

Evaluation of Pediatricians' Awareness, Knowledge, and Attitudes Toward Avoidant/Restrictive Food Intake Disorder

Pediatristlerin Kaçınan Kısıtlayıcı Gıda Alım Bozukluğu Hakkındaki Farkındalık, Bilgi ve Tutumlarının Değerlendirilmesi

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ABSTRACT

Objective: Despite the inclusion of Avoidant/Restrictive Food Intake Disorder (ARFID) in the DSM-5 in 2013, there is limited research assessing physicians' awareness and knowledge of the disorder. This study aimed to evaluate pediatricians' knowledge, awareness, clinical experience, and referral practices related to ARFID.

Materials and Methods: This cross-sectional study was conducted with 216 pediatricians (specialists and residents) working in three major hospitals in Ankara, Türkiye. Data were collected using an original, literature-based questionnaire developed by the researchers.

Results: Among participants, 28.5% correctly identified the expanded form of ARFID, and 38% recognized it as a DSM-5-defined eating disorder. A total of 52.3% misclassified body image disturbance as a subtype of ARFID, suggesting a conceptual overlap with anorexia nervosa. While 34.9% reported encountering ARFID cases in their clinical practice, 29.8% had referred such patients to other healthcare professionals. The most commonly reported referral disciplines were child and adolescent psychiatry, pediatric gastroenterology, and dietetics. Only 4.3% of respondents reported feeling competent in managing ARFID, while 90.7% expressed a need for further education and training.

Conclusion: The findings highlight significant gaps in pediatricians' knowledge and clinical management of ARFID. The development of structured guidelines, standardized diagnostic tools, and targeted training programs is warranted to improve early identification and multidisciplinary management of ARFID in pediatric settings.

Keywords: Avoidant/Restrictive food intake disorder, awareness, pediatricians

ÖZET

Amaç: Kaçınan/Kısıtlayıcı Gıda Alım Bozukluğu (ARFID), DSM-5'te 2013'de tanımlanmasına rağmen hekimlerin bu konu hakkındaki farkındalık ve bilgi seviyesi literatürde yeteri kadar çalışılmamıştır. Bu çalışma, pediatri hekimlerinin ARFID'e ilişkin bilgi düzeyini, farkındalığını, klinik deneyimlerini ve yönlendirme davranışlarını değerlendirmeyi amaçlamaktadır.

Gereç ve yöntem: Ankara'daki üç büyük hastanede görev yapan 216 pediatri uzmanı ve asistanıyla yürütülen bu kesitsel araştırmada, veri toplama aracı olarak literatüre dayalı özgün bir anket formu kullanılmıştır.

Bulgular: Çalışmaya katılan pediatristlerin %28,5'i ARFID'nin açılımını bildiğini, %38'i ise bu bozukluğun DSM-5'te tanımlı olduğunu ifade etmiştir. Ayrıca, %52,3'lük bir kısmı beden algısı bozukluğunu ARFID alt tipi olarak belirtmiş, bu da anoreksiya nervosa ile kavramsal karışıklık yaşandığını göstermektedir. Katılımcıların %34,9'u mesleki yaşamlarında ARFID olgusu ile karşılaştığını, %29,8'i ise bu grup hastayı başka bir uzmana yönlendirdiğini ifade etmiştir. En sık yönlendirilen disiplinler çocuk ve ergen psikiyatrisi, pediatrik gastroenteroloji ve diyetisyenlik olmuştur. Hekimlerin yalnızca %4,3'ü ARFID yönetiminde kendini yetkin hissettiğini ifade etmiş, %90,7'si ise bu konuda ek eğitim ihtiyacı olduğunu belirtmiştir.

Sonuç: Bu çalışmada pediatristlerin ARFID'e yönelik bilgi düzeyi, tanı süreci ve yönlendirme uygulamalarında yetersizlikler olduğu bulunmuştur. Bu bağlamda yapılandırılmış rehberlerin, tanılma araçlarının ve hedefe yönelik eğitim programlarının geliştirilmesinin pediatri hasta bakım uygulamalarına katkı sağlayabileceğini düşünmekteyiz.

