

Impact of Eating Disorder Course for Nutrition Students: Shifts in comfort, confidence, and eating disorder knowledge

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ABSTRACT

Objective: To evaluate the effectiveness of an educational intervention to improve comfort, confidence, and knowledge in working with eating disorders for nutrition students

Design: Quasi-experimental

Methods: The study examined the impact of a four-module course on nutrition students' (nutrition undergraduate, dietetic internship, or graduate) comfort and confidence levels in working with individuals with eating disorders, risk of development of an eating disorder, and their knowledge of working with eating disorders. The study employed a pre-test/post-test design to assess changes in participants before and after the intervention.

Setting: Virtual administration

Participants: 5 participants completed pre- and post-test data

Intervention: Participants completed a four-hour course on eating disorders written by an eating disorder expert in the spring of 2024.

Results: The use of an eating disorder course for nutrition students increased students' self-reported levels of confidence and comfort when thinking about working with eating disorders in their future careers. There was not a significant difference in pre-test and post-test knowledge assessment, however participants' scores remained the same or increased. The average of the participants' pre-test and post-test EAT-26 assessment did not show a significant change.

Conclusions and Implications: The use of an eating disorder course for nutrition students has the potential to improve student comfort and confidence in working with eating disorders, as well as their overall knowledge of nutrition counseling for eating disorders. It is imperative to continue to consider the impact that eating disorder education may have on the risk of eating disorder development for nutrition students.

INTRODUCTION

Eating disorders are complex illnesses with serious mental and physical implications. The impact of an eating disorder can range from symptoms such as dehydration, muscle loss, intestinal distress, and osteoporosis to death. It is estimated that approximately 10% of the American population will be diagnosed with an eating disorder within their lifetime, although this number could be higher than documented due to under-reporting or symptoms not fitting within the criteria for an eating disorder as outlined in the Diagnostic and Statistical Manual of Mental Disorders.¹ Those going through treatment for an eating disorder have the best recovery outcomes when they are able to access care from a clinician with the appropriate education and experience with eating disorders; however, most clinicians do not receive more than a few hours of eating disorder education let alone adequate education to provide the necessary standard of care.²

Most medical professionals do not receive sufficient eating disorder education throughout their schooling.³ In the United Kingdom in 2017 there were three eating disorder deaths that were avoidable, which led to an examination of the education physicians received on eating disorders, discovering that most UK physicians received less than two hours of eating disorder education throughout the entirety of their schooling.³ In the United States it is estimated that only 1.9% of physicians complete a rotation in working with eating disorders during their residency and 93% of physicians are not acquainted with the American Psychiatric Association practice guidelines for the treatment of patients with eating disorders.³

Physicians are not the only medical professionals who do not receive adequate training around these life-threatening illnesses. Nurses have reported limited experience with eating disorders in an educational setting, thus resulting in feelings of inadequacy, decreased patience, and increased frustration when working with those who are going through treatment.⁴ While nurses may recognize physical symptoms, such as dehydration, often associated with eating disorders and provide the appropriate treatment, they may not connect these symptoms to the presence of an eating disorder, thus missing opportunities to help those who are struggling.⁵

Dietitians are the medical professionals who may spend the most direct time with clients, as well as the most time discussing a relationship with food in depth; however, this group as a whole is also woefully underprepared to ensure the highest quality of care for those with eating disorders. Most dietitians receive little to no formal education on eating disorders.^{6, 7, 8} Unpublished needs assessment data gathered in fall of 2023 found that 50% of dietitians spent five hours or less learning about eating disorders while 16% of dietitians reported not discussing eating disorders at all throughout their education experience.

There is even limited experience reflected with those dietitians who do work with eating disorders. It is often dietitians who have the least amount of training who are in positions treating patients at the highest level of acuity. These clinicians report larger caseloads, limited access to continuing education, and higher levels of burnout.⁷ These dietitians reflected both a

desire and a need for more education, training, and professional development in spite of working directly with those in recovery.⁸

Needs assessment data reinforced the fact that dietitians do not receive adequate training on eating disorders. A knowledge assessment of eating disorders administered in the fall of 2023 through an unpublished needs assessment, 84% of dietitian participants scored a 50% or lower. Only 37% of participants were able to correctly identify risk factors for eating disorders. Dietitians were asked to report their comfort levels in working with eating disorders as well as their confidence levels in working with eating disorders. Participants reported an average of 4.33/10 comfort level and 4.19/10 confidence level in working with eating disorders generally. Both comfort and confidence decreased when asked specifically about Anorexia Nervosa, Bulimia Nervosa, Avoidant Restrictive Food Intake Disorder, and Other Specified Feeding or Eating Disorder. Participants were also asked to respond to the statement “I feel that the Commission on Dietetic Registration adequately prepares Registered Dietitians/Registered Dietitian Nutritionists to work with eating disorders” using a Likert scale, where 10 was strongly agree and 1 was strongly disagree, to which the average response was 2.9/10, further underlining need for more education around eating disorders for dietitians, specifically in the undergraduate, dietetic internship, and graduate stages of the profession.

