

Improving Healthcare Provider Knowledge on Recognition and Treatment of
Avoidant/Restrictive Food Intake Disorder (ARFID)

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Major Project/Report submitted to the faculty of the Virginia Polytechnic Institute and
State University in partial fulfillment of the requirements for the degree of
Online Master of Agricultural and Life Sciences

In

Applied Nutrition and Physical Activity

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Date of Submission - 07/24/2024

Keywords:

*Avoidant/Restrictive Food Intake Disorder (ARFID), Autism Spectrum Disorder (ASD),
Diagnostic Statistical Manual-5 (DSM-5), Eating Disorder (ED), Cognitive Behavioral Therapy
(CBT), Family-Based Therapy/Treatment (FBT)*

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Abstract

Avoidant/Restrictive Food Intake Disorder (ARFID) is a newly recognized feeding and eating disorder that is commonly mistaken as picky eating in youth or childhood. It is often difficult to diagnose, as it frequently co-occurs with Autism Spectrum Disorder (ASD). First added to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in 2013, the definition of ARFID was updated in 2022 with clearer diagnostic criteria. Screening practices for ARFID remain limited, and healthcare professionals usually have minimal training on this topic. Due to ARFID being less familiar among healthcare providers, the diagnostic prevalence is low, and treatment options are scarce. This project discusses the importance of increasing the awareness of ARFID among healthcare professionals, which includes the identification and management of this disorder, and the importance of continuing research to understand this disorder better. The goal of this project was to pilot a virtual professional development program with Continuing Education Units (CEUs) for registered dietitians and licensed therapists to increase awareness of the various characteristics and effects of ARFID based on a comprehensive literature review. Participants of the program found it to be informative and valuable to their careers. Increasing education

and awareness among providers is essential to improve the diagnosis and treatment options for ARFID.

Acknowledgments

To my parents, sister, and fiancé- I am sending the world's biggest hug and shouting THANK YOU from the rooftops for your endless love and support and cheering me on throughout this journey.

To Amy LaFalce, Emily Myers, and Stella Volpe- I would also like to thank you for your constant positivity, support, and guidance throughout this project.

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Introduction

Background and Setting

Avoidant/Restrictive food intake disorder (ARFID) is a feeding and eating disorder that was added to the Diagnostic Statistical Manual-5 (DSM-5) in 2013. ARFID is associated with several negative health outcomes, including malnutrition, bradycardia, amenorrhea, and electrolyte abnormalities (Thomas et al., 2017). ARFID is a difficult disorder to diagnose because it most often begins in younger children and co-occurs in individuals with Autism Spectrum Disorder (ASD), who may have communication difficulties (Schimansky et al., 2023).

ARFID can have multifactorial diagnoses that include different clinical presentations with likely multiple etiologies. Although there is little known about the possible causes of this disorder, neurodevelopmental disorders such as ASD may underlie some presentations (Sanchez-Cerezo et al., 2022). Brigham et al. (2018) hypothesized that both biological and environmental factors may contribute to the pathogenesis and that biological bases underlie sensory sensitivity, anxiety, and both homeostatic and hedonic appetites that increase the vulnerability to ARFID. Because ARFID is a relatively new diagnosis, the availability of research evidence is limited on its incidence, prevalence, and treatment methodology. (Sanchez-Cerezo et al., 2022).

The estimated prevalence of ARFID in non-clinical child and adolescent samples is between 0.3% - 15.5% (Sanchez-Cerezo et al., 2022). Grubb (2021) used a national

surveillance methodology to estimate the incidence of ARFID in children and adolescents reaching clinical care to be 2.02 out of 100,000 individuals, or 0.002% of the general population. Cooney et al. (2018) stated that commonly used psychometric tests for eating disorders (EDs), failed to detect individuals with ARFID, with most individuals presenting with advanced illness indicated by two or more physical symptoms at the time of the diagnosis. Comorbidities such as anxiety and ASD are also common (Sanchez-Cerezo et al., 2022). There is no best practice for measuring outcomes of interventions for ARFID. There are several assessments and treatments for ARFID that are still in the early stages of research, including overlap with criteria for pediatric feeding disorder, optimal methods for assessing nutrient deficiencies, and disciplines involved in treatment (Kambanis & Thomas, 2023). The development of assessment measures for ARFID is still slowly progressing (Willmott et al., 2023). As more research and data are uncovered, the treatment options for ARFID continue to evolve and expand. This demonstrates the need to address providers' knowledge gaps related to ARFID to provide the best care for these individuals.

Limited screening practices lead to minimal detection of ARFID, which in turn results in barriers to care and unmet treatment needs (Bryant et al., 2022). As more research becomes available, the treatment options for ARFID continue to evolve and adapt to the unique needs of individuals with this disorder. Current consensus-based guideline recommendations are that clinical care for ARFID involves assessment and

support from multidisciplinary teams consisting of mental and physical health care professionals, including registered dietitians (Archibald & Bryant-Waugh, 2023). With multidisciplinary approaches and various treatment adaptations, healthcare providers and individuals can give and receive the support they need to overcome this disorder. Educational resources should be easily accessible to healthcare professionals to further this knowledge on ARFID for the benefit of both professionals and individuals.

Needs Assessment

Healthcare professionals need quality educational resources for ongoing professional development in their field. This continuing education project was developed for a multidisciplinary practice of healthcare providers who want to improve the educational resources available to their peers. This private practice team of registered and licensed dietitians and a licensed professional counselor specializes in the treatment of a wide range of eating disorders. This private practice was looking to build its own continuing education platform to further expand providers' knowledge on topics that may not be as familiar within the community that it treats. The continuing education learning needs and interests provided in this pilot program were determined through a survey that was distributed to healthcare professionals over email. These prospective participant survey respondents indicated ARFID as a topic of interest. The survey responses were used to develop both a literature review and a PowerPoint presentation for the continuing education class. Table 1 shows the

survey/questionnaire used to determine the topic of the CEU course, which consisted of the following questions:

1. On a scale from 1 to 5 (1 being least, 5 being most). Please indicate your interest in further education on the following topics.
2. Are there any specific subtopics or areas within the field of eating disorders that you are particularly interested in learning more about? Specify, please.
3. What are the biggest challenges or barriers you face in treating individuals with eating disorders that you hope to address through further education?
4. Which of the following educational formats do you prefer for CEUs?
5. What topics or skills would you like to see included in a continuing education curriculum to help develop or further improve upon within your practice?

Through these questions, a consensus was reached that ARFID would be the main topic for this continuing education course, as it was the most popular answer chosen. Free response answers were taken into consideration when it came to the material provided for the presentation, with answers such as “ARFID and ASD,” “Explaining connections between physical and mental effects of malnutrition,” “How exposure therapy in therapeutic sessions can still be helpful,” “Learning more about the connections between physical health and mental health,” and so on. After reviewing the answers provided, they were carefully taken into consideration in building the bulk of the material for the presentation.

Statement of the Problem

Continuing Education Units (CEUs) are mandatory credits that dietitians and other healthcare professionals must earn to maintain their credentials/professional license. CEU credits can be expensive, time-consuming, or otherwise difficult to access. Some require in-person seminars and costs vary significantly. This program includes the combined benefits of being cost-friendly, easily accessible, and travel-friendly with it being conducted via Zoom. This course was also one hour long and around a typical lunchtime for most workplaces, which made it all the more accessible to providers who were interested in learning further about ARFID. The determination of this project came about through the private practice seeing an increase in pricing in continuing education resources. This team already provides outpatient support groups, intuitive eating groups, and teen support groups for a generous price; being able to educate and support colleagues with an affordable and accessible continuing education option was a logical next step. ARFID education was predicted to be the most popular topic selected as there had been an increase in individuals seeking help for ARFID or ARFID-like symptoms, with minimal information available on how to determine and treat the diagnostic criteria.