Anahtar kelimeler: Kaçınan/kısıtlayıcı gıda alım bozukluğu, farkındalık, pediatristler

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Introduction

Avoidant/Restrictive Food Intake Disorder (ARFID) is an eating disorder first introduced in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in 2013 (1). According to the DSM-5 criteria, ARFID is characterized by a persistent restriction of food intake due to low appetite, sensory sensitivities, or fear-based aversions stemming from negative eating experiences. This restrictive intake can result in significant weight loss, faltering growth, nutritional deficiencies, dependence on enteral or oral nutritional supplementation, and marked impairment in psychosocial functioning (1,2,3). Unlike anorexia nervosa (AN) or bulimia nervosa (BN), ARFID is not associated with body image disturbances, which may lead to underrecognition or misdiagnosis in clinical settings (4).

Individuals with ARFID often present with comorbid psychiatric conditions such as anxiety disorders, mood disorders, or substance use, alongside nutritional deficiencies severe enough to impact growth and development (5). Although data have been collected from both community and clinical samples, the prevalence and clinical characteristics of ARFID remain insufficiently explored in the literature, partly due to the recency of its inclusion in the DSM-5 (6).

Limited awareness of ARFID among pediatricians may contribute to delays in diagnosis and intervention (3,7). Given the relatively high prevalence of feeding difficulties and psychiatric comorbidities in both community and pediatric healthcare settings, it is likely that pediatric healthcare professionals encounter individuals with ARFID in routine clinical practice. Notably, an international expert consensus on eating disorders reported that individuals with ARFID frequently present to non-psychiatric medical services, underscoring the importance of cross-disciplinary awareness among healthcare providers who may encounter this population (3,7,9).

Since the inclusion of Avoidant/Restrictive Food Intake Disorder (ARFID) in the DSM-5, awareness among healthcare professionals has increased; however, significant gaps in knowledge and clinical experience regarding diagnosis and management persist

(4,10). In a study conducted in Canada by Coelho et al.(10), only 37% of pediatric healthcare professionals were able to fully identify the DSM-5 diagnostic criteria for ARFID. Moreover, marked inconsistencies in diagnostic practices were observed when participants were presented with clinical vignettes. Similarly, Harrison (2) reported that primary care providers in the United Kingdom experienced difficulty recognizing ARFID in children, and even when a diagnosis was made, there was often insufficient knowledge regarding appropriate referral pathways. Healthcare professionals in that study identified the absence of a specific treatment protocol and referral framework for ARFID as a systemic barrier (2,11).

The lack of standardized clinical guidelines for the management of ARFID remains a critical issue (5,12). A physician survey conducted in the United States revealed considerable variation in inpatient treatment protocols for ARFID cases, with many clinicians applying anorexia nervosa-based protocols. Due to the absence of ARFID-specific treatment pathways, providers reported challenges in developing appropriate management plans (5). These findings underscore the need for enhanced training for healthcare professionals to differentiate ARFID from other eating disorders and to implement tailored management strategies (13).

The diagnosis of Avoidant/Restrictive Food Intake Disorder (ARFID) in childhood and adolescence is closely linked to the knowledge and awareness levels of pediatricians (6,10,14). In Türkiye, there is currently no awareness study specifically targeting pediatricians in relation to ARFID. This study aims to assess the knowledge, attitudes, and awareness levels of pediatric healthcare professionals regarding ARFID and to contribute to the existing body of literature in this field (15).

Methods

Participants and Sampling

This cross-sectional study was conducted among pediatricians and pediatric residents working in the pediatric clinics of three major hospitals in Ankara, each serving diverse patient populations. A conve-

nience sampling method was used. Inclusion criteria were: being an actively practicing pediatrician or pediatric resident providing outpatient or inpatient care in any pediatric unit, and willingness to participate voluntarily. Since there was no existing validated scale for ARFID awareness targeting pediatricians and the questionnaire was developed specifically for this study, the sample size calculation assumed a prevalence of 50%. Using the G*Power 3.1 software, with 50% prevalence, 95% power, and a Type I error rate (α) of 0.05, a minimum of 48 participants per hospital was required to detect a medium effect size (0.5). The study aimed to reach the maximum number of pediatricians and residents across different hospitals to ensure diversity in professional background and institutional settings, thereby increasing the representativeness of the sample. Data were collected using an online and paper-based questionnaire developed by the researchers, informed by prior studies in the literature. A total of 216 pediatricians who completed the questionnaire in full were included in the analysis.

