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Self control and self care: a reflection on nutrition science

Controle de si e cuidado de si: uma reflexão sobre a ciência da nutrição

Abstract

Introduction: Nutrition Science is based on the Cartesian medical paradigm, based on the biologicist, interventionist and specialist-centered vision. The nutritionist, in his clinical practice, acts in a prescriptive, punitive way and is configured as ways to control the patient. Currently, there are other ways of approaching the patient, of the relationship between specialists and lay people and of practicing Clinical Nutrition that are of interest to this study. ***Objective:*** this article promoted a critical reflection of current practices in clinical nutrition. ***Method:*** conceptual study based on a bibliographic review with authors from the areas of Nutrition and Human and Social Sciences, focusing on Michel Foucault's theory, especially on his concepts of self-control and self-care. ***Results:*** the mobilized authors warn of a crisis in prescriptive approaches, intensifying the lack of adherence by interactants and ineffective results. However, the performance of the Nutritionist tends to be more relevant, since chronic non-communicable diseases linked to food increase dramatically. In this scenario, there are several factors that contribute to the maintenance of this crisis, such as: the media, the culture of the diet, the agri-food system and the policies that act as mechanisms of power and control. ***Conclusion:*** There are alternative models to the hegemonic paradigm that establish a relationship based on care and are based on principles such as: autonomy, respect for individualities and subjectivities and the active role of the interactant, the professional should be the facilitator of the process. It is essential to develop human skills and competences not covered in undergraduate courses.

Keywords: Nutrition. Sociology. Food. Self-control.

Resumo

Introdução*:* a Ciência da Nutrição funda-se sob o paradigma médico cartesiano, baseado na visão biologicista, intervencionista e centrada no especialista. O nutricionista, em sua prática clínica atua de modo prescritivo, punitivo e, configura-se como maneiras de controlar o paciente. Percebe-se atualmente, outras formas de abordar o paciente, da relação entre especialistas e leigos e de praticar a Nutrição Clínica que interessam a esse estudo. ***Objetivo****:* esse artigo promoveu uma reflexão crítica de práticas atuais na nutrição clínica. ***Método***: estudo conceitual realizado a partir de uma revisão bibliográfica com autores das áreas da Nutrição e Ciências Humanas e Sociais, com foco na teoria de Michel Foucault, em especial, nos seus conceitos de controle de si e cuidado de si. ***Resultados****:* os autores mobilizados alertam para uma crise nas abordagens prescritivas, intensificando a falta de adesão dos interagentes e resultados ineficazes. Entretanto, a atuação do Nutricionista tende a ter maior relevância, visto que as doenças crônicas não transmissíveis ligadas à alimentação aumentam vertiginosamente. Nesse cenário, há diversos fatores que

contribuem para a manutenção dessa crise como: a mídia, a cultura da dieta, o sistema agroalimentar e as políticas que atuam como mecanismos de poder e controle. *Conclusão:* Existem modelos alternativos ao paradigma hegemônico que estabelecem uma relação baseada no cuidado e se fundamentam em princípios como: autonomia, respeito às individualidades e subjetividades e ao papel ativo do interagente, ao profissional cabe ser o facilitador do processo. É imprescindível o desenvolvimento de habilidades e competências humanas não contempladas nos cursos de graduação.

Palavras-chave: Nutrição. Sociologia. Alimentação. Controle (psicologia).

INTRODUCTION

The history of nutrition is intertwined with the history of biological medicine. Its focus is on disease at the expense of the sick and the nutritionist is the authority that holds the truth. Such truth is imposed on the patient, withdrawing his autonomy, ability to self-care, and participation in the decision and understanding of his own body. In general, nutritionists do not recognize or validate the knowledge brought by patients about their own health problems, thus characterizing an asymmetric relationship.[1] Ultimately, the nutritionist's prescription has the arduous task of educating and changing habits, from an authoritarian and overbearing perspective.