ARFID is more recently identified than other eating disorders listed in the DSM-5. According to the DSM-5, the specific criteria for ARFID include a lack of interest in eating or food in general, avoidance of food based on sensory characteristics, and

concern about aversive consequences of eating which are manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one or more of the following:

1. Significant weight loss or failure to achieve expected weight gain...
2. Significant nutritional deficiency...
3. Dependence on enteral feeding or oral nutritional supplements...
4. Marked interference with psychosocial functioning (US Substance Abuse and Mental Health Services Administration, n.d.).

ARFID was originally named “Selective Eating Disorder” due to its relevance surrounding “picky eating”. The disorder was renamed in 2013, and the diagnostic characteristics have continued to develop since then, with the most recent update occurring in 2022. Because this is a relatively new disorder in the diagnostic handbook, the research surrounding the disorder is still very limited regarding risk factors, prevalence, and treatment. While the diagnostic characteristics of ARFID have evolved, the condition may still need better screening, diagnostic, and treatment parameters.

ARFID is predominantly identified in older adolescents and adults, likely due its early symptoms in childhood being attributed to normal “picky eating” and thus not recognized as ARFID until additional symptoms are present at a later stage. While there is limited research surrounding ARFID, recent literature shows positive signs of progression through the identification of the disorder in both adults and

children/adolescents. Healthcare professionals need to stay current on the latest developments and guidelines for treating ARFID to ensure that individuals with this disorder receive the best possible care and support as treatment options evolve.

Project Objectives

The project objective aims to develop a continuing education program through a growing and independent, professional practice focused on treating eating disorders for registered dietitians and licensed therapists, focusing on Avoidant/Restrictive Food Intake Disorder (ARFID). It seeks to enhance healthcare providers' understanding of ARFID's diagnosis and treatment and increase awareness of its medical and nutritional complications, current treatment options, and barriers to treatment in adolescents. The goal is to equip healthcare professionals in the eating disorder field with the knowledge to better identify signs and symptoms and assess the appropriate level of care for individuals with ARFID. To achieve the goals that have been developed for this project, there were necessary questions to be asked. The questions that were created and have led to this objective included:

1. How effective is a virtual continuing education program in enhancing provider knowledge and skills?
2. What resources or support do healthcare providers need to effectively implement the changes they intend to make?

3. What improvements can be made to the continuing education program to enhance its impact on providers' intentions to change their practice?

Definition of Terms

1. **ARFID:** Avoidant/Restrictive Food Intake Disorder. A disorder that limits an individual's food intake. ARFID is not caused by a negative self-image or a desire to change body weight (Professional, n.d.)
2. **ASD:** Autism Spectrum Disorder. A developmental disability caused by differences in the brain. Individuals with ASD often experience problems communicating and interacting with others (*Signs and Symptoms of Autism Spectrum Disorder*, 2024).
3. **DSM-5:** Diagnostic and Statistical Manual of Mental Disorders. A handbook used by healthcare professionals as a guide to the diagnosis of mental disorders (Substance Abuse and Mental Health Services Administration (US), 2016).
4. **ED:** Eating Disorder. Characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food that significantly impairs physical health or psychosocial functioning (Eating Disorder Hope, 2024).
5. **CBT:** Cognitive Behavioral Therapy. A form of psychological treatment that has been demonstrated to be effective for a range of problems including eating

disorders. CBT can lead to significant improvement in functioning and quality of life (“What Is Cognitive Behavioral Therapy?” 2017).

6. **FBT:** Family Based Therapy/Treatment. A pragmatic approach to eating disorder treatment based on five fundamental assumptions: (1) the therapist holds an agnostic view of the cause of the illness; (2) the therapist takes a non-authoritarian stance in treatment; (3) parents are empowered to bring about the recovery of their child; (4) the eating disorder is separated from the patient and externalized; and (5) FBT utilizes a pragmatic approach to treatment (Rienecke & Grange, 2022)

Review of Literature

Avoidant/Restrictive Food Intake Disorder (ARFID)

Avoidant/restrictive food intake disorder can be characterized as avoiding or restricting eating by volume and/or variety, which leads to weight loss, stunted growth, nutritional deficiencies, dependence on enteral/supplemental feeding, and/or possible interference with psychosocial functioning (Kambanis & Thomas, 2023). An individual with ARFID may experience some or all of these symptoms with this disorder, depending on the severity (Kambanis & Thomas, 2023). An individual who has ARFID may only experience interferences to psychosocial functions as a result of their avoidant and restrictive eating (Kambanis & Thomas, 2023). Three eating behaviors have been included in the DSM-5 diagnostic criteria: (1) A lack of interest in eating; (2) avoidance

based on the sensory characteristics of food; and (3) Concern about aversive consequences of eating (i.e. choking, emesis) (Bourne et al., 2020). ARFID is not weight or body-image-motivated, like other EDs may be. ARFID is associated with alterations in brain regions involved in reward, motivation, and the sensory processing of food (Ramirez & Gunturu, 2024). When exposed to food stimuli, individuals with ARFID may have atypical activation patterns in the insula, leading to aversive responses to certain textures, tastes, or food smells (Ramirez & Gunturu, 2024). As referenced in Figure 1 adapted from Archibald et al. (2023), the Venn diagram demonstrates the three complementary factors of ARFID which include lack of interest in eating or food, concern about the aversive consequences of eating, and avoidance based on sensory aspects of food with the characteristics under each. Thomas et al. (2017) hypothesized that the abnormalities in taste perception, homeostatic appetite, and fear response underlie the three most common ARFID presentations of sensory sensitivity, lack of interest in eating or food, and fear aversive consequences, which are similar to the National Institute of Mental Health's Research Domain Criteria RDoC approach. It is vital to study the many different presenting signs and symptoms associated with the diagnosis of ARFID to increase diagnosability.

Individuals with eating disorders face many barriers to seeking treatment. Many factors play into eating disorders, such as genetic, biological, psychological, and/or social factors. Additionally, environmental factors such as family dynamics, peer

pressure, and social media can also contribute to the development of an eating disorder (*Eating Disorders*, n.d.). About 9% of the population in the United States will have an eating disorder in their lifetime (Horn 2024.). Delayed diagnosis, gaps in service, and lack of availability of specialist care and treatment services are all factors that lead to poorer health outcomes and extend the duration of the eating disorder an individual may have (Pehlivan et al., 2022). Diagnosis and intervention are key in improving health outcomes and reducing the duration of an eating disorder. Access to a specialist and care team is essential in ensuring the best possible care for an individual who has an eating disorder.

Comorbidities

Hambleton et al. (2022) stated that 55 to 95% of people diagnosed with an eating disorder will also experience a comorbid psychiatric disorder in their lifetime, such as anxiety, depression, or obsessive-compulsive disorder. Medical comorbidities can range from mild to life-threatening. These complications are observed across all body systems, including cardiac, metabolic, gastrointestinal, and reproductive systems (Kennedy et al., 2022). Current literature surrounding information presented on ARFID has highlighted a certain degree (about 50%) of comorbidities with other psychiatric, neurodevelopmental, and medical conditions (Kennedy et al., 2022). Generalized anxiety disorder, social anxiety disorder, and obsessive-compulsive disorder are the more common disorders that are reported to co-occur in ARFID, however, depression

may also be present (Kennedy et al., 2022). Clinical attention outside of regular medical treatment may be warranted when food avoidance is primary and associated with significant medical, nutrition, and/or psychosocial compromise (Brigham et al., 2018). Healthcare providers must be well versed on the comorbidities that may present in an individual with ARFID as there are different levels of severity in which this disorder may affect someone.