Dietitians are also at higher risk for developing eating disorders themselves. Nutrition students and professionals perceive pressure to maintain a thin ideal or a certain body type in order to be perceived as credible. This may be linked to the higher rates of body image dissatisfaction, disordered eating, and eating disorders in the dietetic population, compared to non-nutrition professional peers.^{9, 10} There is a prevalence of orthorexia for nutrition students at 49.5% compared to the prevalence of orthorexia at 17% within the general student population.^{9, 10} Not only is it imperative that nutrition professionals receive more education around eating disorders, but it is necessary for this education to not increase risk of eating disorders within this population.

In an effort to address this need for increased education around eating disorders for dietitians, a curriculum specifically for dietetic students was designed with the intention that it be integrated into already existing undergraduate or dietetic internship coursework. Written with the knowledge that dietetic students are at higher risk for eating disorders (or may be going through their studies with an eating disorder) it includes trigger warnings, uses body-neutral language, and uses a wider variety of metrics to measure health than traditional nutrition education resources. This curriculum covers basic information on eating disorders, such as diagnostic criteria and the impact that these diseases can have on the body, but goes further than traditional dietetic education. Warning signs for eating disorders, levels of care, working as a part of an interdisciplinary team, the intersection of medical nutrition therapy with therapeutic approaches, and many other considerations are included to provide a well-rounded approach for nutrition students enhancing their eating disorder knowledge.

The purpose of this pilot study was to evaluate the efficacy of an educational intervention to improve comfort, confidence, and knowledge in working with eating disorders for nutrition students, thus allowing students to be better prepared clinicians.

METHODS

Study Design

This quasi-experimental study aimed to examine the impact of a four-module course on nutrition students' (nutrition undergraduate or dietetic internship) confidence, comfort, and preparedness in working with individuals with eating disorders, risk of development of an eating disorder, and their knowledge about working with eating disorders. The study employed a pre-test/post-test design to assess changes in participants before and after the intervention. The intervention was comprised of a four-module course developed by an eating disorder expert. Approval for this study was obtained from the Institutional Review Board (IRB) at the State University of New York at Oneonta prior to its commencement.

Intervention

The intervention was a structured four-module course focusing on various aspects of eating disorders, developed by an expert in the field. The course content was grounded in evidence-based practices for treating and managing eating disorders and aimed at equipping future nutrition professionals with the necessary skills and knowledge to do so. Participants were asked to complete the online modules in a self-guided fashion within a two-week time frame, with an estimated total completion time of 10 hours. Content was delivered online in a lecture style format that utilized a slide show, a verbal lecture, videos, and social media examples. The course covered five eating disorder diagnoses: Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Avoidant Restrictive Food Intake Disorder, and Other Specified Feeding or Eating Disorder. Prevalence, symptoms, physical manifestations, warning signs, different therapeutic modalities, medical nutrition therapy for eating disorders, and several case studies were also presented.

Participants

Participants were recruited to this study through targeted outreach on social media platforms to dietitian-specific groups, and through referrals generated by word-of-mouth recommendations at various universities and dietetic internship programs. Participants were required to be either undergraduate nutrition students and dietetic interns in order to participate. The study included a total of 18 participants.

Tools

Data were collected using a multifaceted survey instrument. The survey was comprised of three distinct parts. In the first section participants were asked to read statements about confidence and comfort levels in working with eating disorders and respond using a 10-point Likert scale, where 1 indicates strongly disagree and 10 indicates strongly agree. In the second section participants were asked to complete the Eating Attitudes Test-26 (EAT-26) to assess participants' current food attitudes and beliefs as well as to screen for risk of the development of an eating disorder. The third section was comprised of a 10-question exam designed to

evaluate the participants' knowledge about eating disorders. The Eat26 is a validated instrument; other instruments were adapted for the specific context of this study and were written by an eating disorder expert. The survey instrument was administered both prior to and after the intervention.

Data Analysis

The objective of the study was to examine the efficacy of a course about designed for nutrition students to increase their knowledge about working with eating disorders while not increasing their risk of developing an eating disorder. With the goal being to examine changes in students' perceived comfort and confidence levels, risk for eating disorder development, and overall knowledge about working with eating disorders, the t-test allowed for the most practical data analysis. Pre- and post-test data was compared using a paired t-test for the following: self-reported comfort, self-reported confidence, knowledge assessment, and EAT-26 score.

A significance level of $p < 0.05$ was considered indicative of statistically significant differences. The analysis aimed to identify any significant changes in the aforementioned variable, attributing any observed variations to the impact of the educational intervention. Statistical analysis was conducted using Microsoft Excel which facilitated the comprehensive examination of the data collected.

RESULTS

Demographics

(See **Appendix A** for Demographic Questionnaire)

A total of 12 participants were recruited to participate in his study. Of the 12 who originally signed up to participate in the course, only 6 completed the course. Of the 6 who completed the course only 5 participants completed both the pre-test and post-test data and so the data of 5 participants was used (n=5). A demographic profile of the participants of this intervention is presented in Figure 1.

