

Professional identity construction: becoming and being a dietician in Brazil, France and Spain

Construção da identidade profissional: tornar-se e ser nutricionista no Brasil,
na França e na Espanha (resumo: p. 16)

La construcción de la identidad profesional: volverse y ser dietista en Brasil,
Francia y España (resumen: p. 16)

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Professional socialization is a complex process that leads to the professional identity. While several studies have focused on the professional identity of physicians and nurses, few studies analyzed this aspect among dietitians. Furthermore, those studies did not consider the influence of sociocultural norms. The aim of this study was to analyze the construction of the professional identity of Brazilian, French and Spanish dietitians. A qualitative methodology based on semi-structured interviews was set up. The construction of the professional identity of Brazilian, French and Spanish dietitians is characterized by the incorporation of skills, knowledge and roles. This process was marked by transformations, mainly related to food and body. Dietitians from the three nationalities shared similar professional values grounded in a medical-nutritional rationale. However, their professional identity also resulted from a continuous process of interaction with patients, peers and the socio-cultural environment.

Keywords: Dietician. Professional identity. Professional socialization. Qualitative research.



Introduction

The profession of dietician became an essential area of healthcare¹, with an increasing number of countries recognizing this profession². This process has been accompanied by the emergence of national and international organizations, which define professional competencies, training standards, and ethical codes. The construction of the professional identity of dieticians remains relatively unexplored³⁻⁶ despite their growing relevance.

Identity is the result of several socialization processes that jointly build individuals^{7,8}. According to the constructivist approach of Berger and Luckmann⁹, socialization is a constant process of constructing identities associated with different activity spheres in which individuals meet their existence and become actors. In primary socialization, children absorb the social world in which they live. In adulthood, secondary socialization is the incorporation of knowledge acquired on a specialized activity⁹, named by Dubar⁷ as “professional knowledge”: vocabularies, procedures, and a symbolic universe. Professional socialization is

the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge – in short the culture – current in groups of which they are, or seek to become a member¹⁰. (p. 278)

Using a symbolic interactionist approach, Hughes¹¹ considers the profession as a context for socialization accompanied by the development of a vision of the world that includes the thoughts and values implied in the activity. Hughes developed a model of professional socialization from medicine, which was adapted to nurses¹². Professional socialization is both a process of initiation into a professional culture, in the ethnological sense of the word, and a conversion to a new conception of the self and the world and a new identity^{7,13}. Medical training involves both initiation into a new role and the study of techniques. The process begins with the lay culture and proceeds to an immersion in the professional culture. Individuals gradually learn their roles and choose the most appropriate models, which represent the ways of practicing medicine and the “reference group”. Finally, a conversion occurs: an adjustment of one’s identity, involving the adaptation of mental, physical, and personal aptitudes¹¹. Good¹⁴ also points that learning medicine is “a process of coming to inhabit a new world”, not only in the sense of becoming familiar with the medical environment but also as an entrance into a “distinctive reality system”, accomplished by learning knowledge and practices through which physicians formulate the reality in a “medical” way, including specialized ways of seeing, writing, and speaking.

While several studies have focused on the professional identity of physicians and nurses^{12,15-18}, few studies analyzed this aspect among dieticians³⁻⁵. This analysis is essential to understand the field and improve training and professional practices⁴. Furthermore, while the sociocultural context^{8,19} could influence professional socialization, and nowadays health professionals move more and more across different backgrounds²⁰⁻²², the impact of sociocultural norms on the dietician’s professional identity remains under-researched.



This study analyzed the construction of the professional identity of Brazilian, French, and Spanish dietitians. In Brazil, the first Dietetics university course was created in 1939, and France and Spain opened such courses in 1949 and 1988, respectively. Despite differences, this profession is recognized by law in these countries^{1,23,24}. The construction of the dietician's professional identity was analyzed by addressing two fundamental aspects of this process^{8,11,17,19}: the perception and the incorporation of the professional role. Our study is influenced by constructivist and interactionist sociological approaches^{7,9,11,25,26} and is in line with the Critical Nutrition/Dietetic Studies, a field that examines the nutritional discourses, training, and practices²⁷. Based on these perspectives, we analyzed the construction of the professional identity as a complex and interactional process influenced by sociocultural values and norms.