Medical/Clinical Complications

In a restricted diet, there are various levels of malnutrition that an individual may face. In individuals who experience persistent food refusal, the decreased intake can lead to chronic malnutrition that triggers compensatory physiological mechanisms through facing prolonged fasting, like a decreased basal metabolism and hormonal modifications that could lead to cardiovascular, renal, gastrointestinal, hematologic, and bone alterations (De Toroa et al., 2021). Studies that have reviewed hospital records show that youth with ARFID required longer hospital stays and were more likely to require enteral nutrition for stabilization compared to those with anorexia nervosa in an academic medical center (Thomas et al., 2017). While some clinical manifestations and consequences come with ARFID, many clinical complications may overshadow the diagnosis of ARFID or mimic the symptoms/side effects of the disorder. A study published in 2020 by Schöffel et al. stated that about 10% of individuals (children and adolescents) with GI diseases showed symptoms of ARFID after evaluating their self-

report and medical records. Williams et al. (2015) reported that a large portion of children who have symptoms of ARFID may be presenting with medical conditions such as GI disease that can complicate diagnostic decisions. Children and adolescents with other diseases such as asthma and a urological disorder showed the highest prevalence of symptoms of ARFID (Schöffel et al., 2020). Further research is needed to understand how complications of ARFID, when untreated, can lead to medical and nutritional complications.

Nutritional Complications

There can be various complications that are associated with ARFID, one of them being weight-centered. Individuals with ARFID can present at a normal weight, be underweight or overweight (De Toroa et al., 2021). Significant weight loss or severe malnutrition along with interference with psychosocial functioning are the potential effects of not meeting nutritional or energy needs (Kennedy et al., 2022). While not meeting nutritional or energy needs is common in this disorder, the presentation of this eating disturbance does not stem from an existing medical condition, mental disorder, or other eating disorder, and is not attributed to body image disturbances or cultural practices (Yule et al., 2021). The lack of meeting nutritional and calorie requirements stems from the lack of variety within the diet. Presentation of ARFID in individuals may include a sensitivity to texture, taste, and smells, and/or adverse consequences of eating (Di Cara et al., 2023). Consumption of plain, white foods/carbohydrates such as

breakfast cereals, other grains, dairy products, potatoes, and chicken nuggets are considerably most common in the diet amongst adolescents diagnosed with ARFID (Yule et al., 2021). A case study published by Schmidt et al. (2021) noted that the ARFID subtypes of a limited amount versus a variety of food intake significantly differed in macronutrient intake, but not micronutrient intake. In the study, Schmidt et al. (2021) stated that those with ARFID met only 20% to 30% of the recommended intake for most vitamins and minerals. Malnutrition in this case can lead to severe vitamin deficiencies such as vitamins D, C, and B9; malnutrition can also contribute to osteoporosis, scurvy, and myelodysplasia (Kennedy et al., 2022). Nutritional deficiency diagnoses are dependent on dietary intake history following signs and symptoms, and/or laboratory testing.

Nutritional Management

Nutritional management of ARFID is typically introduced after the diagnosis and may come after a medical evaluation to determine what may be lacking or deficient within the individual. Medical evaluation typically involves the standard medical history, physical examination, and laboratory components (Fisher et al., 2023). The history portion of the evaluation focuses on eating patterns, how those patterns have changed over time, and specific factors that play a role in foods individuals do and do not eat, as well as how long it may take an individual to complete a meal (Fisher et al., 2023). Practitioners do not typically obtain vitamin concentrations in most individuals

presenting with ARFID since vitamin concentrations are expected to be within normal range, with the exception of those individuals who follow extreme or rigid diets (Fisher et al., 2023). The primary management of ARFID focuses on gradually improving nutritional adequacy, a balance in eating habits, and weight gain when needed (Ramirez & Gunturu, 2024). Through the expertise of a dietitian specializing in eating disorders as well as a pediatrician to help monitor both the growth and development of an individual, this team ensures individuals are meeting their nutritional requirements (Ramirez & Gunturu, 2024). Hospitalization and/or enteral feeding may be necessary to treat malnutrition in severe cases (Ramirez & Gunturu, 2024). A registered dietitian nutritionist collaborates with the patient and family to further increase the quantity of food consumed while analyzing foods that should be introduced and when they should be introduced (Fisher et al., 2023). Nutritional rehabilitation establishes regular eating patterns and increases the range of food preferences within the diet. Nutritional rehabilitation is also extremely important in ensuring individuals with this disorder are metabolically stable.

Treatment Approaches

ARFID typically presents before the age of 12 but can also develop in adulthood. Current studies suggest it may affect 5% of children, with further studies needing to be conducted to understand the prevalence in adults (Nitsch et al., 2021). Autism spectrum disorder and learning disorders are more prevalent in children with ARFID (Nitsch et

al., 2021). A multidisciplinary team, including a physician, a therapist, a dietitian, and possibly a speech or occupational therapist, is the most common approach for individuals with ARFID (Eckhardt et al., 2019). This team ensures that the patient is meeting their nutritional needs, weight is monitored, anxiety surrounding food is monitored, and chewing/swallowing is evaluated if needed (Eckhardt et al., 2019). Outpatient treatment and cognitive behavioral therapy are most common for individuals with ARFID (Nitsch et al., 2021). Family Based Therapy can help with the engagement of the family in treatment, separating the eating problem from the child, and encouraging parents to help with increasing the volume and variety of foods in their child's diet while promoting weight gain when needed (Eckhardt et al., 2019). Cognitive Behavioral Therapy for ARFID, (referred to as CBT-AR), and Family supported CBT-AR is a specialized treatment that is suitable for all ARFID profiles (Kambanis & Thomas, 2023). Family-supported CBT-AR is a type of treatment where the patient's primary caregivers attend all sessions with the patient and hold the primary responsibility for implementing change (Kambanis & Thomas, 2023). CBT-AR is mainly used for patients who are medically stable and are not receiving enteral feeding, while attending sessions alone and also hold primary responsibility for their treatment and actions (Kambanis & Thomas, 2023). Outpatient treatment and cognitive behavioral therapy are most common for individuals with ARFID (Nitsch et al., 2021). While there are already some therapy treatment options for individuals who are

diagnosed with ARFID, there are no best practices. These treatments and the treatment team focus on helping the patient to identify better negative thought patterns surrounding their relationship with food. Therapy for individuals with ARFID is essential in helping them discover ways to understand their disorder.

Barriers to Treatment

Eating disorders are becoming increasingly prominent while eating disorder-informed professionals and available training resources remain significantly lacking (Bryant et al., 2022). A survey from 2014 found that only 37% of pediatricians were familiar with the diagnosis of ARFID, and only about 30% of that 37% could appropriately apply the diagnostic criteria (Grubb, 2021). Coelho et al. (2020) received 93 survey responses from dietitians, psychologists, and other healthcare providers (Coelho et al., 2020). Of the 93 participants, only 34 (37%) were able to identify all DSM-5 diagnostic criteria, and only 73 participants (78.5%) stated they were familiar with the diagnosis of ARFID (Coelho et al., 2020). Respondents who had selected they have provided care for individuals with ARFID (n=60) reported higher confidence in providing clinical services for pediatric ARFID than those who had not; although both groups reported a relatively low confidence rating, with a mean of 2.77 for providers who have treated ARFID, and a mean of 2.33 for providers who have not on a scale of 1-5 (1 = not at all, 5 = very much) (Coelho et al., 2020). Overall, there has been significant improvement from the 2014 survey to the 2020 survey in the familiarity aspect of

