based approaches that enhance the outcomes of ED treatment. The need of such teams – ideally comprising medical, psychological, and nutritional expertise – is unequivocally recommended by international guidelines as the gold standard for addressing the complex comorbidities of ED.[29,30] However, our findings from Axis II (Class 2) reveal that Brazilian psychiatrists perceive these multidisciplinary teams as largely unavailable or functionally inadequate, a sentiment echoed by research indicating that increased exposure to and training in ED management boosts clinicians' confidence and effectiveness. Therefore, the path to improving care is twofold: it requires not only the potential development of multidisciplinary teams, but also the implementation of a robust and continuous training program to ensure that these teams are competent and confident in managing the complexities of ED.

Notably, multidisciplinary teams in Brazil are notably sparse, particularly in the context of treating patients with ED, which highlights a significant gap in the healthcare system.[18,19] The Unified Health System (SUS) has established a comprehensive psychosocial care network, which includes Basic Health Units (UBS) and Family Health Strategy (ESF) that handle primary care, case identification, and referrals, as well as Psychosocial Care Centers (CAPS) that provide intensive care.[31] However, the absence of essential specialists like nutritionists in the CAPS team presents a significant limitation, as these professionals are vital for effective ED management, in accordance with international guidelines.[30]

The effective social integration of ED care in Brazil will require broad public policy initiatives that can define, based on scientific evidence, minimum standards of care and promote the creation of geographically distributed multidisciplinary teams. A key barrier to progress is the low level of clinical exposure that psychiatrists have, mainly due to the inadequacies in training in medical schools and postgraduate settings, which often results in referring patients to sub-specialist psychiatrists.[24] Clinical exposure has been shown empirically to improve competence and willingness to manage ED, highlighting the immediate need for change within psychiatric and mental health education. [32–34] Complementary continuing professional educational opportunities are also crucial to develop skills and support equitable and high-quality care in this neglected area of mental health.

The complexity of ED care encompasses various factors: patients often exhibit poor insight into their illnesses, as well as notable ambivalence and refusal to accept professional help, which complicates treatment.[35–37] Moreover, responses from our sample highlighted the essential role of family in delivering effective care – families can be a crucial source of information and support, yet, hostility towards the diagnosis or treatment plan from family members, including affected relatives with significant current needs, can critically hinder recovery efforts.[38–40] These insights underscore the necessity for supervised training in clinical practice, as it is in these contexts that professionals learn to deal with transference and counter-transference dynamics, thereby enhancing their ability to manage cases characterized by low insight and motivation through relationship-building and psychoeducation concerning symptoms.

The limitations of this study suggest important avenues for future research. First, most questionnaires responses came from the Southeast region of the country (56,02%), so it's important to assess the availability of essential multidisciplinary teams across different regions in Brazil and their difficulties, that could provide potential solutions to improve service delivery. Such investigations could offer valuable insights into how to address disparities in care and enhance the efficacy of treatment models. Second, our sample was constituted only by psychiatrists. As the care of eating disordered patients usually involve other professionals such as psychologists and dietitians, it´s important to explore also the perspectives of those professionals in the management of ED patients in Brazil. Finally, the perspective of patients and families was not evaluated. By amplifying the voices of patients and families, future studies could play a pivotal role in shaping healthcare policies and programs aimed at improving the management of ED across Brazil.

This research offers valuable insights into the management of ED in Brazil, particularly emphasizing the obstacles present within the national healthcare system. It underscores the significance of multidisciplinary teams, which include professionals from psychiatry, nutrition, and psychology, as they are crucial for delivering holistic care. However, accessing these teams poses challenges, as they frequently lack sufficient resources and training opportunities. This deficiency can hinder the accurate identification and management of symptoms, ultimately affecting treatment effectiveness. The findings advocate for a reassessment of the educational curriculum, particularly concerning the training of essential team members, to ensure both theoretical knowledge and practical skills are available for the diagnosis and treatment of ED.

Furthermore, the incorporation of psychoeducation for patients and their families is crucial: it fosters awareness and understanding of ED within communities. The study underscores the need for initiatives aimed at sensitizing support networks, as well as educating patients about their conditions. By addressing the significance of these awareness initiatives, the research calls for structured prevention strategies that can empower both families and patients. Establishing a robust support system is essential for enhancing recovery outcomes and fostering an environment in which individuals feel secure in seeking help.

Conclusions

Our results indicate that Brazilian psychiatrists face two principal challenges in managing eating disorder patients: insufficient clinical experience, often resulting in referral to subspecialists, and systemic as well as interpersonal barriers that undermine treatment. The latter include inadequate professional training, absence of multidisciplinary teams, low patient adherence, and limited family involvement, collectively constraining the effectiveness and continuity of care within the national context.