<u>Education Level</u>	<u>n=5</u>	<u>%</u>
Undergraduate	3	60.00%
Dietetic Intern	0	0.00%
Graduate	2	40.00%
<u>Gender</u>	<u>n=5</u>	<u>%</u>
Female	5	100.00%
Male	0	0.00%
Transgender	0	0.00%
Non-binary	0	0.00%
Prefer Not To Respond	0	0.00%
<u>Age</u>	<u>n=5</u>	<u>%</u>
18-25	4	80.00%
26-35	0	0.00%
36-45	0	0.00%
46-55	1	20.00%
56-65	0	0.00%
65+	0	0.00%

Figure 1: Demographic Information of Participants

Self-Reported Comfort Levels

(See **Appendix B** for Comfort and Confidence Questionnaire)

• Participants reported an increase in comfort levels when thinking about working with eating disorders after having completed the course. A paired t-test was used to compare pre-test and post-test data. As a group there was found to be a significant improvement in self-reported confidence from pre-test to post-test ($p < 0.01$) as reflected in Figure 2. When examining self-reported confidence attached to specific diagnoses, this significant increase is consistent among multiple eating disorder diagnosis designations as reflected in Figure 3.

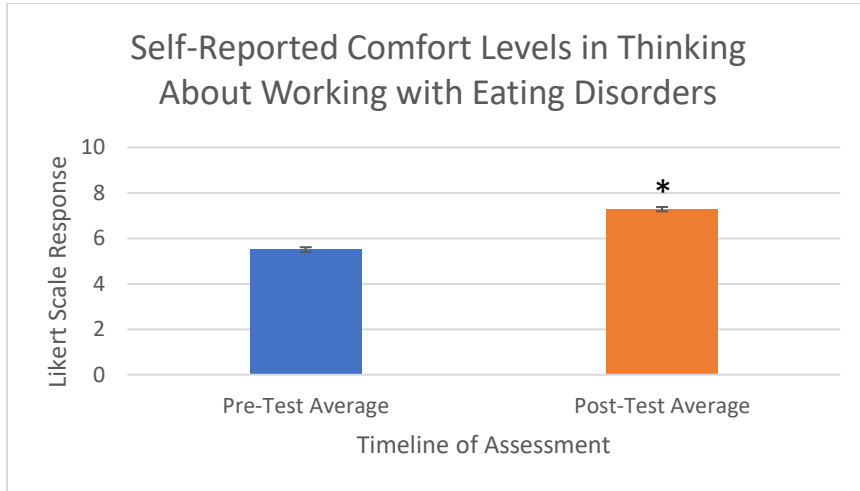


Figure 2: Self-Reported Comfort Levels in Thinking About Working with Eating Disorders. Participants used a 10-point Likert scale with 1 indicating strongly disagree and 10 indicating strongly agree. *Paired t-test $p < 0.01$

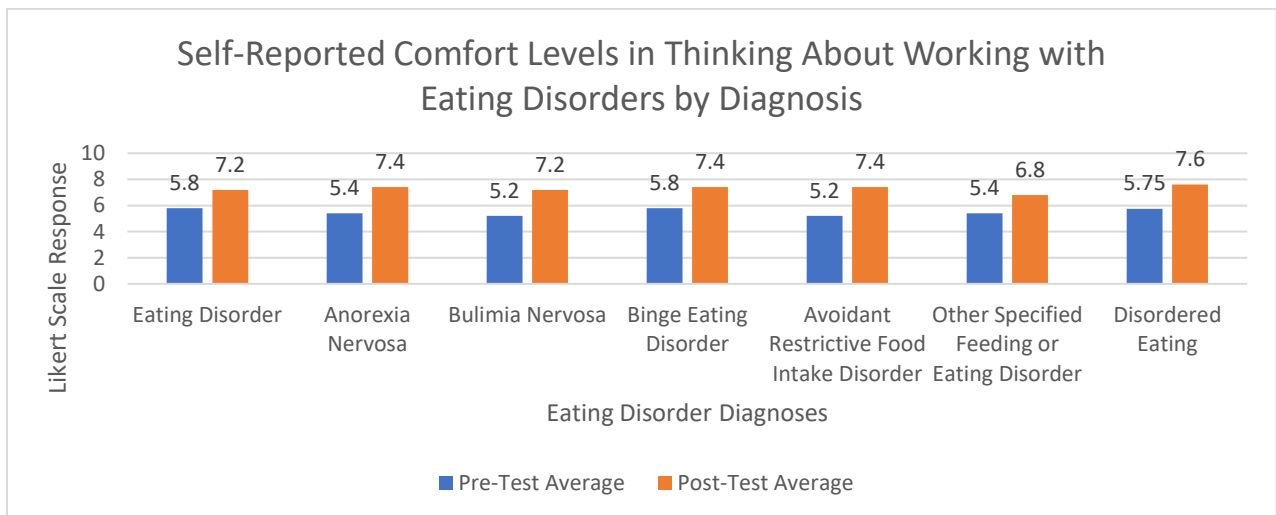


Figure 3: Self-Reported Comfort Levels in Thinking About Working with Eating Disorders by Diagnosis. Participants used a 10-point Likert scale with 1 indicating strongly disagree and 10 indicating strongly agree.

Self-Reported Confidence Levels

(See **Appendix B** for Comfort and Confidence Questionnaire)

• Participants reported an increase in confidence levels when thinking about working with eating disorders after having completed the course. A paired t-test was used to compare pre-test and post-test data. As a group there was found to be a significant improvement in self-reported confidence from pre-test to post-test ($p < 0.01$) as reflected in Figure 4. When examining self-reported confidence attached to specific diagnoses, this significant increase is consistent among multiple eating disorder diagnosis designations as reflected in Figure 5.

