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Intuitive Eating and Health at Every Size in Community Settings: Dietitians' Perceptions of Practice Barriers

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Abstract

Intuitive Eating (IE) and Health at Every Size (HAES) are health promotion paradigms used by dietitians in private practice more commonly than in community-based practice where more diverse and vulnerable populations are served. The primary objective of this study was to examine the perceived barriers and facilitators that dietitians encounter when using IE and HAES in community nutrition practice settings. This phenomenological, qualitative study applied a thematic analysis to identify emergent themes from transcripts of semi-structured interviews with 27 dietitians working in community settings in the United States. Dietitians reported the following perceived barriers to the use of IE/HAES: diet culture, which was often expressed as inconsistent messages patients receive from the media and other professionals that conflict with nutrition providers' messages; legislative restrictions and weight-centric administrative policies; and personal beliefs of clients and colleagues concerning weight and health. Dietitians reported occupational autonomy as a salient factor facilitating the use of IE/HAES in community practice and identified the need for shifts in attitudes about weight and its relation to health achieved through research and dissemination of information on weight-inclusive practices. Collectively, respondents experienced more systemic barriers than individual barriers and identified several macro-level facilitators that remain elusive. The unique experiences of RDNs in community practice provide a roadmap for ongoing research to establish the evidence base for best practices, inform education and training, and achieve cultural shifts that move towards weight-inclusive practice in this setting. More research is needed to explore the generalizability of these experiences.

Key Words: Intuitive Eating, Health at Every Size, Community Dietitians, Weight-inclusive

Introduction

Over the past two decades, a paradigm shift has evolved in nutrition practice, calling for weight-inclusive health interventions to replace weight-normative strategies that emphasize weight loss for the pursuit of health. To be weight-inclusive, an approach must utilize strategies that actively work to reduce bias against bodyweight and must approach health as multi-faceted (Tylka, 2014). When compared in research, weight-inclusive interventions produced significant improvements in biomarkers such as blood pressure and cholesterol as did their weight-normative counterparts (Bacon & Aphramor, 2011). Importantly, weight-inclusive interventions resulted in significant improvements in body image and self-esteem, as well as higher retention of participants and longer-lasting results when compared to weight-normative ones (Bacon & Aphramor, 2011; Schaefer & Magnusson, 2014).

Interest in weight-inclusive approaches has grown given increased awareness of the harmful effects of weight stigma. Weight stigma is the social devaluation of persons living in larger bodies, leading to discrimination against these individuals in institutional and personal ways (Puhl & Heuer, 2010). The importance of stigma in

healthcare is well documented, with clear links between stigmatization (including weight stigma) and worsening of health conditions (Puhl & Heuer, 2010, Schvey, Puhl, & Brownell, 2012, Friedman et al, 2008, O'Reilly and Sixsmith, 2012). In public health and clinical medicine settings, individuals classified as obese are often blamed for their health conditions, viewed as unmotivated to change, and considered a drain on the healthcare system (Pomeranz, 2008, Persky & Eccleston, 2011). Many well-meaning health initiatives are built on the promise of lessening the negative health effects of obesity. However, program materials and counseling techniques that pathologize larger bodies or focus on reducing body size often end up having unintended negative health consequences (Mann et al, 2007). In a recent systematic review, weight stigma (even in the form of language used in public health initiatives) was shown to be associated with factors that increase mortality, such as chronic inflammation, mood disorders, and elevated cortisol levels (Hunger, Smith, & Tomiyama, 2020). These changes were shown to be independent of actual BMI, meaning that while people with higher BMI's likely face more weight stigma that affects their health outcomes, people of all body sizes are potentially harmed by this rhetoric.

Two popular weight-inclusive paradigms, Intuitive Eating (IE) and Health at Every Size (HAES), have gained momentum among dietetic practitioners and their clients. IE is a framework for eating that supports self-care and integrates instinct, emotions, and rational thought into eating decisions (Tribole & Resch, 1995). HAES is a model for holistic healthcare that is grounded in a social justice framework. It advocates for weight-inclusive, life-enhancing, and sustainable practices both for individuals and on a policy-level, acknowledging the impact that weight stigma has on health inequity. (Association for Size Diversity and Health). Dietitians who practice using IE and HAES help clients learn to identify and respect hunger and fullness cues, to understand how feeding themselves affects their physical well-being, and to engage in joyful movement without using weight to track progress or intentionally limiting food intake.