ARFID. Although there has been improvement in recognition, a lack of training impacts not only provider interests in taking care of individuals with eating disorders but also provider comfort in assessing and managing these conditions (Horn, 2024). ARFID is a disorder that has been underdiagnosed (Salatto et al., 2023). Under-recognition of ARFID is common as it is marked by picky eating and does not have a specific assessment or intervention, despite having psychosocial impairment (Richmond et al., 2023). Prevention, clinician awareness, and health service infrastructure may need to be expanded to ensure adequate identification and management of such eating disorders (Hay, 2020). ARFID-specific treatments are still in the early stages of research, and no studies to date have implemented fully powered randomized controlled trials to evaluate the treatment efficacy thus far (Kambanis & Thomas, 2023). Kambanis and Thomas (2023) stated that outcomes of the smaller cases with smaller sample sizes are promising; however, the authors reported that in the child/adolescent sample of a case study, mental health clinicians rated 85% of individuals as “much improved” or “very much improved” by the end of the treatment. Underweight individuals gained an average of 11 pounds, and by the end of the treatment, 70% of individuals no longer met the diagnostic criteria for ARFID (Kambanis and Thomas, 2023). Once identified, positive change concerning increased body weight has been observed across several studies when cognitive behavioral therapy, family-based interventions, exposure therapy, and pharmacological interventions were implemented through treatment

(Archibald & Bryant-Waugh, 2023). Archibald & Bryant-Waugh (2023) stated that because individuals with avoidant/restrictive eating behaviors present in a range of healthcare settings, where healthcare teams may not be set up to provide the level of care required, a referral and care pathway needs to be implemented. While some levels of treatment may be successful, the identification portion of the disorder may still be an issue. Healthcare professionals do not have adequate knowledge of how ARFID should be identified or treated. The optimal method for ascertaining criteria remains unclear because various methods (self-reporting dietary recalls, blood tests, identifying signs/symptoms from deficiencies, etc.) could lead to individuals being diagnosed differently depending on the context which could potentially result in inconsistencies regarding treatment eligibility (Kambanis & Thomas, 2023). Most of the treatments for ARFID are based on approaches for treating other eating disorders and the results from such are reliant on findings from small sample sizes (Kambanis & Thomas, 2023). There are no standard assessment tools for ARFID because there are so many factors that play into the recognition and treatment of this disorder (Richmond et al., 2023). Grubb (2021) concluded that after reviewing various articles and studies, it is apparent that 8 years (from the publishing date of 2021) after the new DSM-5 criteria were developed, practitioners still lack familiarity and knowledge of ARFID, which results in delays in diagnosis/treatment that affects the overall health of the individuals. Evidence surrounding the diagnosis and treatment of eating disorders continues to evolve, so

being able to keep up with them is crucial in a successful road to recovery. Through virtual CEU programs, the accessibility of keeping up with information will continue to develop.

Treatment Adaptation

Currently, ARFID treatment includes cognitive behavioral therapy, and behavioral parent training, in addition to family-based treatment, to adapt certain treatments to this newer disorder; however, more specific guidelines are needed surrounding the treatment of ARFID (Rienecke et al., 2019). Through these different approaches, there have been different treatments within them that are utilized: intensive feeding programs, psychoeducation, in vivo coaching, and parent modeling (Rienecke et al., 2019). ARFID can present in a variety of ways, and based on those presentations there are many approaches for how this disorder is treated. Customizable treatment options are needed. While clinical screening tools are still being developed for the diagnosis of ARFID, there are still no clear leading self-report measures for tracking the treatment progress and outcome in ARFID (Kambanis & Thomas, 2023). Several studies have reported on cognitive behavioral therapy (CBT), and family-based therapy (FBT), amongst others, to treat ARFID; while these treatments have appeared to be promising, they are reliant on data from clinical case studies and small, randomized control trials (Kambanis & Thomas, 2023). There have been no empirically supported interventions for individuals with ARFID across the age and weight range spectrum

that are available yet, but treatment development and evaluation are vital for helping individuals (*Adapting Evidence-Based Eating Disorder Treatments for Novel Population*, 2020). By increasing provider knowledge of diagnostic tools and treatment options, the quality of life may be improved for individuals with this disorder. Overall, the determination of treatment is crucial in determining how an individual will be able to cope with their diagnosis and improve their quality of life throughout the process. Further development and study of validated diagnostic measures and continued clarification of diagnostic criteria are needed (Coelho et al., 2020). Through working with an educated and professional healthcare team, this is possible.

Quality of Life

ARFID can cause many medical, nutrition, and social problems. Many individuals with this diagnosis may struggle silently and not know where or who to go to for help. One method to help assess the impact of a disorder on an individual's life is by evaluating the health-related quality of life through evaluation of physical symptoms, functional status, and disease impact on psychological and social functioning (Krom et al., 2019). ARFID may affect an individual through increased hospital visits, feeding tube replacements, feeding therapy, mealtime stress related to eating, and parent-child-related interaction issues surrounding mealtimes (Krom et al., 2019). Children with ASD and ARFID differ from children who have ASD and neurotypical development through oral sensory processing, and children with an ARFID

comorbidity have scored significantly lower quality of life than peers who are developing on track (Kinter et al., 2023). The combination of sensory deficit and autistic traits does negatively impact the quality of life since anthropometric growth measurements indicating nutritional status and social quality of life are directly affected in this group (Kinter et al., 2023). Knowing the symptoms of ARFID alongside the psychological and social functions is imperative in the eating disorder treatment community. It is important to effectively assess individuals who may have ARFID to help improve their quality of life through appropriate treatment options.

Research Gaps

There are many research gaps when it comes to ARFID and newer information coming to light in recent years. (Estrem et al., 2022) stated there is a gap/lack of studies that have been focused on parents' or caregivers' roles in caring for their children with feeding problems or focus on the state of child and family-centered care. There has been a recognized gap within the literature surrounding ARFID, specifically focusing on the comprehension of the drivers of food avoidance and/or restriction, the efficacy of assessment tools, and the etiology of ARFID (Farag et al., 2021). The etiology and neurobiology of ARFID remain misunderstood within the complex academic literature (Ramirez & Gunturu, 2024). Schöffel et al. 2020 suggest future research should investigate the relationship between ARFID and organic diseases and the potential underlying motivation for restrictive eating behaviors in both children and adolescents

with a physical disorder since it is currently unclear whether or not physical diseases are followed by ARFID or vice versa. Another gap that has been identified throughout many literature reviews is the lack of long-term longitudinal follow-ups after interventions have been carried out (Estrem et al., 2022). Estrem et al., 2022 have stated treatment exploration still remains because it is important to seek lasting outcomes for both children and their families/caregivers. Overall, many areas within ARFID research are still lacking and need to be further explored over time and in much more in-depth detail through longer, more comprehensive studies.

Continuing Education

Continuous learning is a central part of the dietetics profession and has been since its earliest years (Gonzalez et al., 2023). Continuing professional education (CPE) requirements continue to evolve in response to environmental trends, including the need for greater accountability in demonstrating competence and diverse practice perspectives (Gonzalez et al., 2023). Setnick et al reported that eating disorder-registered dietitian nutritionists in North America are dissatisfied with the limited formal training related to eating disorder care that is part of entry-level education (Setnick et al., 2022). Participants in this study stated that a variety of resources are used to advance skills that are beyond entry-level competence (Setnick et al., 2022). Access to these resources required access to opportunities or mentors, while associated costs for them were not reimbursed by employers (Setnick et al., 2022). ED-

specific training to advance credentials within the field is becoming an unattainable luxury due to low compensation, high caseloads, and time off for professional development (Setnick et al., 2022). Recent findings have shown that health professionals prefer virtual continuing education, considering it is more accessible to geographically dispersed health professionals in comparison to in-person education (Cheng et al., 2023). A Study/ review conducted found that online platforms for continuing education were shown to be favored due to accessibility, convenience (reduced travel time, distance, scheduling flexibility), engagement, collaboration, enabling of active participation, and cost-effectiveness (Cheng et al., 2023). Virtual learning for continuing education programs has been shown to be increasingly more beneficial and more cost-effective than traditional in-person learning styles.