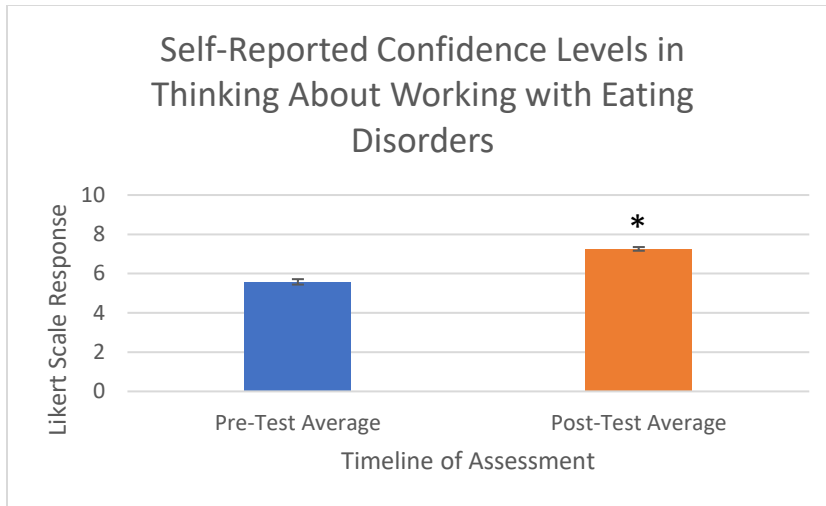


Figure 4: Self-Reported Confidence Levels in Thinking About Working with Eating Disorders. Participants used a 10-point Likert scale with 1 indicating strongly disagree and 10 indicating strongly agree. *Paired t-test $p < 0.01$

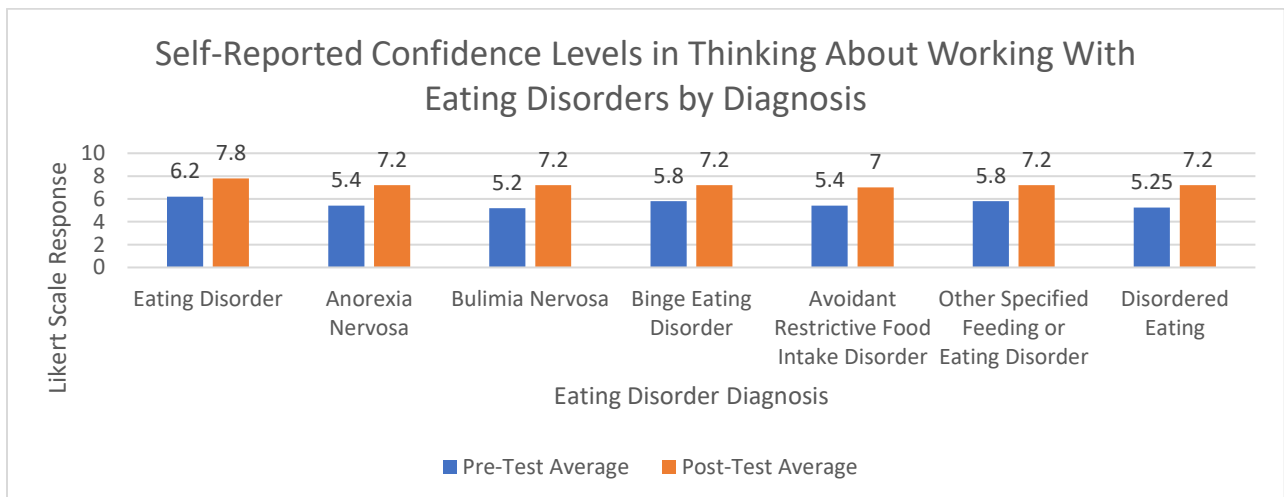


Figure 5: Self-Reported Confidence Levels in Thinking About Working with Eating Disorders by Diagnosis. Participants used a 10-point Likert scale with 1 indicating strongly disagree and 10 indicating strongly agree.

Knowledge Assessment

(See **Appendix C** for Eating Disorder Knowledge Assessment)

The participants' pre-test and post-test data did not reflect a significant shift in knowledge, with the group's average increase in score reflected as 0.84. A paired t-test was used to compare scores and $p > 0.05$ (Figure 6). In reviewing the pre- and post-test data of individual participants, scores remained the same or increased after post-test (Figure 7).