The survey form consisted of four main components: (1) demographic questions; (2) items assessing participants' knowledge of the definition and subtypes of ARFID; (3) questions evaluating clinical diagnostic and referral behaviors; and (4) open-ended qualitative questions exploring participants' educational needs, diagnostic challenges, and referral practices. The content and clarity of the questionnaire were evaluated through a pilot test conducted with 10 pediatricians working in clinical settings, and necessary modifications were made based on their feedback.

Participants were informed about the study's purpose, the voluntary nature of participation, and confidentiality principles. Written informed consent was obtained prior to participation. Each participant was permitted to complete the survey only once, and all responses were collected anonymously. The survey link and study information were distributed through professional communication platforms (e.g., WhatsApp, email, social media) and via pediatricians who were co-authors of the study. Participation in

the survey was entirely voluntary. The online format was preferred to enhance participant accessibility, reduce response time, and improve data collection efficiency.

Data Analysis and Statistical Evaluation

Data were analyzed using IBM SPSS Statistics for Windows, Version 30.0. Descriptive statistics, including mean, standard deviation, median, minimum, maximum, frequency, and percentage, were calculated. Chi-square tests were used to compare categorical variables according to independent factors. A p-value of less than 0.05 was considered statistically significant.

Results

A total of 216 pediatricians participated in this study, of whom 170 (78.7%) were female and 46 (21.3%) were male. The participants included 133 (61.6%) pediatric residents (specialty trainees), 33 (15.3%) general pediatric specialists, 31 (14.4%) pediatric subspecialty residents, and 19 (8.7%) pediatric subspecialists. The mean age of participants was 32.6 ± 6.4 years (range: 23–55), and the mean duration of pediatric clinical experience was 5.8 ± 5.9 years (range: 0.4–26). On average, participants reported seeing 495.4 ± 398.9 patients per month (range: 17–2500). A total of 154 participants (71.3%) were working in institutions with a dedicated adolescent health unit.

Awareness, Knowledge, and Attitudes of Pediatricians Regarding ARFID

The awareness and knowledge levels of pediatricians regarding ARFID are summarized in Table 1. Prior to reading the study title, only 61 participants (28.5%) reported that they knew the full term for ARFID. While 82 participants (38.0%) recognized ARFID as a DSM-5-defined eating disorder, 127 (58.8%) stated they were uncertain. Regarding subtypes of ARFID, 157 (72.7%) identified “food-related fears,” 135 (62.5%) identified “lack of interest in eating,” and 113 (52.3%) incorrectly identified “body image disturbance” as a subtype, indicating a potential conceptual confusion with anorexia nervosa.

Table 1. Evaluation of pediatricians' awareness, knowledge, attitudes, and practices regarding ARFID

	n	%
Were you familiar with the term “ARFID” before reading the title of this study?		
Yes	61	28.5
No	155	71.5
Is ARFID a diagnosis included in the DSM-5?		
Yes	82	38.0
No	7	3.2
Not Sure	127	58.8
Which of the following are diagnostic presentations of ARFID according to DSM-5?[Multiple responses allowed]		
Avoidance based on the sensory characteristics of food	109	50.5
Apparent lack of interest in eating or food	135	62.5
Body image disturbance	113	52.3
Concern about aversive consequences of eating	157	72.7
Are you aware of common psychiatric and developmental comorbidities of ARFID?		
Yes (anxiety disorders, autism spectrum disorder, ADHD)	153	70.8
No	61	28.2
ARFID may present with diminished appetite or disinterest in eating.		
Yes	185	85.6
No	1	0.5
I am not familiar	30	13.9
ARFID may involve avoidance of food due to sensory sensitivities.		
Yes	178	82.4
No	7	3.2
I am not familiar	31	14.4
ARFID may develop following fear of negative consequences related to eating.		
Yes	167	77.3
No	8	3.7
I am not familiar	41	19.0
ARFID may result in significant weight loss or failure to achieve expected weight gain.		
Yes	179	82.9
No	4	1.9
I am not familiar	33	15.3
ARFID may lead to nutritional deficiencies requiring oral supplements or enteral feeding.		
Yes	160	74.1
No	9	4.2
I am not familiar	47	21.8
ARFID can cause marked psychosocial impairment.		
Yes	178	82.4
No	4	1.9