Using weight-inclusive interventions is controversial in the traditional medical model where weight is an objective measure that is used as a predictor of health and serves as a proxy health outcome (Bacon & Aphramor, 2011). However, emerging evidence supports positive outcomes of IE and HAES interventions contributing to their growing use by some practitioners, particularly those in private practice. The use of IE and HAES by dietetics professionals who work outside of the private practice setting is not well-documented. It is unclear why these counseling paradigms are less utilized by dietitians working in community nutrition and public health settings. Understanding this disparity could inform modification of IE and HAES interventions for use across a broader range of settings where counseling needs and client demographics are more diverse, vulnerable, and representative of the general population in need of nutrition services for health promotion. The aim of this study was to identify barriers and facilitators of more widespread use of IE and HAES in community health settings.

Methods

This qualitative study followed a phenomenological approach, where a collective experience is understood through the assessment of individuals' perceptions and attitudes (Harris et al, 2009). It uses thematic analysis informed by grounded theory, a methodology that amasses qualitative data and looks for repeated ideas that can emerge as prominent themes (Martin & Turner, 1986). A brief screening survey was followed by in-depth interviews with registered dietitian nutritionists (RDNs) working in community settings. In this study, "community" was defined as any practice setting that would be accessible to the general public, distinct specifically from the private practice setting. The definition was intentionally kept broad given the limited sample size of a qualitative study. The initial survey and interview questions were reviewed by four RDNs who work in IE/HAES-based practice and research. The study protocol was approved by the City University of New York Institutional Review Board (IRB) with a waiver of written consent. Informed consent was given orally at the outset of the interview.

Participant Recruitment

Participants were RDNs recruited using a snowball approach and information distributed through relevant practice groups of the Academy of Nutrition and Dietetics and professional groups on social media between December 2019 and February 2020. Interested individuals completed an online survey to assess eligibility. Eligibility criteria required the RDN credential, employment in a community setting, and U.S. residence. Those who worked in private practice or did not use IE/HAES in practice were ineligible. A total of 122 RDNs completed the online survey, 67 agreed to be contacted

for an interview and 28 completed the interview. One participant was withdrawn from the sample after the interview because they worked outside of the U.S. Theoretical saturation was reached at 20 interviews, whereafter the authors reached a collaborative consensus that no new themes had emerged outside the existing codes (Glaser & Strauss, 1967); however, all 28 scheduled interviews were completed.

Data Collection

A brief, self-administered survey was sent out in a recruitment email to establish eligibility and collect demographic data. The survey included standardized definitions of IE and HAES. Interviews were conducted by telephone and lasted, on average, 30 minutes. The open-ended, semi-structured interview guide began with asking RDNs to define IE/HAES in their own words, share where they usually got their information on IE/HAES, and report any formal IE or HAES training they had completed. Participants were then asked to describe the clients and communities they served in terms of demographics and health concerns, the barriers they faced when implementing IE/HAES in their practice settings, factors that facilitated their use of IE/HAES in their work, and areas in which they felt they needed additional training. The semi-structured interviews were audio-recorded, transcribed and coded thematically.

Data Analysis

Each interview was transcribed using Trint software (Trint Ltd, Toronto, Canada) and then manually checked for errors by the primary author. Transcripts were uploaded into Dedoose software (SocioCultural Research Consultants, LLC, Manhattan Beach, CA) for qualitative research analysis, using thematic analysis to identify emergent themes (Martin & Turner, 1986). Open coding was performed by both the primary and senior author where transcripts were individually analyzed to develop an initial list of codes which were discussed and refined iteratively. Once codes were agreed upon, all interview transcripts were coded using Dedoose following standard qualitative analysis procedures (Creswell, 2009), with ongoing discussions about emergent themes guided by field notes. Dedoose was used to conduct a descriptive analysis of the codes and to assess the sample characteristics. Exploratory analysis was conducted with Dedoose software to assess relationships between frequently used codes and participant descriptors. The code counts were converted into a binary variable to denote whether the code was found in a given interview or not. Zero signified that the code was not applied at all in the interview, and one signified that the code was applied at least once.

Results

Sample Description

All participants identified as female; they ranged in age from 25-59, with an average age of 34. More than 80% self-identified as white, while the remaining identified as Asian, Black, Hispanic, or multiracial (Table 1). Nine participants had a Master's degree and one held a PhD. Three were certified Intuitive Eating counselors, and about half of respondents had completed some form of advanced certification beyond the RDN credential including board certifications in eating disorder treatment (CEDRD) and sports nutrition (CSSD). Public health practice and community health clinics predominated as practice settings with some participants working in hospital outpatient, retail/supermarket, schools/universities, corporate wellness, eating disorder treatment centers and hospital inpatient. About half of participants had been in their current practice setting for fewer than five years and had been using IE/HAES in their practice for an average of 2.98 years (SD=2.79).