Methods

This work derived from a Ph.D. in Sociology that aimed to understand the relationship between dietary and sociocultural norms through the “healthy eating” category. A qualitative methodology was used, and the primary method applied was a semi-structured individual interview, a proper method for analyzing practices, values, and norms²⁸. This study also used an international comparative and synchronic approach. This methodology seeks to verify the social regularities between two or more sociocultural contexts and the singularities of each case analyzed in a given period of time²⁹. Brazil, France, and Spain were chosen according to their corporeal and food norms³⁰⁻³². The research was carried out in Toulouse (France), Barcelona (Spain), and São Paulo (Brazil). Considering that most dietitians are women^{33,34} and that the history of the profession is gendered^{35,36}, the study was limited to females. No distinction based on their ages was made. All the participants worked in private practice in order to obtain a group that performed equivalent activity.

The fieldwork was carried out between 2012 and 2015. Participants were selected through: (1) internet search: by using keywords in Google or searching on the websites of professional associations, (2) researcher networks: contacts were made through people from the social circle of researchers, (3) “snowball sampling”: participants put researchers in touch with other dietitians. The participants were contacted by e-mail or telephone. We explained the study to them and checked their availability.

Fifteen dietitians were interviewed in each country. The sample size was determined based on the method of saturation, which is when data collected becomes redundant, and no new information is obtained³⁷. The interviews lasted from 50 minutes to 2 hours and were held mainly in their offices. They were conducted by following an interview guide in Portuguese, French, and Spanish, approved by native speakers and divided into two parts. The first part addressed dietitians as individuals within society, approaching their food and body practices and perceptions, and the second part focused on their professional activity. The interviews were digitally recorded and transcribed verbatim.



We carried out a thematic analysis, which consisted of cutting across what, from one interview to the next, referred to the same theme, seeking thematic consistency between interviews. We developed an analysis grid based on the study's problems, hypotheses, and new elements from the interviews. This grid was built according to a vertical and horizontal rationale to account for both individual cases and the dimensions cross-sectional to the various interviews. This type of analysis is relevant for the development of explanatory models of practices and social representations.²⁸ The main categories used were: choice of the profession, dietician roles, dietetic training, dietetic appointment, body and eating transformations, and conflicts with the social environment. The themes mentioned by the informants were found among the three nationalities. We have treated them in a general way by pointing out the peculiarities of each nationality, allowing us to remain faithful to the social reality observed in the field study²⁹.

The Research Ethics Committee of the University of Toulouse approved this study under protocol N° 2019-206. The informed consent was obtained from participants, and their names are fictional.

Results

Dietician's information

Forty-five dieticians were interviewed. The mean age of the Brazilian dieticians was the lowest (29 years), ranging from 22 to 38 years. Eleven Brazilian dieticians graduated in Dietetics in private institutions and four professionals in public institutions. The French dieticians were between 22 and 53 years of age, and their mean age was 33.5 years. Twelve French dieticians were trained in private institutions and three in public institutions. Spanish dieticians had the highest mean age (38.5 years), ranging from 23 to 57. Ten Spanish dieticians had studied in public institutions and five in private institutions.

Professional roles: perceptions and incorporation

Dieticians of all three nationalities considered their role essential for society, even agreeing that their profession is not adequately recognized, especially in Spain. Their professional role was learned in part through a passive process in their college training and an active process during internships and professional experiences. Their professional role perception changed, and the dieticians progressively discovered the skills and fields of their profession. They were pleased with this (re)discovery since the new roles learned seemed more complicated: "I believed that a dietician only calculated the menu. I didn't know it was that broad; I think that what I do is very broad" (Luna, Brazilian, 27). Furthermore, the construction of their professional role occurred through constant interaction among what they perceived to be an "ideal" dietician, society, their patients' expectations, and their unique professional situation.