I am not familiar	34	15.7
Restrictive eating in ARFID cannot be better explained by a medical condition, cultural practice, or food unavailability.		
Yes	120	56.1
No	38	17.8
I am not familiar	56	26.1
Individuals with ARFID fear gaining weight.		
Yes	98	45.6
No	57	26.5
I am not familiar	60	27.9
Have you ever diagnosed or suspected ARFID in your clinical practice?		
Yes	75	34.9
No	140	65.1
Have you ever referred a patient suspected of ARFID to another specialty?		
Yes	64	29.8
No	151	70.2
Which specialties do you refer to? <i>[Multiple responses allowed]</i>		
Child and Adolescent Psychiatry	117	54.2
Pediatric Gastroenterology	99	45.8
Nutrition and Dietetics	98	45.4
I don't refer	78	36.1
Other (e.g., Adolescent Health, Occupational Therapy, Developmental Pediatrics)	9	4.2
How competent do you feel in diagnosing and managing ARFID?		
Not competent at all	86	41.0
Slightly competent	85	40.5
Moderately competent	30	14.3
Quite/Very competent	9	4.3
Have you ever received any formal education or training on ARFID?		
Yes	14	6.5
No	202	93.5
Do you think pediatricians need additional training regarding ARFID?		
Yes	195	90.7
No	20	9.3
Would you participate in ARFID-related training if offered?		
Yes	186	87.3
No	27	12.7

n = frequency; % = percentage of respondents.

Awareness of Clinical Features and Referral Practices Related to ARFID

When asked about their awareness of the clinical characteristics of Avoidant/Restrictive Food Intake Disorder (ARFID), 178 participants (82.9%) indicated that ARFID could lead to weight loss or faltering growth in children. Additionally, 160 participants (74.1%) acknowledged that ARFID may result in significant nutritional deficiencies requiring oral supplements or tube feeding. A total of 185 respondents (85.6%) reported that loss of appetite could be a presenting feature of ARFID, 178 (82.4%) mentioned avoidance due to sensory sensitivities, and 167 (77.3%) cited fear of adverse eating consequences (e.g., choking or vomiting) as possible manifestations.

In contrast, 98 participants (45.6%) incorrectly stated that individuals with ARFID experience a fear of gaining weight. Furthermore, 120 participants (56.1%) correctly noted that the food restriction seen in ARFID cannot be attributed to medical conditions, cultural practices, or limited access to food.

Pediatricians' clinical experience with ARFID and their referral behaviors are presented in Table 1. Of the respondents, 75 (34.9%) reported having diagnosed or suspected a case of ARFID during their professional practice. Additionally, 64 participants (29.8%) had referred such patients to other specialists. The most frequently reported referral destinations were child and adolescent psychiatry (117; 54.2%), pediatric gastroenterology (99; 45.8%), and dietetics (98; 45.4%). Nine respondents (4.2%) selected "other" as the referral category, specifying adolescent health, occupational therapy, and developmental pediatrics as relevant fields.

Pediatricians' perceived competence in ARFID management and their educational background are also summarized in Table 1. Only 9 participants (4.3%) reported feeling "very competent" or "quite competent" in diagnosing and managing ARFID, whereas 86 (41.0%) stated they did not feel competent at all, and 85 (40.5%) reported feeling minimally competent. A total of 14 respondents (6.5%) had previously received any formal training on ARFID. However, 195 participants (90.7%) believed that pediatricians need

additional training on the topic, and 186 (87.3%) expressed willingness to attend such training if offered.

The comparison of pediatricians' knowledge levels regarding ARFID based on their professional titles is presented in Table 2. Pediatric subspecialists demonstrated significantly higher rates of correct responses regarding core clinical criteria of ARFID, such as weight loss and nutritional deficiencies, compared to other groups ($p < 0.05$). They also reported the highest perceived competence in diagnosing and managing ARFID ($p = 0.020$). Pediatric residents were more likely to incorrectly endorse "fear of gaining weight"—a feature associated with anorexia nervosa—as a characteristic of ARFID ($p = 0.020$).