Dietitian Understanding of IE/HAES

All participants were able to articulate a working knowledge of IE/HAES, using the practice definitions of the paradigms as a reference. Respondents' definitions of IE most commonly included the phrases "listening to the body," "hunger and fullness cues," and "internal vs. external cues." Respondents' definitions of HAES most commonly included the phrases, "social justice," "weight neutral," and "health goals."

Perceived Practice Barriers

Two main categories of perceived practice barriers were identified: individual/interpersonal and systemic/institutional (Table 2). Within individual/interpersonal barriers, the two most commonly articulated themes related to differences in the belief systems held by clients and non-dietitian providers that conflicted with the IE/HAES paradigm. Within systemic/institutional barriers, two prevalent themes emerged: (1) legislative and administrative policies that reinforce traditional weight-centric clinical care that opposes the ideals of IE/HAES, and (2) messages about health in relation to weight that are experienced as inconsistent between the dietitian's practice and societal diet culture and/or corporate culture at large.

Descriptor	Number of Participants (n)	Percentage of sample
Gender		
Female	27	100.0%
Ethnic Background		
White/Caucasian	22	81.5%
Hispanic or Latino	1	3.7%
Black/African American	1	3.7%
Asian American	1	3.7%
Multiracial	2	7.4%
Highest level of education		
Bachelor's Degree	17	63.0%
Master's Degree	9	33.3%
PhD	1	3.7%
Certified Intuitive Eating Counselor		
Yes	3	11.1%
No	24	88.9%
Work setting		
Community Clinic	6	22.2%
Corporate Wellness	2	7.4%
Eating Disorder Center	2	7.4%
Hospital In-Patient	1	3.7%
Hospital Out-Patient	4	14.8%
Public Health	7	25.9%
Retail	3	11.1%
School/University	2	7.4%
Years working in current setting		
<5	15	55.6%
5-10	9	33.3%
11-15	0	0.0%
>15	3	11.1%

Table 1. Sample Demographics

BARRIERS		FACILITATORS	
Factor	**N**	**Factor**	**N**
Individual/Interpersonal			
Client beliefs	13	RDN autonomy	12
Non-RDN provider beliefs	12	Shifting attitudes about weight	12
RDN and non-RDN training	8	Cohesive messaging across providers	10
Language barriers	5	Having a community of like-minded professionals	5
Clients' lack of resources	5	Relationships with colleagues	5
Lack of understanding of RDN role	4	Peer mentorship	2
Resistance from colleagues	3		
Cultural expectations	3		
Internalized weight stigma	3		
Lack of communication on healthcare team	2		
Clients' low readiness to change	2		
Institutional/Systemic			
Diet culture	14	Dissemination of IE/HAES information	10
Weight as a metric for success	13	Growing popularity of IE/HAES	3
Administrative policies	12	Increased funding for programming	2
Inconsistent messages about health in relation to weight	12		
Corporate culture	8		
Difficulty documenting success without weight	8		
Legislation/governmental requirements for curriculum content	7		

Table 2. Barriers and facilitators of using IE/HAES in Community Nutrition Practice

Individual/Interpersonal Barriers

The individual and interpersonal barriers that participants faced were related to the beliefs held by their clients and non-dietitian colleagues about weight and the importance placed on weight loss for health.

Client Beliefs

About half of respondents identified client beliefs as significant barriers to implementing IE/HAES-based care. In respondents' experiences, clients held firmly fixed internalized beliefs about their weight and the value of weight loss. One respondent noted that clients had difficulty "trusting that they can be healthy and not be dieting" *(Public health dietitian)*. Another reported that the mismatch between RDN-provider and client philosophies made it difficult to motivate her clients:

> Even if we're not weight-driven and we try not to have a weight-driven approach, that doesn't mean that we don't have participants and clients that are motivated by weight loss.
>
> *-Public health dietitian*

As well, the collaborative nature of IE/HAES counseling was unfamiliar from what some clients were used to with other healthcare providers. A few respondents reported facing cultural barriers where patients saw them as authoritative figures and this limited their ability to fully engage in collaborative care alongside the RDN.

Non-dietitian Provider Beliefs

Almost half of participants noted that some non-RDN providers also held personal beliefs about weight that showed up in patient recommendations and negated the messaging of IE and HAES. RDN respondents described instances where some medical providers were not using evidence-based recommendations when it came to weight loss and were prescribing weight loss when it wasn't necessarily indicated or despite recommendations against prescribing weight loss, as in the care of a patient with binge-eating disorder. Separate from weight-related beliefs, a small number of participants described barriers in the form of non-RDN providers who showed a lack of understanding of the dietitian's role in patient care, resistance to the RDNs efforts to use IE/HAES, and poor communication with other members of the healthcare team.