The informants conceived dieticians as health agents who promoted good eating practices to ensure good health, prevent diseases (notably chronic ones), and achieve a “normal” weight: “The dietician is a health worker, a health promoter” (Laure, French, 35); “To promote health, the main function is to promote health through balanced eating practices” (Silvia, Brazilian, 38). They recognized their importance concerning the vital aspect of eating. The dietician technically qualified for eating management would find solutions to nutrition-related physiological problems. The valorization of the physiological dimension was associated with the valorization of medicine, shown in their discourse and professional practices. The informants wanted to be identified with this professional group and externalized elements associated with them, seeking to affirm themselves as professionals of the medical field. For example, in most interviews, they dressed in white or wore white coats. Moreover, even not having Ph.D. or medical degrees, some of them called themselves “doctors”. This perspective was also found in the informants’ graduate fields, notably in Brazil and Spain. Ten out of 12 Brazilians had studied one or more specialization or masters’ degrees in Clinical Nutrition, and eight out of 10 in Spain. Also, six dieticians had medicine as their first professional choice. Restrictions concerning access to education, such as the entrance exam and the length of study, led to a shift in their career path.

According to the respondents, the dietician was first of all a health educator who transmitted nutritional knowledge to teach individuals how to eat “properly”: “I am an educator, my role is to educate the patient, there is no such thing as a ready-made diet. We work a lot with reeducation. We learn the concept” (Diana, Brazilian, 22); “Like an educator. Like a teacher who explains and should help, accompanying them in their learning” (Magali, French, 35). As this information would seem too abstract to a layperson, the dietician had to “translate” this information into precise advice and applicable menus for daily life, helping the patients to get over their burdening constraints and adapting the recommendations according to the context and eating preferences, opening a space for dialogue. The dietician’s work aimed to grasp the patients in all the dimensions underlying their identity. They even adopted vocabularies that conform to the image they wanted to transmit according to their perceived roles. For example, they adopted the expression “nutritional reeducation” instead of “diet” to identify their treatment.

In this space of dialogue, the dietician could also assume the role of “psychologist”: “If we’re not a bit of a nutricologist, we don’t heal our patients” (Rosana, Brazilian, 33). The role and competencies of a “psychologist” were internalized more during the practical experiences and emerged later to that of an educator, which was more supported in their training. Dieticians of all three nationalities reported that they did not have enough training (for example, psychology or socio-anthropology courses) to understand individuals in their entirety, beyond the biological aspect. This “psychological” posture would, however, be necessary to help patients, acting as their guide or “coach”: “My work, for many people who already know what I’m explaining, is more about accompanying and motivating them” (Monica, Spanish, 32); “The role is to accompany during the nutritional change, to help patients find eating habits that work for them given their needs that are not just physiological, but psychological and social” (Emilie,



French, 47). It is supervision aimed at listening to and understanding the patients concerning food and all their difficulties, seeking to motivate them to establish a balanced body-eating relationship. This vision of their role was linked to a holistic conception of eating, more common among French respondents: “My role is to reassure them, to make them understand that there are no forbidden foods if they are big eaters. It is fine if they eat sweets, they are not to blame, my role is to take away that guilt” (Priscilia, French, 53).

Some dieticians also believed that their activity was related to the search for an ideal body. According to them, weight loss for aesthetic reasons was an important motivation for their patients, mostly women: “Dietician is fundamental in terms of pathology and aesthetics. We have two audiences, one that comes with a medical referral. Those who come alone are all for aesthetics. They want to lose weight. Others are training at the gym, they want to improve their skin... 90% is associated with aesthetics” (Andrea, Brazilian, 30). In this case, the profession of dietician transcended the medical field, into the management of concerns linked to social norms that they shared with them, having come from the same sociocultural contexts as their patients: “I see it a lot in patients. They have been very subjected to these pressures from society. I would say ‘it would not be so necessary because the essence of the human being is what is worthy’. But I think it is so involved in us that I justify this search for an ideal weight” (Graciela, Spanish, 56). This viewpoint was pronounced among Brazilians. In Brazil, some dietician’s offices had mirrors, and three Brazilians offered body aesthetic services. According to the informants, this aspect of their activity was less addressed during Dietetic studies, but it became an implicit element in their profession, enhanced by their patient’s demands.