When pediatricians were stratified by the presence of an adolescent health unit in their institution, those working in institutions with such a unit were significantly more knowledgeable. Among them, 51 participants (33.1%) reported knowing the expanded form of ARFID prior to reading the study title, compared to 10 (16.1%) in institutions without an adolescent health unit ($p = 0.012$). Awareness that ARFID is a DSM-5-defined disorder was higher among the former group (67; 43.5%) than the latter (15; 24.2%) ($p = 0.014$). Additionally, recognition that ARFID can lead to significant weight loss or growth faltering was reported by 135 participants (87.7%) in institutions with adolescent health units versus 44 (71.0%) in those without ($p = 0.013$). Awareness that ARFID can cause psychosocial impairment was similarly higher among pediatricians in adolescent health-equipped institutions (87.1% vs. 71.0%, $p = 0.011$). Furthermore, more pediatricians from these institutions had encountered ARFID cases (39.9% vs. 22.6%, $p = 0.016$) and had referred such cases to other specialists (35.3% vs. 16.1%, $p = 0.005$).

Regarding clinical experience, knowledge levels improved with increasing years in practice. The proportion of pediatricians who reported knowing the expanded form of ARFID prior to reading the study title was 16.1% among those with ≤ 2 years of experience, 30.3% in those with 2–4 years, and 36.8% among those with more than 4 years ($p = 0.025$). Similarly, the percentage of those who had referred an ARFID

case to another specialist increased with experience (17.7% for ≤ 2 years, 36.8% for 2–4 years, and 32.0% for >4 years; $p = 0.043$).

No statistically significant differences were observed in ARFID awareness or attitudes based on the number of patients seen monthly.

Responses to open-ended questions were thematically analyzed. Barriers to diagnosis and management included lack of familiarity with the disorder, difficulty in differential diagnosis, insufficient time during outpatient visits to assess for eating disorders, difficulty accessing dietitians and child/adolescent psychiatry teams, limited physician experience in managing eating disorders, and communication challenges with pediatric and adolescent patients. Recommendations for improving ARFID management included: structured educational programs covering diagnosis, differential diagnosis, and treatment tailored to pediatricians; increased awareness and early detection training for family physicians; extended consultation time for outpatient visits; enhanced awareness among schoolteachers and guidance counselors; and incorporating mandatory rotations in adolescent health units during pediatric residency training.

Discussion

This study revealed that pediatricians have limited awareness and knowledge regarding ARFID, experience difficulties in its clinical management, and express a need for further training. The findings indicate that the proportion of pediatricians who recognized ARFID as a DSM-5-defined eating disorder was relatively low. While participants most frequently and correctly identified “food-related fears” and “lack of interest in eating” as ARFID subtypes, a considerable proportion also incorrectly identified “body image disturbance”—a feature not associated with ARFID—suggesting conceptual confusion with anorexia nervosa. Pediatric subspecialists demonstrated higher accuracy in identifying clinical features such as weight loss and nutritional deficiencies associated with ARFID compared to other professional groups.

The results are consistent with those of Harrison (2), who conducted a study in the United Kingdom

assessing healthcare professionals’ knowledge and referral practices related to ARFID. Among 45 participants, 40% were working in primary care (e.g., general practitioners, school nurses), and 60% in secondary care (e.g., pediatricians, speech therapists, psychologists, dietitians). In the primary care group, 67% reported difficulty diagnosing ARFID and determining appropriate referral pathways. Although 74% of secondary care providers were familiar with the diagnosis, only 33% expressed confidence in making appropriate referrals. The study highlighted key barriers including lack of knowledge, confusion with picky eating, insufficient training, and the absence of multidisciplinary teams. Notably, 88% of participants believed that children with ARFID were falling through systemic gaps without receiving proper care. Similarly, Coelho et al. (4) conducted a study in Canada involving 93 healthcare professionals from various disciplines, including pediatricians, adolescent health specialists, dietitians, psychiatrists, nurses, family physicians, psychologists, occupational therapists, and social workers. Only 37% of participants could accurately identify all DSM-5 diagnostic criteria for ARFID, and most clinicians reported a lack of confidence in their diagnostic abilities. In another qualitative study by Magel et al. (6), more than half of participating professionals—including pediatricians, psychologists, nutritionists, and social workers—had never heard of ARFID, and only 8.6% had received specific training. Participants emphasized the absence of diagnostic and referral protocols and the ambiguity of professional roles in the management of ARFID. Guss et al. (5) surveyed U.S.-based physicians, including pediatricians, child and adolescent psychiatrists, adolescent medicine specialists, and clinicians in nutrition medicine. The study showed that during inpatient refeeding of adolescents with ARFID, protocols designed for anorexia nervosa were commonly used, revealing a lack of standardized approaches. Although multidisciplinary methods were frequently employed, pharmacologic interventions were reported less often. These findings align closely with our own results, which collectively suggest that ARFID remains under-recognized within health systems, and that structural and educational gaps