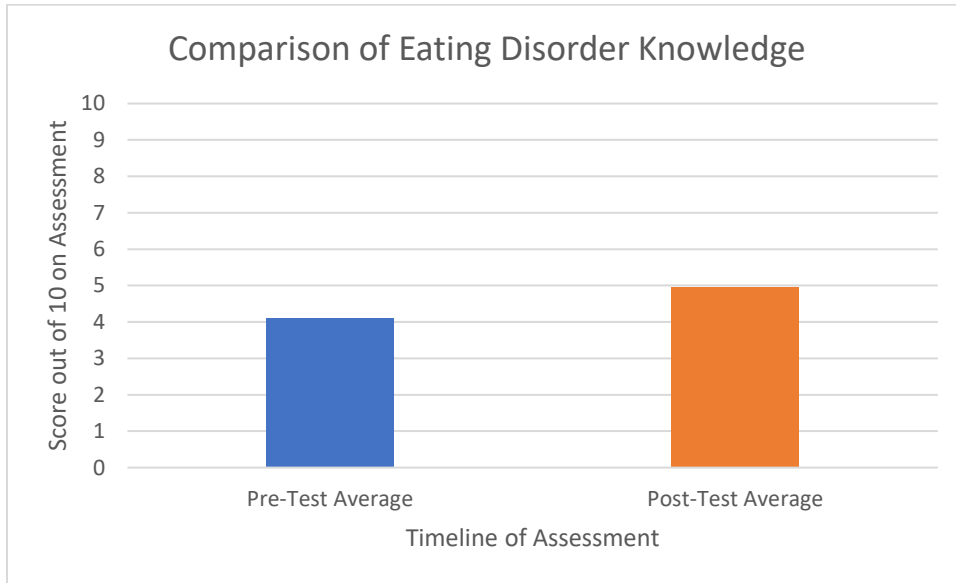


Figure 6: Comparison of Eating Disorder Knowledge. Maximum score of knowledge was 10/10; $p > 0.05$.

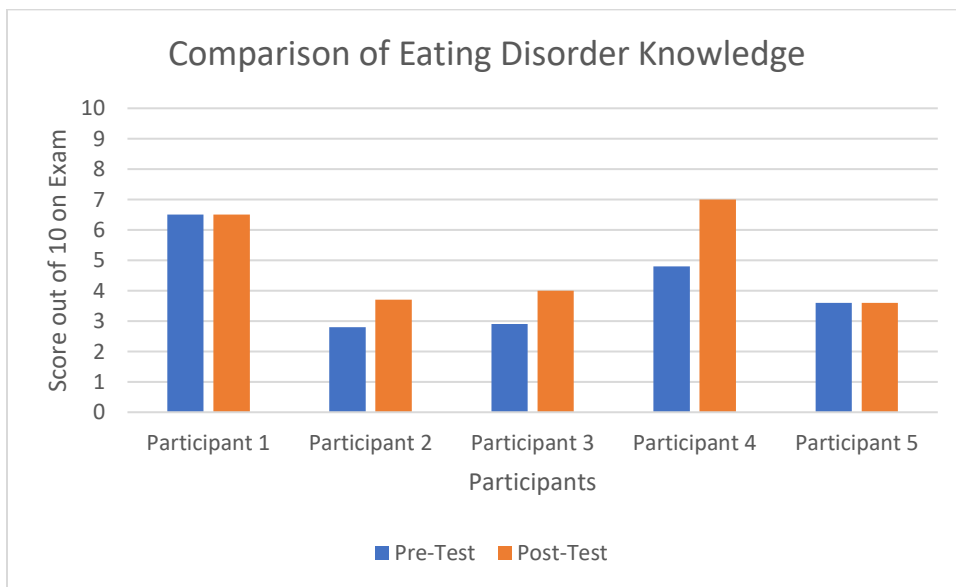


Figure 7: Comparison of Eating Disorder Knowledge by Participant. Maximum score of knowledge was 10/10.

EAT-26 Assessment

(See **Appendix D** for EAT-26 Assessment)

Participants' EAT-26 scores were compared using a paired t-test. Pre- and post-test averages did not show a significant difference, with $p > 0.05$. In comparing individual scores, 4 of the 5 participants maintained their EAT-26 score within 2 points (Figure 8). Only one participant had an increase in 10 points, a 58.8% increase in score (Figure 9).

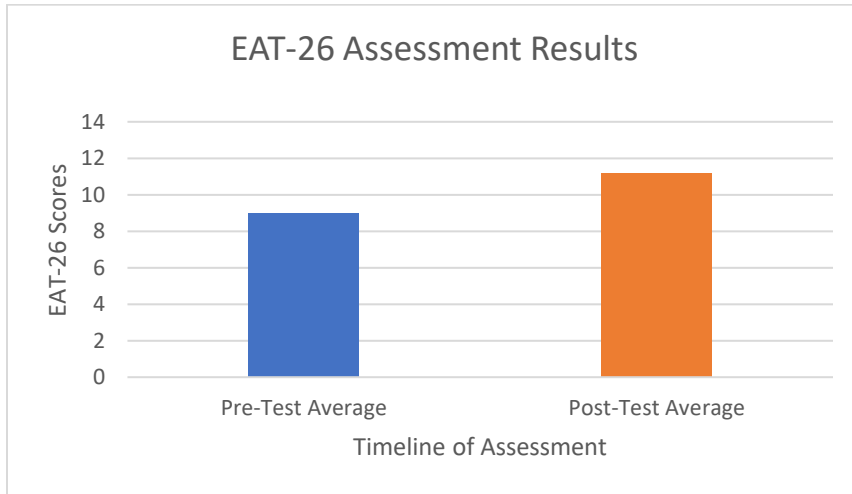


Figure 8: Comparison of Average Pre-Test and Post-Test EAT-26 Assessment Results. EAT-26 scores range from 0-78, with a score of 20 or higher indicating an eating disorder pathology level; $p > 0.05$.