Construction of the dietician’s self

The dietician became a “professional” with inner transformations. During this process, different for each informant and not achieved during Dietetic education, professional/nutritional and sociocultural norms are interwoven not only within themselves but also in the relationship with their social environment. Given that the dieticians perceived their role as educators regarding eating, body, and health, the passage from lay-subject to professional-subject signified a “reeducation” process. They incorporated the recommendations into themselves while keeping a body compatible with the medical and social norms: “You have to be a model that you can transmit to your patient. I apply to myself whatever I advise my patients” (Fabiana, Brazilian, 31).

“I eat, I am, I work.”

Most dieticians indicated changes in their eating practices, seeking a more “balanced” and “light” way of eating. Dietetic studies led to heightened attention given to food, to nutrients, their proportions, how they were consumed, in what quantities and frequencies, impacting the perception of food preparation: “I see a cake, and I cannot stop myself thinking about the amount of margarine and sugar; if I eat it, I’ll feel guilty. This concern has grown with the university” (Rosa, Brazilian, 30). The acquisition of nutritional knowledge increased reflexivity and anxieties regarding physiological effects,



especially related to weight and fat accumulation: “It is distorted by my profession, [a baguette is] synonymous with sugar, with its intake into the blood. I try to replace it in my diet to avoid raising my glycemic index because the higher your glycemia, the worse it is for the body, and insulin will store this sugar in the form of fat” (Corine, French, 28).

The dieticians justified their norms and practices by using their professional “label”: their relationship to eating was “conditioned by their work” and associated with a “dietician’s thing”: “That’s really because of my job. I eat better now than when I ate at my parents’ house. We ate fairly well, but my mother did not pay attention to food balance. I take care, I must do like that, it’s linked to my job” (Matilde, French, 27)”. The internalization of this concern allowed constructing the stereotypical image they had themselves as dieticians, just as a layperson did. However, they complained of having to carry this image in their social life and tried to detach themselves from it: “although I’m a dietician, I have never been obsessed with food” (Graciela, Spanish, 56).

These modifications were part of how dieticians incorporate knowledge and concepts, obtaining more “consciousness” and “criteria” for eating. Their way of eating was also their way of working, being, and living. From the laywoman, through this incorporation process, they internalized a professional identity that infiltrated into their lives, producing a symbolic change: “I eat Chrono-Nutrition, that is why I’m a chrono-nutritionist, so I work with Nutritional Chronobiology” (Elise, French, 48).

The construction of the professional provoked differentiations vis-a-vis laypeople: “It is inevitable as a professional that you are to make the nutritional assessment of that food. A normal person might not think about it” (Marina, Spanish, 35). They incorporated a new technical and medicalized vision of food, particularly to their professional circle. This differentiation was clear when they described the eating changes they induced in their social environment: “At my parents’, we have always eaten more or less well, but since I studied Dietetic, I changed the household habits. We started eating a balanced diet, like in books. I would get home, explain to my mother what we weren’t doing right, when there were no carbohydrates, proteins, stuff like that, when normally you don’t know” (Jimena, Spanish, 26).

In some cases, they made moral judgments and this rationale stirred conflicts resulting from a confrontation between the nutritional patterns and the practices guided by tradition, commensality, and pleasure: “Christmas in my family is a huge party. We would find a mountain of desserts before... Today, I’m not in favor of that. This does not go well with my Italian family. It’s complicated. There’s much conflict” (Rosana, Brazilian, 33). However, this differentiation concerning laypeople was blurry in some cases. For example, to motivate patients, dieticians tried to affirm themselves as social beings, affected by the same problems of laypeople.