Table.2 Comparison of pediatricians' knowledge of ARFID according to professional title

	Pediatric Resident	General Pediatrician	Subspecialty Fellow	Subspecialist
	n (%)	n (%)	n (%)	n (%)
ARFID may result in significant weight loss or failure to achieve expected weight gain.				
Yes	112 (84.2)	21 (63.7)	28 (90.3)	18 (94.7)
No	3 (2.3)	1 (3.0)	-	-
Not familiar	18 (13.5)	11 (33.3)	3 (9.7)	1 (5.3)
p :0.051 chi square : 12.513				
ARFID may lead to nutritional deficiencies requiring oral supplements or enteral feeding.				
Yes	98 (73.7)	16 (48.5)	28 (90.3)	18 (94.7)
No	7 (5.3)	2 (5.1)	-	-
Not familiar	28 (21.1)	15 (45.5)	3 (9.7)	1 (5.3)
p :0.002 chi square : 20.873				
Individuals with ARFID fear gaining weight.				
Yes	72 (54.1)	10 (31.2)	10 (32.3)	6 (31.6)
No	25 (18.8)	11 (34.4)	12 (38.7)	9 (47.4)
Not familiar	36 (27.1)	11 (34.4)	9 (29.0)	4 (21.1)
p:0.020 chi square : 15.038				
ARFID can cause marked psychosocial impairment.				
Yes	111 (83.5)	22 (66.7)	27 (87.1)	18 (94.7)
No	3 (2.3)	-	1 (3.2)	-
Not familiar	19 (14.3)	11 (33.3)	3 (9.7)	1 (5.3)
p:0.073 chi square : 11.556				
Restrictive eating in ARFID cannot be better explained by a medical condition, cultural practice, or food unavailability.				
Yes	72 (54.1)	13 (40.6)	21 (70.0)	14 (73.7)
No	27 (20.3)	5 (15.6)	4 (13.3)	2 (10.5)
Not familiar	34 (25.6)	14 (43.8)	5 (16.7)	3 (15.8)
p:0.101 chi square : 10.612				

n = frequency; % = percentage of respondents.

persist in both diagnosis and management. Greater efforts are needed to implement training programs, clinical guidance, and interdisciplinary collaboration.

In our study, pediatricians working in tertiary university and training hospitals were assessed in terms of their awareness, knowledge, clinical experience, and referral behaviors regarding ARFID. The results mirror international findings. Only 28.5% of participants reported knowing the expanded form of ARFID, and 38% identified it as a DSM-5-defined disorder. These figures are comparable to Harrison's (2) findings, where 67% of primary care providers reported difficulty identifying ARFID. Moreover, 52.3% of participants in our study mistakenly identified "body image disturbance" as an ARFID subtype, reflecting the

diagnostic confusion noted by Coelho et al. (4), who found variability in clinicians' interpretation of diagnostic criteria. The fact that 45.6% of pediatricians believed individuals with ARFID feared weight gain further illustrates a misunderstanding of a key distinguishing feature of the disorder.

With respect to clinical experience, only 34.9% of participants reported having diagnosed or suspected an ARFID case, and 29.8% had referred a patient to another specialist. These findings support the notion, emphasized in Harrison et al.'s research (2), that children with ARFID often fall through gaps between disciplines due to insufficient referral pathways. Likewise, Magel et al. (6) reported that only 8.6% of clinicians had received ARFID-specific train-

ing, while 57.1% had managed ARFID cases without formal training. Consistent with our data, many participants lacked knowledge about appropriate healthcare services to which ARFID patients should be referred and often continued treatment themselves without involving specialized care.