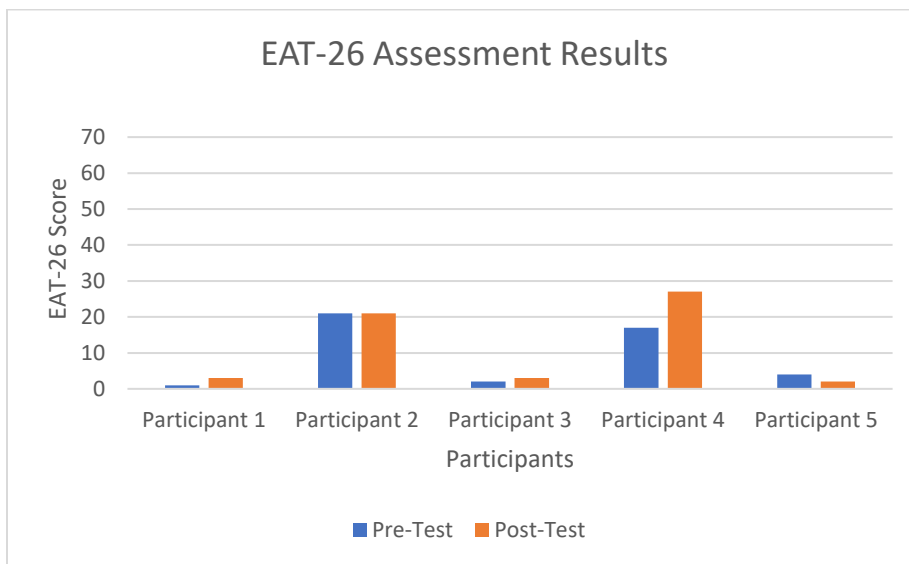


Figure 9: Comparison of Individual Pre-Test and Post-Test EAT-26 Assessment Results. EAT-26 scores range from 0-78, with a score of 20 or higher indicating an eating disorder pathology level.

DISCUSSION

In spite of the recognition of the need for continued training and education around eating disorders for dietitians, there is a noted absence in research focused on interventions around eating disorder education for nutrition students.¹² Practicing dietitians have reflected that they have not received adequate eating disorder education and thus have to pursue continuing education on their own time and at their own expense to support their knowledge.⁷ While this study did not indicate a statistically significant increase in eating disorder knowledge, noting the motivation of currently practicing dietitians to find their own eating disorder education reinforces the idea that the education intervention examined may show an increase in efficacy when attached to an incentive.

Previous studies reflect that dietitians do not receive adequate training around eating disorders and thus lack comfort and confidence in working with clients who are in recovery from an eating disorder.^{2, 6, 7, 8} This study indicated that focused eating disorder material geared toward nutrition students can result in a significant increase in comfort and confidence, thus laying a foundation for students to become better clinicians.²

It has been shown that nutrition students and nutrition professionals are at an increased risk for the development of an eating disorder.^{7, 10} Pre- and post-test measures of the EAT-26 assessment suggest that eating disorder education can be integrated for nutrition students without further exacerbating the risk for the development of an eating disorder. The use of a validated screening tool to examine risk for the development of an eating disorder in research has the potential to be used as a way to connect students with professional resources, thus decreasing eating disorder development risk, however there is limited research on this style of its use and it remains an area for further research.

Based on the significant increase in mean group scores in self-reported comfort and confidence levels, the results indicate that the participants gained emotional benefit from participation in the intervention course. This suggests that this intervention course can be an effective tool to support clinical growth for nutrition students in counseling for eating disorders. This has the potential to support positive recovery outcomes for clients going through with recovery who work with clinicians reporting comfort and confidence in treating eating disorders.

There was no statistically significant increase for participants' EAT-26 scores. This provides evidence that the implementation of this course can be beneficial to nutrition students' exposure to eating disorder education without increasing the risk of eating disorder development. It is important to note that while there was no significant change for the group, there was one participant who experienced a 10-point increase in their EAT-26 score, placing their score at 27 which is indicative of a clinically-significant presence of eating disorder symptoms. While this study was developed by an eating disorder expert through a trauma-informed lens, this individual's score represents a limitation of this study, which is the impossibility to control risk factors outside the study that may exacerbate a student's risk for

the development of an eating disorder. If this course were to be implemented into undergraduate programs, dietetic internships, or graduate programs, it may be prudent for these programs to consider administering the EAT-26 prior to the course and connecting students at risk for the development of an eating disorder with the campus counseling center, or a community therapist and dietitian with expertise in the field of eating disorders, to account for other risk factors outside of the course.

Participants' pre- and post-test knowledge assessments did not reflect a significant increase, suggesting that this course may not be effective in increasing overall eating disorder knowledge of students. However, in comparing individual pre- and post-test data all participants either maintained or increased their scores. It is important to consider that this course was voluntary and outside the courseload of the students, thus other stressors may have shifted time and attention from consistent interaction with this course material. Additionally, this course was self-paced and so the time between start to finish of the course could also have played a role in the reflected knowledge outcomes. This study did not offer incentives for participation and so it is possible that this impacted participant investment in material. If this course were to be implemented into higher education nutrition-focused programs, knowledge outcomes may increase if they were tied to grade-based incentives.