Dietitian and Non-dietitian Training within the Traditional Medical Model

About one-third of participants noted that both their dietitian and non-dietitian colleagues had mostly received training within the traditional medical model where there is an emphasis placed on weight loss to promote health. These colleagues had little exposure to or training with weight-inclusive techniques. This led to difficulties coordinating care and sometimes practitioners became polarized. One RDN commented on how medical residents and fellows are taught to treat a high BMI with weight loss in all cases without consideration of alternative approaches for health promotion. *"They are just following the rules and doing what they've been taught."* (Hospital outpatient dietitian).

Some respondents expressed feeling that their own lack of training in IE/HAES was a barrier to practice, citing lack of inclusion of the paradigms in their formal education. Another respondent discussed how practicing an alternative paradigm felt polarizing and in opposition even to other dietitians whose practice includes weight loss therapy. This leads to disagreements in how to approach patient care when clear-cut, universal solutions are lacking:

> Another perspective, I think, is just from dietitians in the field that have been doing a very traditional approach to counseling. And probably have had success… So I think that's the challenge; when you have success in two places...who is right and who is wrong?
>
> *-Public health dietitian*

Other Individual and Interpersonal Barriers

A few respondents cited that their clients' lack of access to resources like money and time were barriers to the implementation of IE/HAES. Some cited language barriers, a likely reality of the lack of diversity in the RDN workforce that does not align well with clients in community nutrition settings. Others noted that IE/HAES strategies were difficult to implement in their practice setting when the client's stage of readiness to change was low, as was often the case in the community settings where respondents worked.

Systemic/Institutional Barriers

Systemic barriers were those that existed on a societal and institutional level, which influenced important aspects of the respondents' work.

Diet Culture

"Diet culture" is a system of beliefs that equates thinness with health and moral value (Harrison, 2019, p.7). Participants described diet culture as a barrier to IE/HAES practice, noting that diet culture is pervasive

both in society and their corporate culture where clients are inundated with messages about the value of losing weight and living in a smaller body. Participants also noted how even when clients were interested in the concepts of IE/HAES, diet culture often manipulated messages of body positivity and weight inclusivity, using them to promote weight loss programming. Clients were reportedly confused by this and skeptical about the intention of RDNs promoting IE/HAES.

> IE and body positivity has been co-opted. I saw a women's magazine that said, 'lose weight with intuitive eating.' That's 100% not what this approach is.
>
> *-Public health dietitian*

Inconsistent Messages about Health in Relation to Weight

Diet culture sustains societal messages that clients hear in their everyday lives and these messages are not consistent with IE/HAES principles. Weight-centric societal messages negatively influence clients when echoed by healthcare teams. Respondents noted the difficulty they encountered when counseling clients using weight-inclusive strategies when the rest of the healthcare team focuses on the importance of weight above other health indicators. One dietitian observed how this discrepancy led to tension on the team and disjointed patient care when working in an eating disorder center:

> Well, I feel like when the team is not unified in their approach, then clients and families are confused…[and] it creates tension amongst the team and I think... we're giving suboptimal care when our team isn't agreeing on a treatment approach and goals.
>
> *-Hospital outpatient dietitian*

Participants observed that non-RDN providers in their workplace were giving clients messages about weight and health that were in direct opposition to the behavioral goals set in nutrition sessions where RDNs de-emphasized weight outcomes. Conflicting goals and advice confused clients and eroded trust in the nutrition provider.

Administrative Policies

Dietitians were limited by appointment time, lack of required follow up, and most often, the requirement of taking weights to prove the success of a nutritional intervention. The nature of many community-based sites is one of not only brief and overbooked visits, but also lack of follow-up, either due to insurance constraints or the requirements of the facility itself. Respondents noted that without consistent follow-up, a counseling paradigm like IE was difficult to implement with their clients.

Weight as the Primary Measure of Success

About half of respondents reported that it was difficult to practice IE/HAES when they were expected to document weight as the primary measure reflecting the success of their work. This situation added to client confusion because in HAES, clients are encouraged to pursue weight-neutral indicators of health such as increased engagement in joyful movement or less anxiety and more confidence when making food decisions. Dietitians experienced friction in the workplace over this.

> It's where the world of wellness and the world of management just don't work really well because management needs numbers, they need data. They want to show success and I think Intuitive Eating is so hard to put on a spreadsheet.
>
> *-Corporate wellness dietitian*

Respondents felt strongly that using weight as a measure of success was a major barrier in their practice, as it made their interventions appear unsuccessful in spite of measurable changes achieved in other health-related outcomes like lower blood sugar and cholesterol levels, and behaviors like self-efficacy with physical activity and cooking. Almost one in three respondents reported that it was difficult to find other accepted, objective measures of success besides weight. Some practitioners developed their own pre- and post-test surveys to measure the success of their programs separate from weight to circumvent this barrier.