Learning Theory and Intention

Adult learning theory is built on the theory and practice arising from the specialized study of adults and what makes them special as a group of learners (Rothwell, 2023.). Health professionals need continuous professional development in order to maintain a high level of competence in their careers (Chuang, S. 2021). Online education permits more interaction and collaboration among participants, and the effectiveness of adult education and training can be influenced by how well instructors understand and apply fundamental learning theories and principles to their practice (Chuang, S. 2021). It can be challenging to measure the value and impact of training/

learning, but it is easy to see what people have been taught by consulting the measurable instructional objectives (Rothwell, 2023). Rothwell 2023 stated that measuring the impact of learning performance may be difficult, however, individuals usually become more efficient and effective when they gain experience through learning. The theory of planned behavior can be utilized in the way that intention is measured through the theories predictors (attitude toward the behavior, subjective norms, perceived behavioral control, and intention behind the behavior), thus the proposed behavioral change should be able to be measured through action and time (Ajzen, 2020).

Conclusion

More studies are needed to understand how ARFID impacts not only the individuals who experience it but also the providers who work with those individuals to treat this diagnosis. Increasing provider knowledge of diagnostic tools and treatment options will help improve access and reliability for both patients and providers overall. Lack of awareness and knowledge of ARFID presentation may lead to over-identification or a diagnosis of another eating disorder when symptoms of ARFID are observed but not recognized (Archibald & Bryant-Waugh, 2023). There is a strong acknowledgment that the recognition and knowledge around the presentation of ARFID remains very limited, along with the lack of experience or confidence in ARFID identification (Archibald & Bryant-Waugh, 2023). More research is needed to be able to

achieve rigor, transparency, and generalizability of findings in feeding disorders, such as ARFID (Estrem et al., 2022). Through continuing education programs and online education, accessibility and competency will continue to improve over time.

Theoretical Framework

The Theory of Planned Behavior is a theory that the intentions of the individual stem from three factors: Attitudes toward the behavior, subjective norms, and perceived control over the behavior (Casper, n.d.). This model can be used to provide healthcare providers with a frame of reference for the treatment of ARFID, where the boundaries lie, and what needs to be further researched to improve the diagnosis and treatment of this evolving disorder (*Research Guides: Organizing Academic Research Papers: Theoretical Framework*, n.d.). This theory of planned behavior also provides a model for behavior modification in addition to prediction when assessing an individual's attitude, norms, and perceived behavioral control (PBC) that may be applied to create communication strategies to alter these elements and/or intention and behavior (Casper, n.d.). The theory of planned behavior can be a useful framework for designing different behavior change interventions and illustrating the mechanisms through which interventions are expected to affect the behavior (Steinmetz et al., 2016). The theory of planned behavior is centered around the idea that beliefs provide the basis for attitudes, subjective norms, and perceptions of behavioral control, and according to the theory of planned behavior, attitudes toward the behavior are based on behavioral beliefs, subjective norms rely on

normative beliefs, and PBC is based on control beliefs (Steinmetz et al., 2016). Steinmetz et al. (2016) stated a successful intervention could increase beliefs about positive outcomes, decrease beliefs about negative outcomes, increase the skills or knowledge to perform the behavior, and decrease actual barriers. There are many factors throughout the theory of planned behavior that may determine the outcome of an individual's actions. This theory has also been used in continuing education courses for healthcare providers in applying new assessment tools for individuals, and it was shown to be successful (Casper, n.d.). The theory of planned behavior was thoughtfully considered when designing the intervention of this project. The target behavior was defined through the creation of an initial survey that inquired prospective participants about the type of CEU topic, program style, etc. which also helped to better define the needs within that community. The questions in the survey considered the three components of TBP; Attitude, Subjective norms, and Perceived Behavioral Control. The intervention was then designed through the creation of project-objective questions that identified issues surrounding ARFID. The seminar was created around the selected topic (ARFID), with the components of attitude, subjective norms, and beliefs kept in mind. These three components played into the information added to the presentation. The outcomes were measured once the intervention had been implemented, which included a follow-up survey and post-lecture quiz for the analyses of data. The data were then analyzed and will be used to create a lecture that further improves the course on various topics in the

future. The Theory of Planned Behavior was used to further evaluate the effectiveness of the intervention, as well as also being able to make needed adjustments to improve the rate of participation and learner satisfaction.

Summary and Significance of the Problem

While there has been an increase in research on the diagnosis of ARFID, there is still room to grow when it comes to improving the likelihood of individuals being able to receive appropriate treatment through the diagnosis. While the DSM-5 provides specific criteria for diagnosing ARFID, the subjective nature of the eating disorder can make it challenging to diagnose. The limitations surrounding the diagnosis of ARFID have come from it being a newer disorder in the eating disorder field, with research still being conducted. There is a lack of knowledge that surrounds ARFID as an entirety, more specifically how to spot different individuals in the community who have ARFID, treat those effectively that are discovered to have it, and prevent further progression within the diagnosis. Another complication with this disorder is the inability to differentiate between picky eating and ARFID in younger children who may be considered to be in their “picky eating” years. With the continuation of research on this disorder, educational material should be more readily available, and discussions surrounding this disorder should be more prominent within the disordered eating field. As research surrounding ARFID continues to expand and new information about this disorder is discovered, it is incredibly important to ensure that the professionals who

work with this disorder are well-versed in the information that is surfacing. Broadcasting and publishing this information to ensure that both healthcare professionals who diagnose/treat ARFID and individuals who have ARFID are crucial in increasing the awareness and seriousness of this disorder. It is imperative to ensure providers who work with individuals with this disorder remain up to date, educated, and prepared to explore new or different treatment options in greater depth to ensure individuals are being treated properly.

Overview

Targeted Population:

The targeted population for this continuing education program is healthcare providers involved in the diagnosis and treatment of eating disorders.

Participating Audience:

The participating audience of this continuing education program includes dietitians and licensed therapists looking to expand their education on ARFID through virtual educational platforms.

Program Methodology:

This project aims to provide an overview of the difficulties in diagnosing and treating ARFID. This continuing education overview will provide a greater summary of the need for awareness of this disorder, and approaches that can be taken to increase the knowledge of healthcare providers who diagnose and treat the eating disorder

ARFID. In addition to these approaches, there will also be a discussion of underlying or co-occurring problems as well, such as ASD, and how they may correlate to the diagnosis of ARFID. As this continuing education course is developed, the information provided will hopefully be utilized by healthcare professionals in the future for individuals who struggle with ARFID.

This continuing education program, titled “Empower and Nourish: A Guide To A Better Understanding of the Management of ARFID”, was presented by two registered and licensed dietitians on May 17, 2024, through a virtual, recorded format. There were a total of 14 participants who attended the presentation. The participants held various credentials; licensed professional counselor (LPC), certified eating disorder specialist (CEDS), Master of Science (MS), registered dietitian nutritionist (RDN), registered dietitian (RD), licensed dietitian (LD), doctor of psychology (PSYD), and national certified counselor (NCC). The presentation was one hour long. A post-lecture quiz to obtain feedback was sent out via email and the link was available for the participants via a quick response (QR) code at the end of the presentation. The topics presented during this hour-long course consisted of:

1. Definition and background of ARFID...
2. Key diagnostic criteria...
3. Medical complications...
4. Physical effects of ARFID...