From this hegemony, in general, the nutritionist bases his conduct on reductionist, interventionist, controlling practices and with a limited view of food - as a biological act, disqualifying his psycho-socio-cultural dimension. By disregarding the complex system of social, political, religious, ethical and aesthetic symbols that food represents, it ends with a standardization of human nutritional needs, facilitating the elaboration of recommendations aimed at the control and maintenance of hierarchical structures of power. Thus, a utilitarian view of the body is promoted, of great interest to the capitalist society that needs the productive body.[2-4]

When observing the practice of clinical Nutrition, it is noticed that there is a negative conception of food-health-disease, guided by the logic of prescribing restrictive and standardized diets - based on the energy-quantitative view defined by the nutritionist. [5] An exercise is promoted of the profession alien to the subject and his subjectivities, as well as strictly technical and fragmented views in care. [6]

Given this scenario, it is important to understand current practices and the attempt to think about new possibilities that are connected to the real health promotion of the population; in search of a health vision that goes beyond immediate results and is not limited to diseases. This article proposes a reflection on the clinical practice of Nutrition based on two Foucaultian concepts: self-control and self-care. The idea of control refers to academic Nutrition practices based, mainly, on the prescription of restrictive and standardized diets, inserted in a context of disputes and power. The idea of care, on the other hand, alludes to practices that are committed to the patient's autonomy and their unique development, promoting eating practices combined with their subjectivities.

Clinical nutrition will be problematized by exploring the conducts and the type of relationship that is established between the health professional and the patient, since new conducts and practices open space to question the hegemonic approach to clinical nutrition. It is agreed with Demétrio,[7] for whom there is a resolutive exhaustion of the biomedical model, in addition to a wear on the nutritionist-patient relationship and the dominant nutritional discourse.

To build this critical conceptual study, authors from Human and Social Sciences and Collective Health were mobilized, in order to expand and enable an interdisciplinary look at Nutrition Science. For this, a bibliographic review was developed around concepts that circulate the idea of control and self-care, such as biopower, autonomy, hierarchy, ethics, humanization, body and health. We must highlight the fact that the theme is little explored in nutrition, and that is why authors, who stand out and have discussed the subject for a long time, were brought up in this article due to its relevance to the area.The authors of the human and social sciences, on the other hand, are considered mostly classics, and for this reason they also conduct this investigation, especially Foucault.

SELF-CONTROL

From Foucault's perspective,[8] it is understood that the forms of control exercised by an agent are a way of conducting human behavior. Control is one of the strategies for establishing power relationships, and it is always associated with some form of knowledge. Control is not something that can be appropriated; it takes place in the relationship between bodies, operating in a diffuse way, spreading through social networks, through agents (specialists) or institutions (state, family, school, clinic, hospitals).

The author points out several devices of power created to exercise control and domination, materialized over the human body.[9] But from the 19th century onwards, its scope became more complex based on corporate interests to consolidate the utilitarian conception of the body, making the objectives effective political and economic.[10]

This period stands out for the centrality of scientific knowledge, becoming the means by which, the neoliberal governmental rationality was established based on natural processes.[11] The body became an easy, utilitarian and docile target of activities that could contribute to its development. better functioning and greater productivity in the form of a dressage.[4]

The main strategy of training the body is the action aimed at a fake freedom, encouraging the people to become more productive and entrepreneurial, essential characteristics for docilization.[11] Thus, power in the therapeutic sphere is not built as something negative.

The control applied in clinical nutritional care aims to improve health, maintain an adequate weight, and teach the ideal diet, based on predetermined rules and standards. This perspective refers when Foucault[10] talks about the seductive and positive effect of power that is perpetuated with a certain tranquility:

> We have to stop describing the effects of power in negative terms, such as: it 'excludes', 'represses', 'censors', 'abstracts', 'masks', or 'hides'. In fact, power produces reality, produces fields of objects and rituals of truth.(...) what keeps power, and is accepted, is simply that it does not weigh only as the force that says no, but that in fact it permeates, produces things, induces pleasure, forms knowledge, produces speech (p. 172). (Author´s free translation).