Legislative Policies

Several dietitians, particularly those in public health settings, faced the unique challenge of needing to comply with government regulations for nutrition programming which were often in direct conflict to the ideals of IE/HAES. One RDN working in a state department of public health noted that the currently approved nutrition curriculums were often focused on reducing body weight instead of addressing the social determinants of health or working to develop a positive relationship with food despite prevalent issues of food insecurity and limited access:

> We work in SNAP-ED...it's a USDA program. If you have an educational component to it, they have a very strict evidence-based

> curriculum[...]and that's the only curriculum that's been tested and there's no new curriculum that's really being developed, especially nothing that has to do with HAES or Intuitive Eating… So because we don't use any of those approved curricula, we kind of do our own curriculum. We frequently get notifications that we are not being compliant with our program.
>
> *-Public health dietitian*

This dietitian's experience was relatively common. About one in three interviewees across all settings reported using IE/HAES strategies regardless of pushback they received from governmental agencies, colleagues, and management. Participants felt strongly about their work and its ethical implications and were willing to stand down opposition.

Facilitating Factors

Facilitating factors were similarly categorized as individual/interpersonal and systemic/institutional. (Table 2). The one facilitating factor that was grounded in the RDNs lived experience was autonomy. Other facilitators that were identified were more futuristic in nature, reflecting what respondents believed was needed in order to truly facilitate their IE/HAES work: shifts in attitudes about weight and weight stigma among providers and clients, and greater dissemination of information about IE/HAES.

Individual/Interpersonal Facilitators

RDN Autonomy

A notable factor among respondents who found it easier to practice IE/HAES was their relative position of power within their institutions. Those who had more autonomy, less clinical oversight, were managers or department heads reported having fewer barriers to practicing IE/HAES. One comment summarizes this, *"I feel I have a pretty privileged position in that because I have so little clinical oversight, I can kind of do whatever. So, there's not actually that much in my way."* (Community clinic dietitian). One respondent posited that perhaps dietitians leave community practice settings when they want to do more IE/HAES work:

> A dietitian feels like they need to go into private practice in order to be able to practice in a way that feels ethical to them.
>
> *-Community clinic dietitian*

Shifting Attitudes about Weight

About half of respondents articulated a belief that a shift in attitudes about weight is needed to facilitate their ability to use IE/HAES. It was reported that if their coworkers and clients placed less value on weight loss or felt less negatively about larger bodies, they may be more willing to focus on other treatments for disease. Many respondents felt that a shift in attitudes about the importance of weight was needed for reporting outcomes, believing that if non-weight-related measures of success were accepted, it would be easier to provide weight-neutral care. Some respondents were already experiencing this shift and felt hopeful, *"I think people are becoming more open to like, OK, health is more than just physical health."* (Public health dietitian).

Systemic/Institutional Facilitators

Greater Dissemination of Information about IE/HAES

A change in attitudes is precluded by the lack of dissemination of information about IE/HAES. Some respondents felt that if IE/HAES were more widespread, buy-in from providers and clients would be easier. Reportedly, the more their peers and clients had learned, the more acceptable it was to them and the easier it was to implement it in practice. One respondent described change on her college campus:

> I've worked very hard to change the culture over the last few years with the sports that I worked with. It's definitely a slow process...I'm working on making the message more widespread, but I won't sit here and tell you that all 700 people know about IE. But if they were to come to me or go to our webpage or Instagram account or see our written materials in the weight room they'd find handouts on the principles of Intuitive Eating.
>
> *-University dietitian*

Other facilitating factors

Respondents wanted clients to receive cohesive messaging from all healthcare providers about weight-inclusive health promotion to reduce confusion caused by diet culture. A few described an IE/HAES-aligned community, peer mentorship, and close relationships with colleagues as facilitators of adopting a novel counseling paradigm. The need for greater funding to enable IE/HAES programming, such as new, weight-neutral curricula for SNAP participants, was also mentioned.

Education and Training Needs

Respondents were asked to identify areas in which they felt they required more training with IE/HAES. Needs were articulated in the following areas: application of the paradigms, messaging surrounding the paradigms, and inclusion in formal education.

Application of IE/HAES

Respondents expressed the need for training in setting-specific application of the IE/HAES approaches. Respondents were uncertain how to modify some of the principles of IE and HAES to the non-traditional settings where they practiced, an unmet need of existing IE/HAES training. This was notable in settings where RDNs do not provide direct counseling, like public health programming where *"there's this gap...of how people are applying this in different settings or ways that isn't that 1:1 counseling."* (Public health dietitian).