5. Biological elements of ARFID...
6. Physiological elements of ARFID...
7. Sociocultural elements of ARFID...
8. The difference between ARFID and anorexia nervosa...
9. The link between Autism spectrum disorder and ARFID...
10. How to differentiate picky eating and ARFID...
11. Internal and external influences in *both* ARFID and ASD...
12. Lab irregularities...
13. Nutritional deficiencies in ARFID...
14. The role of a Dietitian vs. a speech-language pathologist (SLP)...
15. Interventions such as Cognitive behavioral therapy, Family-based therapy, and multidisciplinary approaches...
16. Book recommendations for further, individualized education at the providers' discretion.

There was a quick response (QR) code included into the material at the end of the presentation. This QR code was provided for the participants attending the presentation. At the end of the presentation, this was used to test their knowledge of what they learned, as well as a follow-up email that was sent out for a post-educational survey on what they would like to see in the future and what could be improved in the

future. One Continuing Education Unit (CEU) was offered for this one-hour-long online course and was provided to the participants.

Data Collection:

Once the Continuing Education course was complete, an educational quiz was sent out to the participants both via email and was also provided through a QR code at the end of the presentation, as each format was provided depending on if time permitted. The feedback and data were collected to review the participants' knowledge and determine if it had changed. The post-lecture quiz depicted in Table 2 consisted of the following questions:

1. Which of the following best defines ARFID?
2. Which age group is *most* commonly diagnosed with ARFID?
3. What distinguishes ARFID from anorexia nervosa?
4. True or False: Individuals with ARFID often require nutritional supplements or alternative feeding methods to meet their nutritional needs.
5. True or False: Cognitive-behavioral therapy is an ineffective treatment approach for ARFID.
6. True or False: People with ARFID typically avoid only non-nutritious foods.
7. List two potential health complications that might arise from ARFID.

8. Describe one method that can be used to treat or manage ARFID.

After the presentation, a post-lecture survey, separate from the post-lecture quiz, was administered for further data collection to obtain feedback. These data will be used for future continuing education presentations to help develop a better educational format for participants. The post-survey was utilized to determine how much new information the healthcare professionals learned about ARFID through this continuing education course. The survey was created and sent to the participants for data collection after the course ended. All answers were set up to be received anonymously. The questions on the survey consisted of various multiple-choice and open-ended questions, such as:

1. How well did this lecture meet your expectations?
2. How clear/understandable was the information presented?
3. What part of the lecture did you find most informative?
4. Was there anything about ARFID discussed that you found confusing or unclear?
5. What additional topics or details would you like to see included in future lectures about ARFID?
6. How likely are you to recommend this lecture to a colleague or friend?

The answers from this survey were then carefully reviewed and considered for future CEU projects.

Summary

Analyses

As seen in the results of the surveys and post-lecture quiz, providing further education on ARFID diagnostics and treatment was shown to be helpful. There were a total of five responses for the post-lecture survey and a total of seven responses for the post-lecture quiz. After reviewing the post-lecture survey, 80% stated the lecture met their expectations, while 20% stated the lecture exceeded their expectations. When the participants were asked if the information was clear and understandable, 80% stated it was very clear, while 20% stated the information was somewhat clear. On the open-ended questions, Participants stated the part of the lecture they found most informative where the differences between ARFID and other eating disorders specific nutrient deficiencies, the information on nutrition interventions, division of responsibility, and exposure therapy, and comparing ARFID vs other disorders. When asked if there was anything discussed about ARFID that was found unclear, participants stated they would like extra clarification on vitamin deficiencies, that the information was reviewed quickly, and how to best conduct ERPs would be helpful. Additional topics or details participants would like to see included in future lectures about ARFID include food challenge tips, extra details on interventions, and specific interventions for CT who have ARFID/other neurodivergent disorders. Overall, 100% of participants stated they would be very likely to recommend this lecture to a colleague or friend within this

healthcare profession. Once the presentation and questions concluded, participants were asked to take a post-presentation quiz. The following questions “Which of the following best describes ARFID?”, “True or False: Individuals with ARFID often require nutritional supplements or alternative feeding methods to meet their nutritional needs”, and “True or False: People with ARFID typically avoid only non-nutritious foods” received a 100% correct score out of 100. The three questions “Which age group is *most* commonly diagnosed with ARFID?”, “What distinguishes ARFID from anorexia nervosa?”, and “True or False: Cognitive-behavioral therapy is an ineffective treatment approach for ARFID” received an 85.7% correct score out of 100. When participants were asked to list two potential health complications that might arise from ARFID, there were various answers such as low body weight and nutritional deficiencies, malnutrition, anemia, delayed growth, hormonal imbalances, nutrient deficiencies, and more. When participants were asked to describe a method that can be used to treat or manage ARFID, participants listed answers such as food exposure, CBT, the plate method, addressing fear foods/introducing new foods/gradual food exposures, and ERP. After reviewing the quiz and the survey, it was demonstrated that this pilot program is making positive strides, and that implementation of continuing education on topics/disorders that are not regularly taught about is beneficial to both individuals and healthcare professionals as a whole. The results of this educational format exceeded expectations as this is the very first educational program like this one, that the private

practice has ever performed. The dietitians at the private practice stated that the presentation went well and that they were satisfied with how it went. One barrier that occurred, however, was that the dietitians ran out of time for participants to complete the survey, but it was later emailed out to the participants to complete. The anticipated impact of the project aligned with the projected outcomes of the project from the reported data. The outcome of the data collected from the surveys has been shown to correlate with the supporting data that have been researched thus far. The supporting literature has continuously mentioned that this disorder is much newer than the other various eating disorders and is of popular interest amongst researchers.

Recommendations for the project include adding more time to the overall presentation timing or reducing the amount of information provided during the presentation to allow for overall comprehension, as well as time for questions and comments. These findings will be beneficial for the future development of continuing education programs aiming to reach similar populations. Through the results of the post-lecture survey, it is shown that providers intend to change their practices by continuing their knowledge and advancing their skills. This has been shown through their continuing interest in learning more about ARFID and requesting more information to be shared through future lectures. Answers such as “another webinar with how to best conduct ERPs would be helpful”, “more details on interventions, such as application of exposure therapy, as well as information on managing the sensory components and other

aversions in ARFID”, “how to break down sessions with parents and specific homework for families to work on”, and “specific interventions for clients who have ARFID and other neurodivergent disorders” indicate a further level of interest in applying the learned information to their practices.

Strengths and Limitations

While there has been an increased quantity of research completed surrounding ARFID, one of the biggest limitations of this project was the difficulty in being able to provide definitive and concrete information about this topic due to the still-emerging information. A strength that has come from this limitation, however, was that the research itself has proven that there is not enough education surrounding the diagnosis and treatment of ARFID with the evolving definition. Another limitation within this project was the duration of time allotted to the presentation itself (60 minutes) as the participating individuals felt the information provided was reviewed too quickly for the depth that was covered. In addition, with the presentation time being too short (or there is an overflow of information), the ability to get the post-presentation survey and quiz completed by the total number of audience members was not fulfilled. However, those who did complete the survey provided informative and constructive feedback for the next CEU presentation in the future. This project provided useful insight regarding the development of continuing education resources. This project also provided useful

insight into how to effectively educate professionals on the diagnosis and treatment of ARFID.

Conclusion

The intention and goal of this project was to create a pilot program as an educational tool for both dietitians and licensed therapists who work in the disordered eating field. The project's aim was to explain the difficulty in diagnosing ARFID, along with the continuation of further learning about ARFID since limited information has been released about this disorder. The overarching goal of this project was to provide a continuing education program for healthcare professionals in the eating disorder field. The main objective for the first piloted program was to provide education surrounding the diagnostic and treatment qualities of an eating disorder titled ARFID, which is still relatively new and has not been researched as in-depth as other eating disorders. Many healthcare professionals who work in the eating disorder field are still learning about ARFID. In being able to educate and extend information to other healthcare professionals about ARFID, the treatment and knowledge surrounding it will in turn become easier to produce, especially through ongoing research. Through this comparative literature review, contact/engagement with many healthcare professionals who participated in educational surveys, quizzes, and a presentation, this project was created to help inform and further learn about the depths of ARFID. This specific pilot project on ARFID had a meaningful impact on healthcare providers who work with

ARFID. Moving further in the future, the information and tools learned through this CEU course will apply to the healthcare providers' future practices when it comes to treating or working with individuals who have ARFID.