Almeida et al.[4] reiterates the need to promote speeches and policies aimed at the organization of life and disciplined bodily practices that materialize from the concept of biopower - relevant for understanding contemporary society, allowing the visualization of tensions and conflicts in the field of biomedical sciences and technologies.[12] Foucault (p. 3)[13] describes biopower as: "the set of mechanisms by which what, in the human species, constitutes its fundamental biological characteristics, will be able to enter a policy, a political strategy, a general strategy of power" (author´s free translation).

The era of biopower is translated by the growth of these regulatory mechanisms of the global population, through practices and knowledge that are based on concepts such as care and risk, with the intention of making the population live in a regime aimed at maintaining order.[13] Speeches about the importance of a 'healthy lifestyle', for example, socially accepted, comes to have the value of a positive control.[14]

Biopower trains the body in such way that it creates unhealthy high standards and products (protein powders, energy drinks, etc.). Thus, a logic of commercialization of health is fostered, having direct effects on those who need care, and also on caregivers. Under a dissymmetric relationship of power, the patient is subjected, dominated, either through specialist knowledge (the nutritionist) or institutional knowledge (the hospital, the university).[8]

What makes control a powerful therapeutic weapon is the fact that there is more and more specialized knowledge that has helped to reduce the mortality of the population. Foucault[9] calls for disciplining this society which, through hygienic practices, makes the body a productive workforce. Thus, there is a new need to deal with these bodies, fighting the disease fiercely. After all, it is important to keep the population performing their work with maximum performance.

Currently, it can be seen how much this subject has become an objectified body that undergoes interventions by health professionals, promoting their knowledge to control the disease. Dehumanized practices are established that turn health into a commodity. These increasingly specific, technical and isolated knowledge, called by Chauí[15] specialisms, result in the fragmentation of the body that

> [...] ceases to be a body to become a body piece; body part that becomes part of body parts; parts of body pieces that shatter therapeutic knowledge into tiny fragments, to the point that we could ask ourselves if this production still moves within the scope of human relationships, since at the other end there is another expropriated of his body, crippled from any relevant knowledge about him, another silenced and deafened by the specificity of a knowledge that has no reach (p. 72).

Clinical nutritional care is the moment when the knowledge-power relationship becomes effective between the nutritionist and the patient. Such a relationship is based on a normative discourse based on self-control, based on rules originated in the 18th century and the hygienist view. This discourse advocates a hierarchical relationship, promoting repressive attitudes in an attempt to discipline the body and eating.[16]

An example of this power relationship, is the moment when the nutritionist believes that he is the holder of food knowledge, placing the patient in a passive position that disqualifies his previous experience, beliefs and desires; and implicitly in the terminology given to the practice and those involved - clinic and patient. Clinic, in the sense of looking at the bed, already characterizes a hierarchical relationship. The patient has the role of passivity and patience, the one who endures without complaining.[17]

Another illustration of this hierarchy is the nutritional clinic environment itself, which constitutes a strategic place of power. The face-to-face position of the specialist dressed in white predominates and, separated from the patient / layman by a table and chairs of different patterns, placed in aseptic and formal environments. In practice, there is, for the most part, a reduced consultation time, an unfriendly environment, purely technical, biologic, vertical and prescribing service. This spatial configuration creates a distance between the actors, offering technical knowledge under a neutral relationship. Baroni and Cunha (p. 687)[16] define this hierarchical relationship when they state:

> The movement towards a relationship of domination on the part of the therapist over the patient is more common in the clinical practice of traditional bias, directly linked to the medical pedagogical discourse, which understands the therapist as the holder of knowledge and the patient submitted to clinical treatment, that is, this model establishes well-defined domination relations, with well-defined and immutable hierarchical roles, in principle.