This study was limited by its small sample size. While there was diversity in age ranges and education levels, those who participated in the study are unable to truly reflect the diversity of the nutrition student population. Additionally, all participants were female-identifying individuals which, while the dietetic population is predominantly female, does exclude male-identifying individuals, trans individuals, and non-binary individuals from the reflected outcomes.

CONCLUSION

This research suggests that the intervention course is an effective tool to assist nutrition students in moving forward in working with those in eating disorder recovery. This course can support increases in both comfort and confidence for nutrition students working with eating disorders in their future careers thus establishing a foundation for capable practitioners. With considerations to increase investment in material, such as grade-based incentives, it is possible that this course will also support an improvement in overall knowledge in eating disorder counseling for nutrition students. This course is also a valuable tool for nutrition students on nutrition counseling strategies for eating disorders without reflecting an increased risk for eating disorder development for students themselves; however, it is important for those considering its formal implementation to consider safeguards for at risk students and how to connect students to resources as needed.

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APPENDIX

Appendix A – Demographic Questionnaire

- 1. What level of education are you currently completing?**
 - a. Undergraduate
 - b. Dietetic Internship
 - c. Graduate
- 2. How much time have you spent learning about eating disorders through your education programs (combined):**
 - a. I have not learned about eating disorders.
 - b. 0-5 hours
 - c. 6-10 hours
 - d. 11-15 hours
 - e. 16-20 hours
 - f. 21-25 hours
 - g. More than 25 hours
- 3. How much time have you spent learning about eating disorders outside of your education programs?**
 - a. I have not learned about eating disorders.
 - b. 0-5 hours
 - c. 6-10 hours
 - d. 11-15 hours
 - e. 16-20 hours
 - f. 21-25 hours
 - g. More than 25 hours
- 4. Have you had previous experiences with eating disorders in a non-education situation?**
 - a. Yes – I was personally diagnosed with an eating disorder.
 - b. Yes – A friend/family member was diagnosed with an eating disorder.
 - c. Yes – but I do not want to disclose any additional information.
 - d. No
 - e. I prefer not to answer.
- 5. Is your nutrition degree a second degree?**
 - a. Yes
 - b. No
- 6. *If you answered no to question #5, skip this question.* How much time did you spend learning about eating disorders through your previous degree?**
 - a. I have not learned about eating disorders.
 - b. 0-5 hours
 - c. 6-10 hours

- d. 11-15 hours
 - e. 16-20 hours
 - f. 21-25 hours
 - g. More than 25 hours
- 7. *If you answered no to question #5, skip this question.* How much time did you spend learning about eating disorders through your previous job experience?**
- a. I have not learned about eating disorders.
 - b. 0-5 hours
 - c. 6-10 hours
 - d. 11-15 hours
 - e. 16-20 hours
 - f. 21-25 hours
- 8. What is your gender identity?**
- a. Male
 - b. Female
 - c. Transgender
 - d. Non-binary
 - e. Prefer not to answer
- 9. What is your age?**
- a. 18-25
 - b. 26-35
 - c. 36-45
 - d. 46-55
 - e. 56-65
 - f. 65+

Appendix B – Comfort and Confidence Questionnaire

Please answer the following questions about the intersection of your professional experience and eating disorders. These questions use a scale of 1-10, where 1 indicates strongly disagree and 10 indicates the strongly agree.

Strongly Disagree					Neither agree or disagree					Strongly Agree	N/A
1	2	3	4	5	6	7	8	9	10		

1. I feel comfortable thinking about working with a client who has an eating disorder on their nutrition.
2. I feel comfortable thinking about working with a client with Anorexia Nervosa on their nutrition.
3. I feel comfortable thinking about working with a client with Bulimia Nervosa on their nutrition.
4. I feel comfortable thinking about working with a client with Binge Eating Disorder on their nutrition.
5. I feel comfortable thinking about working with a client with Avoidant Restrictive Food Intake Disorder on their nutrition.
6. I feel comfortable thinking about working with a client with Other Specified Feeding or Eating Disorder on their nutrition.
7. I feel comfortable thinking about working with a client who has disordered eating on their nutrition.
8. I feel confident thinking about working with a client who has an eating disorder on their nutrition.
9. I feel confident thinking about working with a client with Anorexia Nervosa on their nutrition.
10. I feel confident thinking about working with a client with Bulimia Nervosa on their nutrition.
11. I feel comfortable thinking about working with a client with Binge Eating Disorder on their nutrition.
12. I feel confident thinking about working with a client with Avoidant Restrictive Food Intake Disorder on their nutrition.
13. I feel confident thinking about working with a client with Other Specified Feeding or Eating Disorder on their nutrition.
14. I feel confident thinking about working with a client who has disordered eating on their nutrition.
15. I feel that my undergraduate education has prepared me to work with clients who have an eating disorder diagnosis.
16. I feel that my dietetic internship education prepared me to work with clients who have an eating disorder diagnosis. (select n/a as needed).
17. I feel that my masters level education is adequately preparing me to work with clients who have an eating disorder diagnosis. (select n/a as needed).