“You can give advice, but you must first give an image.”

For most dietitians, their body was a mirror of how they ate and their professional competency, carrying the legitimacy of their professional status. Therefore, their appearance was an essential element of their professional identity: “People cannot consult an overweight dietician, because thinness is a factor that counts” (Fabiana, Brazilian, 31). Dietitians had a dual status concerning body norms. They were women subject to sociocultural norms of thinness, but they were also professionals working within medical norms linked to body size. On the one hand, the body shape included them in the professional group. On the other hand, the corporeal deviance led to peer marginalization. Being “normal” or even thin represented the image consistent with the dietetic professional, and all dietitians were critical of their overweight colleagues: “You must not be overweight. You also have to be credible by your appearance” (Priscilia, French, 53); “I wouldn’t go to someone who is overweight and has to lose weight. I would say ‘dear, first lose and then tell me how to lose weight’. A dietician cannot be chubby” (Julia, Brazilian, 27).

The importance of having a body that is “normal”, thin, was incorporated into the image of the dietician by the informants even before their Dietetic education. The existence of such a concern, during or after their studies, could, however, escalate, since their physical appearance could influence their professional success and how their patients saw them: “I was never concerned with being thin, but when I started my studies in Dietetic, I was increasingly concerned, because if I gained weight and I had a patient before me, what kind of example could I give if I’m fat?” (Nora, Spanish, 27); “I had fewer people calling me. I think that a dietician who’s size 42, in the patients’ image is not ok. Now, I am lucky to not have to care. But I know that if my body takes on a bit of weight I will have to pay attention” (Caroline, French, 31). Silvia (Brazilian, 38) stated that this concern increased when she started working in private practice since appearance would be more critical in this context. According to Silvia and other practitioners, a dietician with overweight could not work in private practice but must limit her activity to less prestigious fields like food service. The concern was so present for Silvia that she wanted to stop smoking a few years before the interview, but she was afraid of gaining weight.

The appearance was even stated as a selection criterion for a job interview. If, on the one hand, dietitians collaborated to transmit to society a “thin” body model as the showcase of their work (starting with the images on their websites, for example), then laypeople reciprocated with an image similar to that of the adequate dietician: “People who come to see me are reassured to see that, in quotes, I match the image of a dietician who applies what she says” (Angélique, French, 34). It was the image that dietitians needed and wanted to transmit and the image patients wanted to find in front of them, an image fed by practitioners and the general public.



Discussion

This study was the first to compare the dietician's professional identity - a result of the complex process of professional socialization^{7,12,19} - in Brazil, France, and Spain. Academic education, apprenticeship, or clinical training are contexts for professional socialization^{14,15}. Moreover, professional socialization continues throughout the professional career^{8,16}. Learning the professional roles is a fundamental step in the professional identity construction^{8,17}. A role is what subjects expect of themselves and what others expect from them. In some situations, the roles cannot be learned until a certain level of competency is attained or certain career stages have been accomplished¹¹. Dieticians from the three nationalities assigned themselves multiple roles, which in some cases are only incorporated during their professional experiences. They shared similar professional values grounded in a medical-nutritional rationale, shaping their ways of being and acting within the professional and personal domains. They reported that their training was based on technical and medicalized perspectives focused on physiological and nutritional dimensions³⁸. While differences in the length of study exist among the countries, a similar disciplinary basis seems to structure each program^{36,39,40}, shaping professional identity.

Dietetic training can create a detachment from the self, an internal change, due to the internalized knowledge⁴¹. The construction of the professional identity of Brazilian, French, and Spanish dieticians working in private practice was marked by transformations, mainly related to food and body, aiming at the construction of an "ideal" professional model. According to Dubar⁷, the professions are built in peer groups with codes, rules, and a common language, defining stereotypes that exclude those who do not correspond to them. Individuals must "learn how to sell themselves" to be recognized and finding a place in the world of work. It is a personal construction of an identity strategy that puts the image of the self into play.⁷ Lordly and MacLellan⁵ observed that dietetic students are socialized in a competitive environment and, to find a job, they try to understand what is expected from a dietician and then construct an identity that conforms to this image. Thus, the construction of the dietician's identity is a process where the individual makes choices in the construction of an ideal model of the profession, notably the image shown by the reference group, considered as the "role models"¹⁹.