The nutritional consultation, in general, is divided into three main moments: the clinical history; anthropometric and nutritional assessment and prescription. Anamnesis is the main instrument used to explore the patient's history. This interview, historically, consists of directing the professional's view of the disease, without considering the patient. It is a set of systematized questions to ask the reasons that brought the patient to the consultation: habits, routines and information that, in general, insert patients into categories or population parameters such as sex, weight, height and body mass index. Usually, in this protocol, questions are closed and limited to biologic questions, a safe path that prevents the experience of total surrender, configuring itself as a control strategy to conduct the consultation.[17]

With this ritual, there is little or no time dedicated to getting to know people in depth, which is aggravated when the consultation is conditioned to a health plan and the service time is even shorter. The collection of shallow information will inevitably lead to inefficient conduct and prescriptions that do not dialogue with the patients' intrinsic motivations - which are not even explored. Under such a context, few chances for behavioral changes should be expected.

The moment of the physical evaluation is supported by equipment such as the scale, the caliper, and the body composition analyzer whose performances are realized in the patient's body, over which the power is exercised, endorsed by the technical knowledge of the nutritionist. In practice, the professional does not even question whether

the individual wishes to carry out the assessment. Certainly, it would be essential, at the very least, to ask the patient's permission to perform such an assessment.

For some nutritionists and even other health professionals, 'teach a moral lesson' or 'pull the ear', strategies could be set up to encourage behavior change, as well as physical assessment. However, Brown[18] emphasizes that shame is associated with destructive behaviors, which prevent people from asking for help, accepting treatments or giving any positive feedback.

The socially constructed idea of a normal individual, under which disproportionate power is attributed to anthropometric measurements and biochemical tests, deprives the subjects of their individual context. In addition, the standardization of bodies, lifestyles and means to obtain health at any price, permeates behaviors that can lead individuals to become ill, since the focus on the disease disrupts their social context.

Nutritional prescription constitutes the third moment of nutritional assistance with great influence from the quantitative view based more and more on medicalization, health linked to the lean body, on nutrients and their properties, ignoring the origin of food and environmental, cultural, political and related to eating. Within this rationalization, called by Scrinis[19] of *Nutritionism*, Azevedo[20] emphasizes that the importance of culture and traditional commensality is excluded, as well as pleasure, making the act of eating a source of anguish and doubt. As a result, there is an increasing insecurity and distrust of the eater, a phenomenon called Fischler[21] of *gastro-anomia*, suggesting a psychopathological state related to eating.

The prescription of supplements, capsules and other compounds is configured as a control conduct, since the patient becomes, in some degree, hostage to the expert and the pharmaceutical industry. Health is no longer available at the fair, but at the pharmacy and can only be purchased with a prescription linked to a specialist. The health-disease process, when administered by pharmacology, becomes more controlled.[22,23] A sovereignty of standardized models and 'healthy' lifestyles that interest different institutions and food and pharmaceutical industries.[24]

The diet, an important strategy used by nutritionists to promote nutritional education and 'health', can also be seen as a biopower strategy, an exercise in positive control to achieve a desired state of health - and perfect body - through strict rules.

Under a dynamic of food restrictions and demonization - 'poisons', the result is an increase in guilt and compulsion. Restrictive diet is synonymous with loss of pleasure and freedom.[25] Paradoxically, the greater the restriction, the greater the compulsion.[26]

The excessive rationalization of food is a phenomenon associated with several aspects such as the increasing dissemination of media information about the functionality of food.[23] Social networks also define a set of actions that reinforce the culture of control in nutrition, such as photos of bodies perfect and the hashtags used by the specialists that label the patient who achieves the expected results: #ProudNutritionist, #Beforeandafter, and #NoPainNoGain.