Messaging when Discussing IE/HAES with Others

Respondents expressed interest in learning how to talk about IE/HAES in a less polarizing way so that other providers would be open and interested in learning about them. It was generally believed that this would achieve better understanding, greater buy-in and shifting of attitudes that would facilitate the work of the RDN. Respondents felt that the rhetoric around IE/HAES often alienated their colleagues, or that widespread acceptance of the traditional medical model made it difficult to broach the subject.

> How do we communicate [about IE/HAES] in a way that doesn't push people away? Because I think that has kind of been happening within the dietetics field. That it's just become really divisive and that doesn't really get people open to listening to an alternative view. And I don't know the best way.
>
> *-Public health dietitian*

Inclusion in Formal Education

Some respondents wanted IE/HAES to be included in formal education for RDNs, believing that early didactic exposure would facilitate acceptance of these treatment approaches. Including IE/HAES in dietetics education was considered a key strategy to increase the RDNs self-efficacy with these tools. A need for professional supervision in IE/HAES was also articulated.

Discussion and Conclusion

This qualitative study provides insight into the experience of RDNs using the weight-inclusive paradigms IE and HAES in under-studied practice settings serving diverse client populations (Konkel, 2015). A variety of perceived barriers that RDNs face when implementing IE and HAES in community settings were readily identified. More challenging to discern were facilitators of using IE/HAES in community nutrition practice. Only one facilitator, RDN autonomy, was based on actual experience in practice; the other facilitators were imagined, described as requiring substantial groundwork and cultural shifts in order to realize the benefits in practice. Collectively, respondents experienced more systemic barriers than individual barriers and identified more macro-level facilitators that remain elusive (Figure 1). The unique experiences of these RDNs provide a roadmap for ongoing research to establish the evidence base for best practices, inform education and training, and achieve cultural shifts that move towards weight-inclusive practice.

Respondents most commonly experienced the following barriers to practicing IE/HAES in community settings: diet culture and the resultant inconsistent messaging that patients received about health priorities; the inflexible nature of legislative and administrative policies, especially those that emphasize weight as the primary measure of success; and the stigmatizing beliefs towards weight (influenced by diet culture) held by clients and non-RDN providers that interfered with the IE/HAES strategies used by dietitians. Individual barriers manifested in RDNs, non-RDN healthcare professionals, and clients. Some facilitators directly stemmed from needs to overcome barriers. For example, respondents felt hindered by inconsistent messaging about IE/HAES from other providers and considered consistent messaging from all members of the healthcare team essential for cohesive patient care. Practicing IE/HAES was facilitated by the respondent's autonomy within their institution and the commonly held belief that shifting attitudes towards more acceptance of weight-inclusive paradigms and the dissemination of information about IE/HAES would potentially increase its practice.

The barriers identified in this study were contextualized in a social-ecological model, wherein respondents experienced interrelated barriers on a systemic level, an interpersonal level, and an individual level. Similar to

other studies that examine the experience of community dietitians, the interviewees described the influence from the legislative and administrative sphere to be one that negatively impacted their ability to work (Devine et al, 2004).

In a divergence from the experience of community dietitians more generally (Devine et al, 2004; Fuhrman, 2002), participants in this study did not cite a lack of respect for their role as a dietitian to be a primary barrier to practice. While some in this study cited poor understanding of the RDN role by other professionals, very few reported feeling disrespected by, or unequal to, their non-RDN colleagues. This could be due to an increased recognition of the importance of dietetics practice in recent years, but it may also provide insight into the facilitating factors highlighted by the interviewees. The more an RDN is respected, the more likely it is that their ideas will be accepted by their colleagues and novel approaches embraced.

Respect may also be linked to the relative power that RDNs command. Respondents in supervisory roles experienced autonomy in clinical decision-making or leadership that was a key facilitator of using IE/HAES. RDNs with autonomy implemented IE/HAES into their practice without much pushback and their recommendations for staff practices were trusted and adopted. Without autonomy, it was difficult to implement weight-inclusive practices, especially for those who were beholden to government legislation or administrative mandates for weight-based outcomes data. Many public health policies are grounded in the belief that obesity is the most salient cause of declining health, and many policies and lines of research fail to sufficiently attune to the influence of the social determinants of health. Few initiatives assess for harm in weight-based interventions (for instance, if participants experienced worsened mental health while restricting calories). Public health initiatives focused on fighting the "obesity epidemic" focus almost entirely on weight loss as the indicator of success. Unlike other practice settings, dietitians who work in public health departments must work within strict regulations in order to be compliant with well-established intervention programs. Until there are more long-term studies that show the benefits of weight-inclusive programs and strategies, it is unlikely that large scale changes will be made to these governmental programs.