In both the current and previous studies, the lack of training emerged as a key barrier. Notably, 90.7% of pediatricians in our sample emphasized the need for formal education on ARFID. Compared to the above-mentioned studies, our findings indicate even lower rates of ARFID awareness and referral practices among pediatricians. In Türkiye, the prevalence of ARFID in childhood is unknown. Therefore, the frequency of encountering ARFID cases in outpatient or inpatient settings may differ from countries where previous studies were conducted, suggesting that population-level differences could account for the observed disparities.

The diagnostic complexity of ARFID—particularly when symptom profiles overlap with neurodevelopmental conditions such as autism spectrum disorder—was reported both in our findings and in the study by Magel et al. (6). Additionally, Guss et al. (5) found that during hospital admissions of ARFID-diagnosed adolescents, inpatient refeeding protocols were often modeled after those for anorexia nervosa, reflecting a lack of disorder-specific treatment models and considerable heterogeneity in clinical practice. These findings align with our data, where 76.3% of pediatricians did not feel competent in managing ARFID.

Coelho et al. (4) showed that experienced clinicians demonstrated higher confidence in diagnosis and greater likelihood of referring ARFID cases. This finding corresponds with our result that pediatricians working in institutions with adolescent health units and those with more than four years of experience exhibited significantly greater awareness and referral behaviors.

In summary, insufficient knowledge, diagnostic confusion, limited referral pathways, and ambiguity surrounding refeeding practices for ARFID appear to be prevalent across healthcare systems. These challenges underscore the urgent need for interdisciplinary collaboration, standardized diagnostic and treat-

ment protocols, and targeted education programs, as consistently highlighted in the international literature.

In addition to variability in the interpretation of ARFID diagnostic criteria, the impact of these differences on patient management practices may partially explain discrepancies in prevalence data. Distinguishing ARFID presentations that involve only psychosocial impairment—but not medical compromise—also remains diagnostically challenging (3). Furthermore, validated assessment tools developed to objectively evaluate ARFID symptoms (e.g., PARDI, NIAS) have only recently been introduced into clinical practice, contributing to diagnostic heterogeneity (8,9). We believe that achieving greater diagnostic consensus and integrating high-validity screening instruments into routine practice are crucial steps toward standardization of ARFID diagnosis.

Strengths

One of the key strengths of this study is that it represents the first investigation in Türkiye to assess ARFID awareness among pediatricians. All participants were actively practicing physicians, including both pediatric residents and specialists, from tertiary care hospitals providing inpatient and outpatient services. The questionnaire used in this study was developed through a comprehensive review of the current literature, and unlike previous studies (2,4), it addressed DSM-5 diagnostic criteria alongside referral practices and educational needs. Furthermore, inclusion of physicians from university and city hospitals that serve diverse patient populations, along with a relatively large sample size compared to similar studies, enhances the generalizability of the findings.

Limitations

This study included only pediatricians and did not assess other professional groups involved in ARFID management, such as child and adolescent psychiatrists, psychologists, and dietitians. Although this may be viewed as a limitation, it is important to note that in Türkiye's healthcare system, pediatricians are often the first point of contact in the diagnostic process. Therefore, we do not consider this exclusion to be a significant limitation.

Conclusion

The findings of this study reflect challenges that align with those reported in the international literature, including limited recognition of DSM-5 diagnostic criteria for ARFID, confusion with anorexia nervosa, gaps in referral systems, and unmet educational needs. Most participants had only limited familiarity with the concept of ARFID and reported uncertainty regarding appropriate referral pathways following diagnosis.

Factors such as length of clinical experience and institutional structure—particularly the presence of adolescent health units—were significantly associated with better awareness and referral behavior. In light of these findings, we conclude that implementation of structured training programs, interdisciplinary referral guidelines, and standardized clinical protocols is necessary to improve early and accurate identification of ARFID in pediatric practice. Moreover, due to the heterogeneous clinical presentations and high rates of psychiatric comorbidities, enhancing both the conceptual and practical clarity of ARFID diagnostic criteria—and promoting the use of validated assessment tools—will be essential to achieving diagnostic and treatment standardization.

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Ethics: The study received approval from the Non-Interventional Clinical Research Ethics Committee of Non-Interventional Clinical Research Ethics Committee of Ankara University (Approval No: İ05-421-25). All participant data were treated with strict confidentiality. Participation was entirely voluntary, and no identifying personal information, such as names or contact details, was collected.

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