In short, a perspective of control in clinical nutritional care is perceived, based on the standardized classificatory approach, interventional diet therapy, Nutrition, medicalization and the centrality of the specialist. That is, from practices, institutions and experts there is a legitimacy of discourses in favor of practices that standardize conduct.[9]

With the union of State and specialist, a disciplinary system is formed, a field of intervention and the production of truths. The nutritionist is the professional who will legitimize conduct of this type in a therapeutic model supported by science, popularly encouraged by the media and social networks.[23]

Castiel et al.[27] reveal an adverse effect of this pathogenic model: the fear of gaining weight or becoming ill increases anxiety and suffering. A study by Gaier and Grudging cited by Heinzelmann et al.[28] shows that despite the longings for their own bodies, Brazilian women are no longer thin or healthy.

As reactions to such a model, Demétrio[7] draws attention to different principles and guidelines that regulate health and food policies and which oppose the idea of control - humanization, integrality, autonomy, participation, salutogenesis, health promotion, traditional commensality, inclusion, cultural identity, sovereignty - and that dialogue with the theme of self-care, which will be explored below.

SELF-CARE

The notion of care is polysemic. The Latin term is similar to healing, expressing an attitude of attention, zeal, good treatment, concern, interest in the object or loved one. Boff[29] adds:

> Care only comes when someone's existence matters to me. I then proceed to dedicate myself to him; I am ready to participate in your destiny, in your searches, in your sufferings and in your conquests, in short, in your life [...] care implies a way of being through which the person leaves himself and focuses in the other, with care and solicitude (p. 29).

In the Heideggerian perspective, taking care of things implies seeking intimacy, feeling, welcoming, respecting at the exact moment that it is not possible to be anticipated. To care is to establish communion. All are born with the potential to care and need care, learned over time.[30,31]

Understanding oneself is essential for the practice of care. Self-care is an art of becoming better, more sensible, requiring self-knowledge and self-control. This demands from the subject a daily effort of personal, non-transferable transformation that takes effect through constant exercise - so much so that the word that describes this process, *arkésis*, means exercise or practice.[32,33] Taking care of oneself means not being a slave to others, govern or themselves and their own passions.[34]

The aesthetics of existence, defines the aesthetic and ethical criteria for good living and consists of rational and intentional practices that not only determine rules of conduct, but promote self-modification, based on values with which the human being identifies.[35] Therefore, there were no external codes and the rules of conduct should be sought in and by the subject himself.[33]

What health professionals have in common is assistance to human beings. And to take care of people, it is essential to take care of oneself as a prerequisite, it is not possible to separate personal and professional dimensions. Only when self-care is practiced, can one donate to the other, offering the best of his knowledge and presence.[17,36]

Certain ways of being and doing harm the professionals of care and, consequently, the assistance to patients.[34] There is a circularity that involves the specialist in a critical and reflective attitude so as to have the ability to understand the practice of caring for oneself and the patient. other. The neglect of self-care would be a setback found through frequent situations of neglect with oneself, physical and mental fatigue among health professionals.[37] It is understood that the psychological and emotional state of the health professional also needs to receive due attention, since that it affects and is affected in clinical practice.

Bosi et al.[38] highlights that students and nutrition professionals are highly susceptible to developing eating disorders. Studies show that health professionals' beliefs and prejudices can directly impact the way they will behave during an appointment - using less time or reticence to develop a closer therapeutic relationship with the patient, including the nutritionist had the highest score on the scale of fat phobia.[39,40]

It is interesting to reflect on how care has been understood by clinical nutritionists. Under a restricted view of health, (self) care is often associated with aesthetic issues. However, care requires a deeper understanding of the concept of health. A priori, the World Health Organization establishes that health is a state of complete physical, mental and social well-being and not just the absence of affections and illnesses. Even knowing that such a state is a utopia, the concept signals that health is a complex and multifaceted object that implies different points of view, depending on looks, meanings, cultures and the articulations with the environment in which one lives.