Several factors related to autonomy could explain why community dietitians use IE/HAES less often. The majority of respondents had worked in their current setting for fewer than five years. Entry-level practitioners are generally subject to more clinical oversight and have less power and autonomy. The ability to make unilateral decisions about practice is a salient attribute of private practice and possibly one of several key reasons why private practice dietitians use IE/HAES more often than RDNs in community practice.

Entry-level dietitians work in community settings more often than private practice (Ward et al, 2011) and earn a substantially lower annual income than private practice dietitians (Rogers, 2018). Additionally, RDNs working in community settings may not have employer support or personal finances to fund continuing education, making the financial burden of additional training for IE/HAES skills untenable for many. As RDNs move into the private sector and increase their earnings, they are better positioned to afford and prioritize advanced training. Years of counseling experience has been shown to significantly predict dietitian's feelings of self-efficacy in their skills (Lu & Dollahite, 2010), so new RDNs may lack the confidence to try new counseling paradigms.

A lack of confidence in our study sample was notably reflected in the identified need for training on IE/HAES. A lack of attention to weight-inclusive counseling paradigms in formal education was commonly reported, with most noting that their first exposure to IE/HAES occurred well after they finished training. Dietetics training is conventionally modeled on the traditional medical model which is weight-centric and can lead to weight bias amongst dietetics students (Puhl, Wharton, & Heuer, 2009). Additionally, RDNs often cite a lack of training in all counseling modalities in their pre-registration education (Rapaport & Nicholson, 2000). When IE/HAES are not included in formal dietetics training, dietitians wanting to practice these paradigms must seek training at their own expense, which can be prohibitive.

Respondents articulated the need for setting-specific training that would allow them to adapt IE/HAES to their specific community practice setting. In addition to a lack of generalized exposure to IE/HAES education, RDNs are challenged trying to use paradigms that are not well-suited to their specific practice settings. IE/HAES interventions involve relatively longer appointments and long-term client follow-up; these conditions are not often

feasible in community practice settings. Adaptations of IE/HAES strategies applied in settings with abbreviated interactions and shorter duration follow-up are needed.

The dissemination of information about IE/HAES was believed to be a necessary factor to facilitate its use, highlighting the importance of more research and communication of evidence through scientific, clinical and public health communities. Increased exposure to IE/HAES and its evidence-base as a treatment model serves as a potential gateway to a shift in attitudes about weight and the relative importance of other indicators of health and well-being. This phenomenon is supported by the diffusion of innovation theory which plots the adoption of a new practice on an S-curve, highlighting how people are generally either leaders of an innovation or followers, stratified by how willing they are to accept and adopt new ideas. The leaders, "early adopters," spread the word about the innovation which eventually leads to more widespread acceptance and adoption (Kaminsky, 2011). Respondents in this study, considered early adopters of IE/HAES, called for more evidence and dissemination.

In community settings, the populations served are often quite diverse in terms of race, ethnicity and socioeconomic status (Kaiser Family Foundation, 2010). RDNs in our study broadly cited low-income populations as the majority of their client base. Surprisingly, food insecurity and lack of financial security were not cited more commonly as barriers to practicing IE/HAES, especially in public health, hospital, and community-based clinic settings. Food insecurity creates an environment of scarcity in which IE/HAES are difficult to implement. Ellyn Satter (2007) suggested that without first meeting the basic need of having ongoing access to food in sufficient quantities, it is impossible to pursue a healthy relationship with food. Lack of food makes it impertinent to listen to natural signs of hunger and fullness, and creates a destabilizing mistrust in the availability of food that can lead to overeating later when food becomes less scarce (Satter, 2007). Five RDNs in our study cited limited client resources as a barrier to the implementation of IE/HAES, yet only one mentioned food insecurity specifically. It is possible that because this study focused more on the RDNs' practice experience and did not ask directly about perceived client experiences, respondents may have been less likely to report some client-facing barriers.