In order to address this reality, we proposed the following targeted measures: (1) enhance medical and health-professional training in ED, incorporating mandatory clinical exposure to ED patients in academic

curriculum; (2) Expand access to multidisciplinary teams specialized in DE, from public provision for contracts, to actions that encourage and engage the specialization of professionals in this area; (3) widely disseminate accurate information about ED to reduce stigma and improve patient adherence; (4) provide support and education to families, enabling them to recognize their vital role and actively contribute to ED recovery (Fig. 2).

Declarations

Data availability statement: Data is available upon request.

Funding statement: We did not receive any financial support.

Conflicts of interest disclosure: The authors have no conflict to declare.

Ethics approval statement: This study was performed in line with the principles of the Declaration of Helsinki, and it was approved by the Universidade Federal do Rio de Janeiro Ethics Committee.

Consent to participate: Informed consent to participate in the study was obtained from psychiatrists' respondents.

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Author Contribution

MCA participated in the conceptualization, formal analysis, writing and reviewing of the paper. MAP, JCH, PPL, MAN, TC, AS, DC, AGS contributed to the design, writing and reviewing of the material. MA, MAAP assisted the data curation, formal analysis investigation, and reviewing of the article. JCA was responsible for the conceptualization, methodology of the study, besides the supervision and reviewing of the manuscript.

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Figures

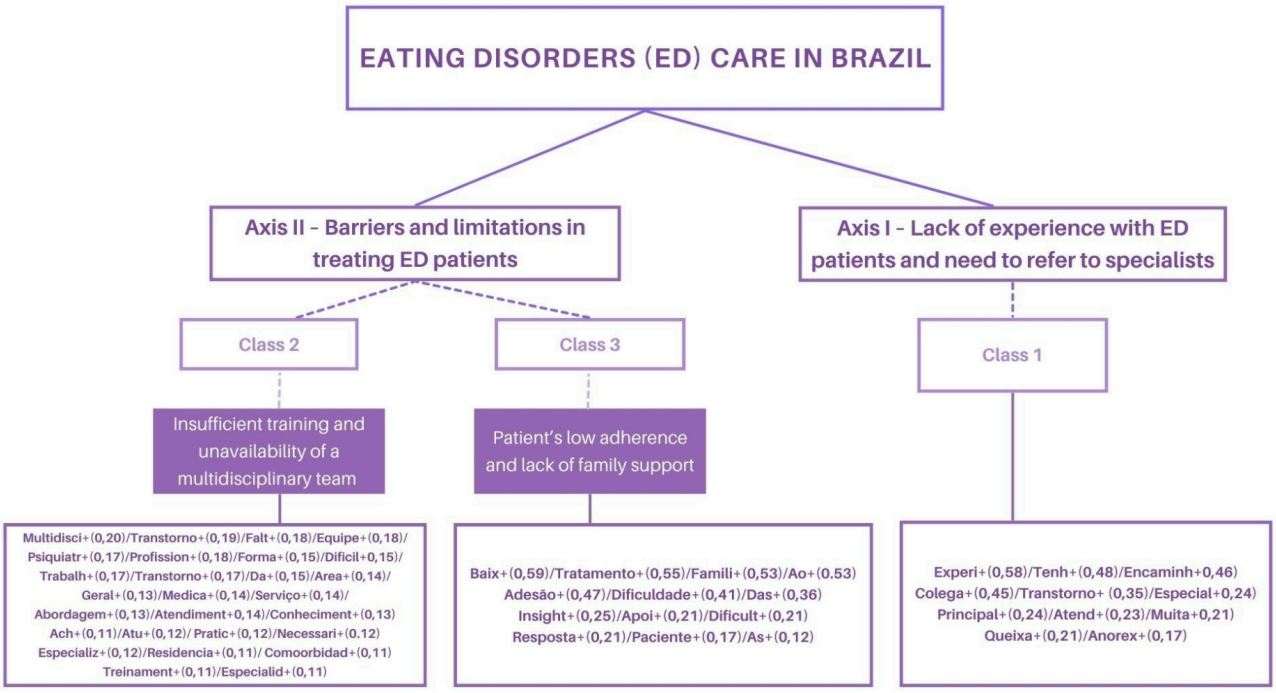


Figure 1

Hierarchical Descending Classification (HDC) Dendrogram representing the difficulties and challenges of eating disorders´ care in Brazil through the perception of Brazilian psychiatrists



Figure 2

Focal points for improvement of eating disorders' care in Brazil, according to the perception of Brazilian psychiatrists