Tables

Table 1. Questions and Responses from the Survey Used to Determine the Continuing Education Unit Course

On a scale from 1 to 5 (1 being least, 5 being most). Please indicate your interest in further education on the following topics:	# of votes chosen to be most interesting
<ul style="list-style-type: none"> ● Dialectical Behavior Therapy (DBT) application in dietetics ● Medication and nutrition interactions for eating disorders ● Mindfulness and intuitive eating approaches ● Management of Avoidant/Restrictive Food Intake Disorder ● Nutritional rehabilitation and refeeding protocols ● Weight stigma and body image issues in ED treatment ● Cultural competency in ED treatment 	<p>6</p> <p>11</p> <p>10</p> <p>14</p> <p>10</p> <p>8</p> <p>9</p>
<p>Are there any specific subtopics or areas within the field of eating disorders that you are particularly interested in learning more about? Specify, please.</p> <ul style="list-style-type: none"> ● Helping parents of teens with eating disorders navigate treatment at home. ● How IE can be seen as a diet, cultural difference concerns (i.e., how foods from certain cultures tend to be demonized as unhealthy) ● Connecting with more clinicians and RDNs of color to engage in conversations about cultural competency in eating disorder treatment ● ARFID and ASD: Tools for mindful eating while integrating a therapeutic alliance ● Working virtually ● Working with persistent negative body image ● Binge eating disorder/compulsive eating ● Medications/co-occurring medical condition refreshers are always welcome ● Specific techniques or resources for LGBTQI populations ● Trauma and Dissociation in relation to EDs ● Psychological triggers behind eating disorders ● Advanced group facilitation ● Explaining connections between physical and mental effects of malnutrition ● The overlap between body dysmorphia & disordered eating; evidence-based treatment for this comorbidity 	
<p>What are the biggest challenges or barriers you face in treating individuals with eating disorders that you hope to address through further education?</p>	

- Tips and tricks to helping clients open up or navigate those sessions to make the most of the time
- How exposure therapy happening in therapeutic sessions can still be helpful
- ARFID
- Family Support and Recovery.
- Financial resources; motivation to change
- Interventions to help with body image distress
- Helping individuals unlearn diet rules and restrictive eating habits.
- Willingness to commit to outpatient treatment
- Resources, techniques
- Lack of trauma and dissociation competent care
- Openness to HLOC when needed
- Parent awareness and willingness to get early treatment, outdated medical model approaches to discussing weight with pediatric individuals and their families (BMI charts)
- Treating severe eating disorders in a client who is financially unable to go to a higher level of care.
- Knowing which evidence-based modality is best for each type of eating disorder
- Client motivation, ambivalence, and hopelessness
- Being able to communicate with parents about the importance of incorporating an ED-experienced RD on the treatment team
- Adding new tools/techniques to my toolbox when comfortable with my foundation.

Which of the following formats do you prefer for CEUs?	# Responses
● Online webinars or courses	23
● In-person workshops or seminars	16
● Interactive case studies	8
● Literature reviews or research article discussions	7
● Practical skill-building sessions	12

What topics or skills would you like to see included in a continuing education curriculum to help develop or further improve upon within your practice?

- Ethical considerations in ED treatment; working with transgender and gender fluid/non-binary clients; collaboration with other providers and education for other providers on ED-informed treatment
- how to work with someone who expresses a desire for weight loss while still wanting to work with a provider who is anti-diet/weight neutral, PCOS/medical diagnosis and

ED history concerns, how therapists and dietitians can effectively work together in outpatient settings across practices

- Continuity in marketed CE Classes
- Autism
- Working remotely; the intersection of eating disorders and gender dysmorphia or nutrition for trans folk
- Body image
- Eating disorders and relationship to hormone health
- Helping our providers understand target weights established by an RDN - this occurs often
- Short-term goals and therapeutic interventions I could add to my treatment plan
- Learning more about the connections between physical health and mental health
- Practical tools/techniques that can be included in therapy

- ED: Eating Disorder
- RDN: Registered Dietitian Nutritionist
- ARFID: Avoidant/Restrictive Food Intake Disorder
- ASD: Autism Spectrum Disorder
- LGBTQI: Lesbian, Gay, Bisexual, Transgender, Queer/questioning, and Intersex
- HLOC: Health Locus of Control
- RD: Registered Dietitian
- PCOS: Polycystic Ovarian Syndrome
- CE: Continuing Education

Table 2. Questions and Responses for the Post-Quiz

Question	% correct
<p>Which of the following best defines ARFID?</p> <ul style="list-style-type: none"> ● A preference for certain types of foods ● An eating disorder characterized by highly selective eating habits, sensitivity to taste and texture, and/or fear of adverse consequences of eating ● A disorder caused by a lack of interest in food ● A type of phobia concerning specific food items 	100%
<p>Which age group is <i>most</i> commonly diagnosed with ARFID?</p> <ul style="list-style-type: none"> ● Infants ● Toddlers ● Adolescents ● Adults 	85.7%
<p>What distinguishes ARFID from anorexia nervosa?</p> <ul style="list-style-type: none"> ● The presence of distorted body image in ARFID ● The dietary restrictions are due to sensory issues or fear of aversive consequences in ARFID, not due to body image issues ● Weight loss is more severe in ARFID ● ARFID only occurs in children 	85.7%
<p>T or F: Individuals with ARFID often require nutritional supplements or alternative feeding methods to meet their nutritional needs</p>	100%
<p>T or F: Cognitive-behavioral therapy is an ineffective treatment approach for ARFID</p>	85.7%
<p>T or F: People with ARFID typically avoid only non-nutritious foods</p>	100%
<p>List two potential health complications that might arise from ARFID</p> <ul style="list-style-type: none"> ● Low body weight and nutritional deficiencies ● Malnutrition, anemia ● Delayed growth, hormonal imbalances ● Electrolyte disturbances and receding syndrome ● nutritional deficiencies and hypoglycemia ● Anemia/iron deficiency and cardiac issues related to malnutrition ● Nutrient deficiencies and GI disorders 	

Describe one method that can be used to treat or manage ARFID

- Food Exposure
- CBT
- The plate method
- Addressing fear of foods/gradual food exposures/introducing new foods
- starting with lower-stress foods, working gradually up to eating the new foods.
- ERP/Exposures involve systematic exposures to fear foods based on a hierarchy of anxiety levels

- ARFID: Avoidant/Restrictive Food Intake Disorder
- GI: Gastrointestinal
- CBT: Cognitive Behavioral Therapy
- ERP: Exposure and Response Prevention

Table 3. Post-Lecture Survey Responses

<p>How well did this lecture meet your expectations?</p> <ul style="list-style-type: none"> ● Exceeded expectations ● Met expectations ● Below expectations ● Significantly below expectations 	<p>% Of responses chosen</p> <p>20%</p> <p>80%</p> <p>0%</p> <p>0%</p>
<p>How clear/understandable was the information presented?</p> <ul style="list-style-type: none"> ● Very clear ● Somewhat clear ● Not clear at all 	<p>% of responses chosen</p> <p>80%</p> <p>20%</p> <p>0%</p>
<p>What part of the lecture did you find most informative?</p>	
<p>Was there anything about ARFID discussed that you found confusing or unclear?</p>	
<p>What additional topics or details would you like to see included in future lectures about ARFID?</p>	
<p>How likely are you to recommend this lecture to a colleague or friend?</p> <ul style="list-style-type: none"> ● Very likely ● Somewhat likely ● Unlikely 	<p>% of responses chosen</p> <p>100%</p> <p>0%</p> <p>0%</p>