Health is this relationship of opposites, of a dynamic, singular state, which does not correspond to the absence of diseases. It involves a subject who is not passive in the environment, but who undertakes, acts and builds on him. Therefore, health is experienced in the relationship between human beings and the environment. It is a possibility for people to conduct their vital processes, commanding their way of living. That is, it is not a linear path, it is a process, a world of possibilities where ways are found to resist the disease.[41]

Living health is synonymous with a joint process with becoming ill, after all, we are imperfect beings and there is no life without this symbiotic relationship between states of health and disease. [42]

The disease can be described as a kind of chaos, a disturbance of the human ecosystem.[43] Cangulheim[44] puts the disease as an opportunity to express the imbalance that the organism experiences emotionally, mentally or physically. In both cases, it is necessary to create conditions for reorganization - and the caregiver can enhance this process.

Each subject can experience health-illness in different ways and may suffer from different spheres and intensities. It is interesting that the lay subject recognizes the ability to capture phenomena in their different nuances and help him / herself to perceive themselves as a co-builder of knowledge.[45] In this sense, the role of the nutritionist is much more revealed in the idea of creating conditions and powers for patients - or perhaps interacting[a] - to be encouraged to understand the disease individually and to become protagonists in the healing process. When conceiving self-care as a way of being in the clinic, relationships become more horizontal and empathic. It is up to the professional to facilitate this process.[17]

The therapists of Alexandria understood that the primary role of the caregiver was to stimulate the person's ability to make sense of what ails him, building his own path and understanding that each has its possibilities and limitations.[46]

The precept of self-care has been overlooked in Western thought due to the emergence of the Cartesian paradigm - the birth of modern rationality that qualifies 'know yourself' but disqualify 'take care of yourself' that values the subjective of the human being.[47]

Caring is an interactive process foreseen in an affective relationship between subjects.[31] It is not an instrumental analytical reason, which has a specific function, but the cordial reason, the spirit of delicacy. More than the logos (reason) it is the pathos (feeling) that occupies the centrality. Only what has gone through an emotion, evokes a deep feeling and promotes care, leaving permanent marks on those involved.[29]

In order to establish this connection with the care process, one must have trust, attention and responsibility and never treat the other as an object or a mere disease. The human being is much more important than his symptoms, with which he should not be identified.[31,46]

[a] When understanding that the individual ceases to be passive in the process, becoming the author of his own healing process, the term patient does not make sense. Naturology proposes the term interacting agent as an option.

Caring is not restricting or controlling, on the contrary, it is producing potencies for healing.[17] For the production of these potencies, care is structured from some key points, among them: listening, speaking, empathy, welcoming, trust, respect and autonomy.

Fochesatto[48] recalls that Freud contradicted the medical paradigm, as he put the patient's knowledge as a starting point to understand the symptoms of diseases. The subject's discourse allows him to connect internally and have the opportunity to vent and reframe his emotions, emerging his own cure. Speech and attentive listening are, therefore, the starting point within a care centered on care. To care is not to keep the word; is to favor speech in the search for solutions.[17,49,50]

For this, it is essential that the caregiver is curious and empathetic and abandons pre-established concepts and universalizing behaviors in order to produce care in the act, in the present moment, in the list of active actors.[17,50]

There is space to listen. Thus, care-based anamnesis should be an instrument to guide the professional and not to limit people's responses, favoring open questions. The nutritionist leaves the role of an interviewer and becomes a listener and caregiver; its focus is centered on the person, not on the disease, in an attempt to reach subjectivities.[17] Therefore, the life story reported by the patient must be considered and investigated, as every body has a history. Stamm[51] and Tavares[52] argue that for this, it is not enough just technical knowledge, it is essential that there is also the development of other skills and competences such as empathy, communication, bonding and resilience, and the development of a relationship based on trust with the patient.

Clinical nutritional care based on care must be built in a warm and inviting place to foster gentle and horizontal conversations. The environment must refer to a safe, intimate place, an allusion to the house. In this sense, some elements can corroborate with indirect light, comfortable armchairs, rugs, plants and decorative objects.