If dieticians from the three countries shared knowledge and roles based on a medical-nutritional rationale, sociocultural norms associated with femininity, body and food also shaped how the profession was understood and practiced. Some roles that dieticians assigned to themselves were in line with the roles implied in the construction of the female identity related to cooking, educating and caring for others⁴². During primary socialization, individuals internalize gendered manners of being that guide their actions in society. Women are generally oriented towards the so-called "feminine" professions that reproduce characteristics attributed to women in the private domain⁴³. Souza *et al.*³⁵ suggested that the trajectory taken by the profession of dietician, throughout a socialization process in which social roles are typified, is expressed in the fact that it is normalized as a feminine profession.



In addition, we observed the influence of aesthetic norms, which historically served to standardize the women's body rather than the men's body⁴⁴. Over the last century, the phenomenon of fatphobia intensified in most industrialized societies and thinness became a social norm^{36,44,45}. Dieticians interviewed had internalized fatphobic norms and a positive perception of thinness. The concerns related to body shape, internalized by women from different sociocultural contexts⁴⁶, seemed to be consolidated during Dietetic training and professional activity. If healthcare professionals learn how to see the body through biochemical and anatomical parameters¹⁴, paradoxically, for dieticians, this medicalized vision emerges at the same time as the legitimization of sociocultural norms.

Studies have shown that dietetic students are influenced by the norms of thinness and show a more substantial likelihood of experiencing eating disorders^{47,48}. Koritar and Alvarenga⁴⁹ observed that a thin body was a social norm linked to dietician's professional identity. Fatphobia and the valorization of thinness are also found among dieticians⁵⁰. Araujo *et al.*⁵¹ revealed that Brazilian dieticians with obesity were discriminated against by the general population and their peers, and their weight was putting them in conflict with their professional identity and limiting their professional activity. Therefore, more than just subject to social discrimination, dieticians "outside the norm" also suffer professional discrimination. This situation is more common in private or clinical practice, showing "intra-professional identities"¹⁸, segregation within professions, and hierarchies reserving more prestigious activities for practitioners in conformity with the dominant stereotype⁷. In Brazil, Cervato-Mancuso and Silva⁵² observed that 42.5% of dietetic students wanted to work in Clinical Nutrition, while Food Service was one of the least attractive work fields. In our study, dieticians also considered the clinical and private practice as the more prestigious activities, usually associated with the dominant stereotype of an "ideal", "thin" body. These results indicated that the training of dieticians should incorporate and deepen discussions on corporeal issues. Silva and Cantisani³⁶, discussing fatphobia in dietetic profession, identified the need of establishing a dialogue between nutrition and social sciences to eliminate simplistic views on body and health to bring a critical approach and to qualify training and professional practice.

The comparative approach also revealed differences according to the nationality that may be linked to sociocultural aspects in each country, leading to distinct perceptions of the professional role. Brazilian dieticians, for example, were more likely to associate their role with aesthetic issues and half of them justified their professional choice with aesthetic concerns. Brazil is world-renowned for its revering of body aesthetics, and body transformations are more socially accepted in this country, to the point that Malysse⁵³ observed an "autoplastic body paradigm". In 2016, Brazil was the second country in the number of cosmetic surgeries performed, representing 13.9% of the global cosmetic surgeries (in France: 2.5%; in Spain: 2.2%)⁵⁴. Appearance modeling is central in the relationship to the body, and diet is one of the "tools" used for body shaping⁵⁵. In France, we observed the influence of food culture. This country is renowned for its gastronomy, a symbol of national identity. The French food model centers on pleasure, taste, conviviality, and culinary activity³². French dieticians were more likely to justify their professional choice due to food's culinary, hedonistic, and taste dimensions. Furthermore, they were more likely to conceive their role according to a "holistic" perception of the eating act.