Appendix C – Eating Disorder Knowledge Assessment

- 1. What is the most common eating disorder:**
 - a. Anorexia Nervosa
 - b. Bulimia Nervosa
 - c. Binge Eating Disorder
 - d. Avoidant Restrictive Food Intake Disorder

- 2. In what therapeutic model are the following stages present: parents in charge of weight restoration, parents hand eating control back to adolescent, the discussion of adolescent developmental issues.**
 - a. DBT
 - b. CBT
 - c. ACT
 - d. FBT

- 3. Which of the following are indicators of Anorexia Nervosa?**
 - a. Low body weight
 - b. Hair loss
 - c. Constipation
 - d. Irregular blood urea nitrogen lab values
 - e. All of the above
 - f. A and B only
 - g. A, B, and C only

- 4. Which of the following is true about a client with an eating disorder of any diagnosis who may need to weight restore?**
 - a. They will likely need to restore to the weight they were at when they first reported their eating disorder symptoms.
 - b. If they were overweight, they will only need to weight restore to a weight that puts them in a BMI range of 18-25.
 - c. They will likely need to restore to a weight higher than when they first started experiencing symptoms.
 - d. Not everyone will not need to weight restore, only those with Anorexia need to weight restore.
 - e. Not everyone will not need to weight restore, clients with Binge Eating Disorder actually need to lose weight.

- 5. Which of the following is the most accurate description of the role of the dietitian in eating disorder recovery?**
- Provide nutrition education around good and bad foods to promote healing.
 - Follow the lead of what the client is willing to do and help push them forward.
 - Create meal plans without any input from the client.
 - Remaining focused on medical nutrition therapy, allowing the client to work on their feelings about food solely in therapy.
- 6. What is the best way to determine caloric needs for individuals who need to weight restore?**
- Mifflin St. Jeor equation
 - 25-30 kcal/kg of IBW
 - 25-30 kcal/kg of ABW
 - Pick a starting point and track client's weight trajectory to reach target weight goal
 - Harris-Benedict equation
 - Penn State equation
- 7. A client with Anorexia and no purging history complains of frequent constipation. What should you do?**
- Encourage them to eat adequately
 - Suggest an over-the-counter osmotic laxative
 - Provide examples of foods that may promote comfortable bowel movements
 - Ask them to reach out to their physician
 - All of the above
 - A and C only
 - None of the above
- 8. Which of the following is NOT an example of iatrogenic harm from the medical community for a client in recovery from an eating disorder?**
- A school nurse encouraging weight loss for a client with a BMI of 25
 - A dietitian providing education on good fats and bad fats
 - A physician prescribing weight loss surgery to an individual who weighs 200 lbs
 - A dietitian providing a 4000kcal meal plan
 - A OBGYN office providing Cool Sculpting

9. When is movement integrated into eating disorder recovery?

- a. It shouldn't be integrated until the individual is fully recovered as this puts the individual at risk for relapse.
- b. It is reintegrated when the individual reaches their target weight or is cleared by a physician.
- c. It is never stopped, rather it is adjusted for the stage of recovery that the client is in at a given time.
- d. All of the above
- e. None of the above

10. Check which of the following are risk factors for the development of an eating disorder?

- History of trauma
- Co-occurring mental illness
- Clean eating
- Having received recommendations for weight loss
- Diagnosis of a spectrum disorder, i.e. ADHD or autism
- Tracking calories
- A history of long-distance running
- Being a dietitian
- Exposure to the media
- Family history
- Having a food allergy

Appendix D – EAT-26 Assessment

Check a response for each of the following statements:		Always:	Usually:	Often:	Some times:	Rarely:	Never:
1.	I am terrified about being overweight.						
2.	I avoid eating when I am hungry.						
3.	I find myself preoccupied with food.						
4.	I have gone on eating binges where I feel that I may not be able to stop.						
5.	I cut my food into small pieces.						
6.	I aware of the calorie content of foods that I eat.						
7.	I particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)						
8.	I feel that others would prefer if I ate more.						
9.	I vomit after I have eaten.						
10.	I feel extremely guilty after eating.						
11.	I am occupied with a desire to be thinner.						
12.	I think about burning up calories when I exercise.						

13.	I other people think that I am too thin.						
14.	I am preoccupied with the thought of having fat on my body.						
15.	I take longer than others to eat my meals.						
16.	I avoid foods with sugar in them.						
17.	I eat diet foods.						
18.	I feel that food controls my life.						
19.	I display self-control around food.						
20.	I feel that others pressure me to eat.						
21.	I give too much time and thought to food.						
22.	I feel uncomfortable after eating sweets.						
23.	I engage in dieting behavior.						
24.	I like my stomach to be empty.						
25.	I have the impulse to vomit after meals.						
26.	I enjoy trying new rich foods.						

In the past 6 months have you:		Never	Once a month or less	2-3 times a month	Once a week	2-6 times a week	Once a day or more
A.	Gone on eating binges where you feel that you may not be able to stop?*						
B.	Ever made yourself sick (vomited) to control your weight or shape?						
C.	Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?						
D.	Exercised more than 60 minutes a day to lose or to control your weight?						
E.	Lost 20 pounds or more in the past 6 months	YES			NO		
F.	Have you ever been treated for an eating disorder?	YES			NO		

*Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control.