In this person-centered approach, the quantitative dietary prescription should be reviewed. An alternative is nutritional counseling, a 'non-diet' that offers space for collective construction with the patient and considers their life history, habits, perceptions, needs, desires and beliefs, in order to stimulate and strengthen eating skills and attitudes aimed at for self-care.[26]

Another alternative presented by the same authors, also associated with self-care, is conscious eating and mindful eating - Intuitive Eating and Mindful Eating - proposals that allow the development of a healthy relationship with food and the body, using body wisdom, that is, internal signs of hunger and satiety to guide eating behavior. In addition, they explore the multiple senses to promote experiences connected with the present moment, proposing meditative eating, with full attention and without judgment.

The conception and practices of mindful eating include the relationships that are established during meals, the place and the way they eat, as well as the origin of the food, including organic, fresh, local, seasonal foods and also stimulating culinary practice.

Anthroposophical Nutrition argues that the main function of the nutritionist should be to discuss the qualities of each food, accompany the patient in his own food choice and stimulate his unconscious eating instincts.

Other knowledge from Psychology or Pedagogy can also contribute to care such as cognitive behavioral techniques, motivational interviewing, group dynamics and autonomy pedagogy. From such perspectives, care is not just about actions or behaviors, but fundamentally about ways of being in the world, of being with people. Life management, to paraphrase Foucault.

FINAL CONSIDERATIONS

The self-control model experiences a profound crisis in the approaches, treatments and clinical interventions in Nutrition, especially in terms of adherence and the results achieved. The nutritionist will probably be more and more active in the coming decades, since most diseases can be prevented, alleviated or cured through adequate food. However, this model based on control, prescription, punishment, reductionism to the biological body and distance from the reality of interactants and their subjectivities needs to be problematized, which this study proposes.

It is important to think that, despite the apparent opposition of two categories - control versus care - this division was conceptual. It is understood that there are no pure approaches or ideal types. A clinical nutritionist can use elements that were presented here in the context of control - such as anthropometric strategies - and build an affective and horizontal relationship with the patient, qualified as an element of care. What is discussed is that the nutritionist must be aware that, in order to promote care, it is essential to develop human skills and competences that are not always taught in the academic context. And it is essential to turn to the concept of taking care of yourself before taking care of the other.

The scope of care is multiple, as are human desires. It is not possible to conceive of a single definition of health, healthy eating, a standardized style of good living. And, only by respecting the subjectivity, diversity and power of the human being is it possible to be an agent of care, remembering that the professional is only a facilitator of the process, the patient being the central agent.

It is worth remembering the interference of factors and tensions that are established around the nutritionist, such as the influence of the media, companies, industries, public policies and other mechanisms of power. The patient himself suffers from these influences and arrives at the office, often expecting a restricted diet, supplements or attitudes that imply control.

As we have seen, proposals emerge from different fields that are based on self-care and can be improved and / or adapted to the area of Clinical Nutrition, in order to contribute to a performance centered on the care of interactants and whose principles are autonomy, accountability, agency and the appreciation of individuals' subjectivities.

In view of so many perspectives and approaches based on care, it is up to the professionals in the area to commit to the promotion of new studies that can demonstrate the effects and consequences of a practice that privileges a horizontal, empathic, expanded, non-prescriptive relationship with a focus on self-knowledge and self-care of the interactants.

Finally, it is necessary to think about the training of the professional nutritionist, understood not only as a subject that is constituted individually, but as a product, both of power relations and of the production of knowledge in the historical path.

Nutrition expands significantly when analyzed under the stamp of Human and Social Sciences. Historical, environmental, political, geographical, philosophical, anthropological and sociological perspectives are crucial for the understanding and resolution of food issues since the act of eating happens according to social rules, influencing everyone who lives here.

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Villela, M created and developed the study through all of it's peocess; Azevedo, E reviewed the essay.
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