These analyses indicated that although dieticians incorporated a professional identity, shifting from layperson to professional⁸, some aspects of their social identity remained active. According to Berger and Luckmann⁹, secondary socialization presupposes primary socialization, involving an articulation between those processes and the knowledge internalized in each one. Continuity seems to operate between primary socialization (construction of social identity) and secondary socialization (construction of professional identity). If these two universes can be disconnected in some circumstances, norms, values, and roles learned in the primary socialization are maintained and reinforced with the professional choice and practice. An articulation, a series of “negotiations”¹⁹ between the professional’s world and that of the layperson, between two identities, are observed, although some dieticians accumulated many years of experience. The dietician’s professional identity is thus part of a broader social identity⁸.

Conclusion

The construction of the dietician’s professional identity is a result of a continuous process of interaction with patients, peers, and the sociocultural environment. The professional becomes and is a dietician according to the standards regulating the profession, their training, the nutritional knowledge learned, the external expectations of the patients, and the sociocultural context. Despite incorporating a new role and a medicalized perspective, some elements of their social life interweave with their professional activity.

Some methodological limitations need to be pointed out and the dieticians’ professional identity should be further explored. The results cannot be generalized to all dieticians because the respondents are part of specific groups (dieticians working in private practice from specific urban areas). Furthermore, a quantitative approach would be necessary to verify the extension of the results in a broad population. Since our study was conducted with dieticians working in private practice, it could be interesting to compare our findings with dieticians working in other sets, observing the intra-professional identities and the influence of sociocultural norms in different contexts. Finally, comparative studies on their training and students’ transformations over the years could provide new insights concerning the construction of the professional identity.



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Conflict of interest

Both authors have no conflict of interest to declare.

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A socialização profissional é um processo complexo que leva à identidade profissional. Embora vários estudos tenham focado a identidade profissional de médicos/as e enfermeiros/as, poucos estudos analisaram esse aspecto entre nutricionistas. Além disso, esses estudos não consideraram a influência das normas socioculturais. O objetivo deste estudo foi analisar a construção da identidade profissional de nutricionistas brasileiras, francesas e espanholas. Foi usada uma metodologia qualitativa baseada em entrevistas semiestruturadas. A construção da identidade profissional das nutricionistas brasileiras, francesas e espanholas foi caracterizada pela incorporação de competências, conhecimentos e papéis. Esse processo foi marcado por transformações, principalmente relacionado à alimentação e ao corpo. As nutricionistas das três nacionalidades compartilhavam valores profissionais semelhantes, baseados em uma lógica médico-nutricional. No entanto, sua identidade profissional também resultou de um processo contínuo de interação com pacientes, pares e o contexto sociocultural.

Palavras-chave: Nutricionista. Identidade profissional. Socialização profissional. Pesquisa qualitativa.

La socialización profesional es un proceso complejo que conduce a la identidad profesional. Aunque varios estudios se centraron en la identidad profesional de médicos/as y enfermeros/as, pocos analizaron este aspecto entre dietistas. Además, estos estudios no consideraron la influencia de las normas socioculturales. Nuestro objetivo fue analizar la construcción de la identidad profesional de dietistas brasileñas, francesas y españolas. Se aplicó una metodología cualitativa basada en entrevistas semi-estructuradas. La construcción de la identidad profesional de las dietistas brasileñas, francesas y españolas se caracterizó por la incorporación de habilidades, conocimientos y roles. Este proceso estuvo marcado por transformaciones relacionadas con la alimentación y el cuerpo. Las dietistas de las tres nacionalidades compartían valores profesionales similares basados en una lógica médico-nutricional. Sin embargo, su identidad profesional también resultó de un proceso continuo de interacción con los/as pacientes, pares y el entorno sociocultural.

Palabras-clave: Dietistas. Identidad profesional. Socialización profesional. Investigación cualitativa.