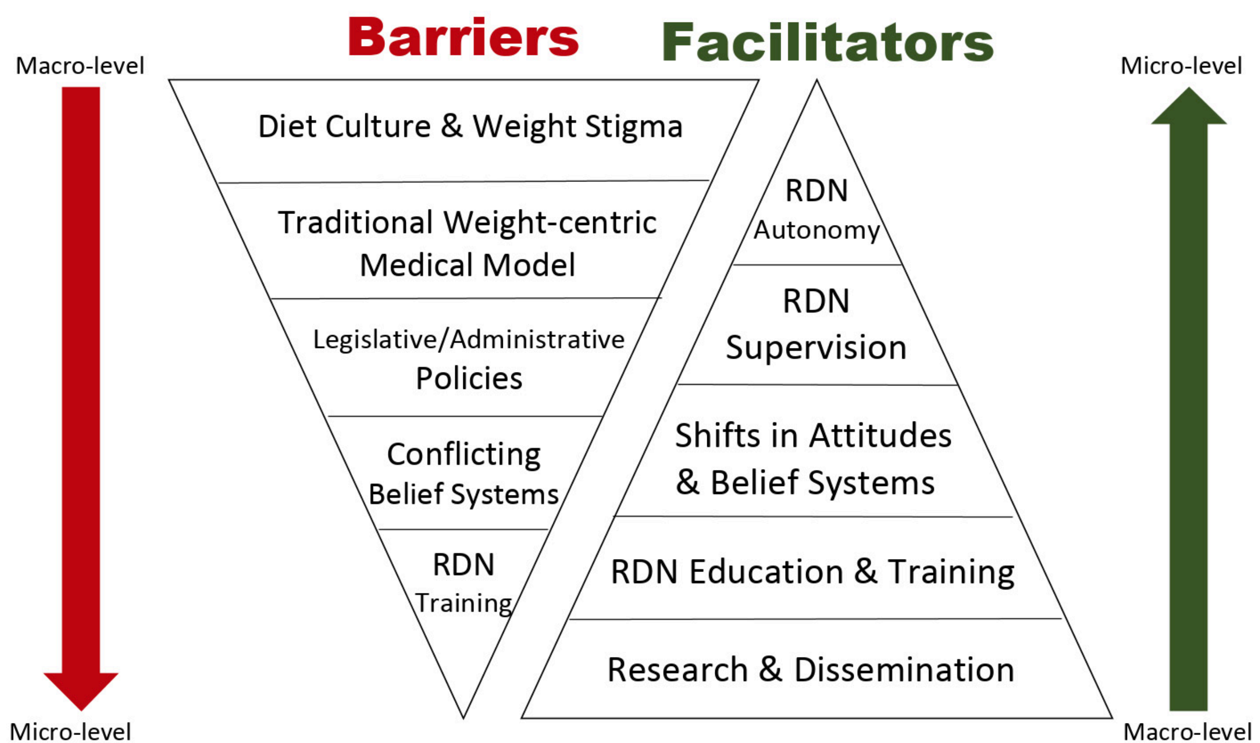

Figure 1. Macro- and Micro-level Barriers and Facilitators of Intuitive Eating and Health at Every Size Practice in Community Nutrition

Strengths and limitations

This study's strengths included a sample size that extended beyond the point of data saturation. Input from professionals working in the IE/HAES field guided the creation of the interview and survey questions. The two RDN authors are knowledgeable about IE/HAES from use in clinical practice and the senior author offered a non-user perspective to minimize bias.

The potential for self-selection bias in the sample is a noted limitation. RDNs invested in using IE/HAES may have been more likely to participate, while those who could not participate may have been limited by time or other unknown stressors. As designed, this study did not capture the views, and therefore the perceived barriers, of RDNs who work in community settings and are not yet using IE/HAES in practice. The sample size did not allow for evaluation of differences across practice setting type. Additionally, the lack of diversity in our study sample, reflected in the dietetics profession as a whole (Wynn et al, 2017), may limit the generalizability of these findings. Experiences of dietitians from other racial, ethnic and gender groups may be different. These are factors that should be explored in future research.

Implications for research and practice

These findings have important implications for research, education and training. There is a need for rigorous research to generate evidence needed to endorse the use of IE/HAES in broader populations, as much of the existing research has been done in small, homogenous samples. Research on the feasibility and effectiveness of IE/HAES interventions in community practice settings is needed. There is also a need to incorporate IE/HAES into dietetics education and training. Clinical supervision is needed to guide dietitians working in community settings on how to modify IE/HAES for practical applications that are setting-specific.

This study has implications for the practice of IE/HAES. RDNs who are "early adopters" of new counseling strategies have the potential to enhance the dissemination of innovative and alternative behavioral strategies by engaging in and communicating research, sharing resources and providing in-service training to other RDN and non-RDN providers. Dietetics educators can actively work to incorporate these practice modalities into their curriculum and encourage students to delve into these topics through projects or community-based behavioral health initiatives. Increased awareness of weight-inclusive practices is expected to lead to wider use.

By identifying barriers to the use of IE and HAES in the community nutrition practice setting, future research into the paradigms' broader applicability and setting-specific training can address the needs of RDNs outside of the private practice sphere. Extending the reach of weight-inclusive health promotion programs to community settings and diverse, vulnerable populations will facilitate the delivery of impactful, non-stigmatizing, and effective behavioral nutrition services to those most in need. By being more inclusive of diversity in body types and eating habits, use of IE/HAES strategies promote cultural humility and the ethical practice of dietetics.

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