- ARFID: Avoidant/Restrictive Food Intake Disorder

Figures

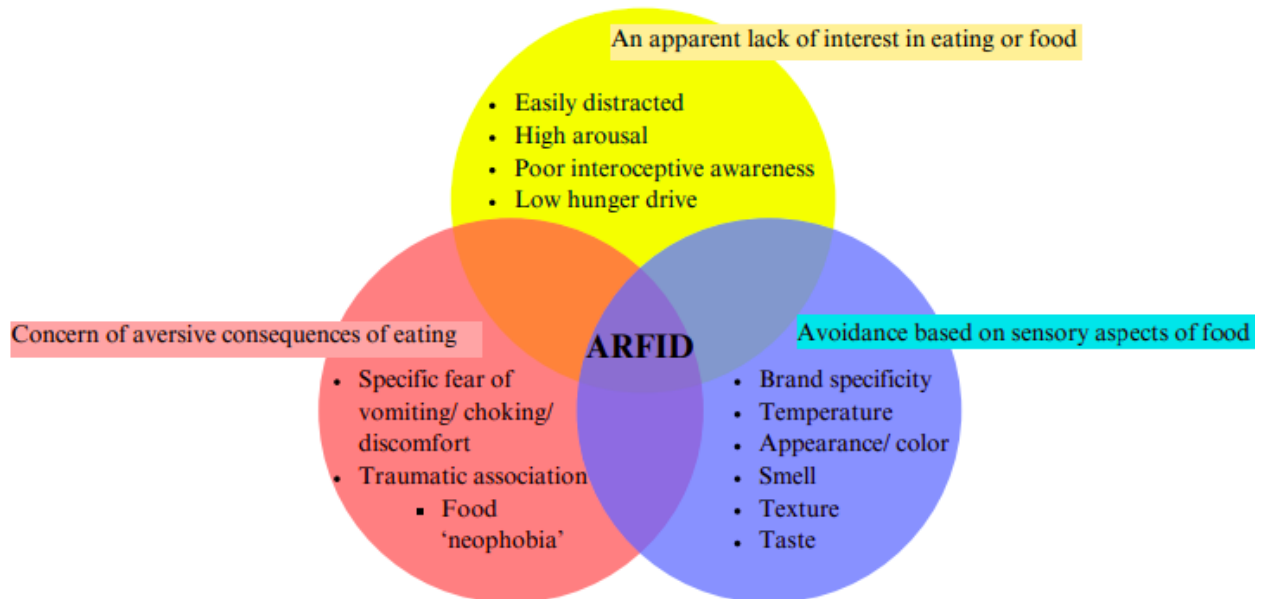


Figure 1. Three complimentary but different factors of Avoidant/Restrictive Food Intake Disorder (ARFID). (Adapted from Archibald et al., 2023)

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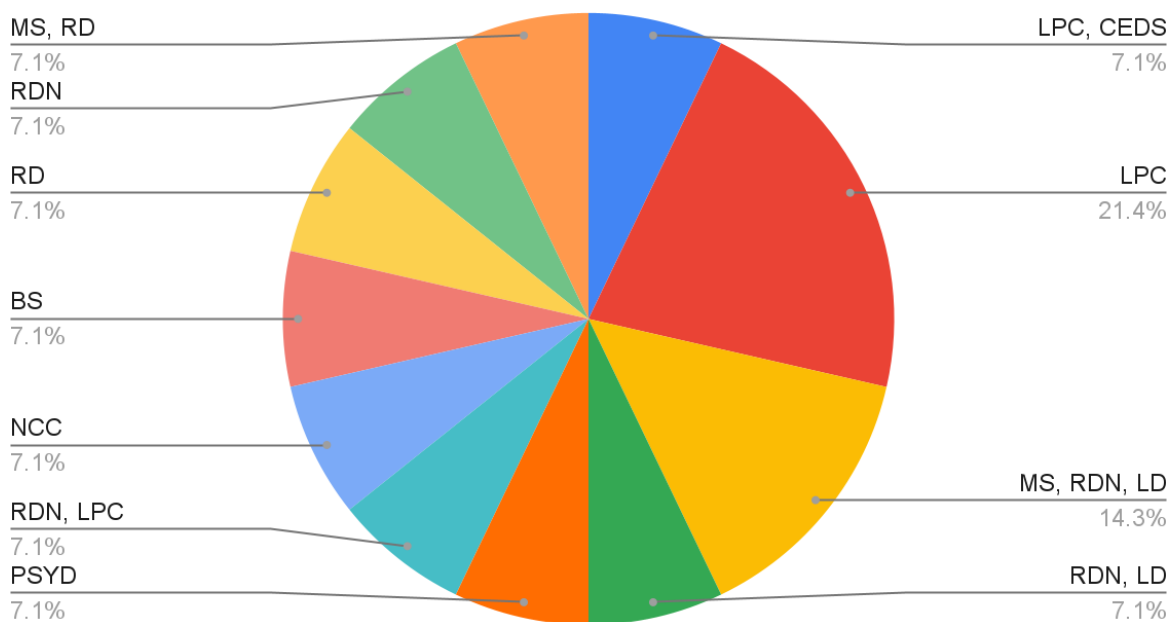
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APPENDICES

APPENDIX A: Count of Credentials (n=14)

Count of Credentials

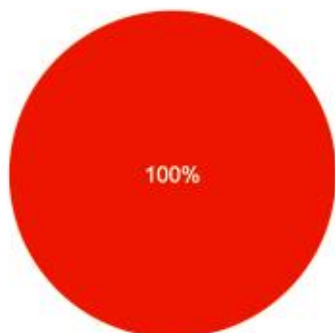


- MS: Master of Science
- RD: Registered Dietitian
- RDN: Registered Dietitian Nutritionist
- BS: Bachelor of Science
- NCC: National Certified Counselor
- LPC: Licensed Professional Counselor
- PSYD: Doctor of Psychology
- CEDS: Certified Eating Disorder Specialist
- LD: Licensed Dietitian

APPENDIX B: Post-Quiz Results

which of the following best defines ARFID??

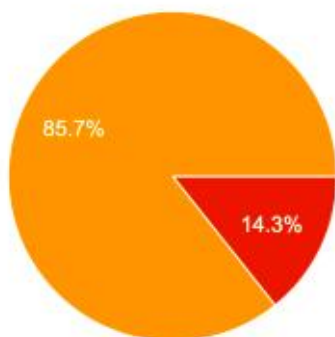
7 responses



- A preference for certain types of foods
- An eating disorder characterized by highly selective eating habits, sensitivity to taste and texture, and/or fear of adverse consequences of eating
- A disorder caused by lack of interest in food
- A type of phobia concerning specific food items

which age group is most commonly diagnosed with ARFID?

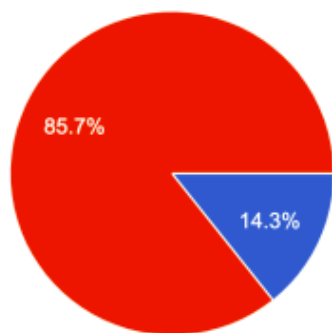
7 responses



- Infants
- Toddlers
- Adolescents
- Adults

what distinguishes ARFID from anorexia nervosa?

7 responses



- The presence of distorted body image in ARFID
- The dietary restrictions are due to sensory issues or fear of aversive consequences in ARFID, not due to body image issues
- Weight loss is more severe in ARFID
- ARFID only occurs in children

- ARFID: Avoidant/Restrictive Food Intake Disorder