Original articles

Women with chronic low back pain in a rural settlement: challenges from a physical therapy perspective

Mulheres com dor lombar crônica em um assentamento rural: desafios de um olhar contextualizado a partir de uma formação em Fisioterapia

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Abstract

This article discusses the need for physiotherapists to develop greater cultural competence for a broader approach to chronic pain. We first review different models of body and pain, from an anatomy laboratory training and anthropological perspective. By contrasting these perspectives, we analyze three situations experienced during the fieldwork, while researching six women with chronic low back pain in a rural settlement. Based on these situations, we discuss how life trajectories mark the ways in which we perceive our bodies, how cultural competence is relevant to develop the professional's ability to listen and take action, and how conviviality and collective action among these women during work in a cooperative can contribute to coping with pain in this rural context. A more qualified understanding of the background of patients with chronic back pain reveals the limits of physical therapy education and allows to rethink the treatment needs and possibilities in different contexts.

Keywords: Pain; Chronic Pain; Physical Therapy; Cultural competency; Anthropology of the Body and Health.

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DOI 10.1590/S0104-12902023220262en

Resumo

Este artigo apresenta uma reflexão sobre a necessidade de fisioterapeutas desenvolverem maior competência cultural, para uma abordagem ampliada da dor crônica. Para desenvolver esta reflexão, apresentamos inicialmente uma revisão sobre como modelos de corpo e dor diferem, a partir de uma formação que toma como referência o laboratório de anatomia e uma perspectiva antropológica. A partir do contraste entre essas perspectivas, analisamos três situações vivenciadas no trabalho de campo, durante o desenvolvimento de uma pesquisa junto a seis mulheres com dor lombar crônica em um contexto de assentamento rural. Essas situações nos permitiram discorrer sobre como as histórias de vida marcam as formas de percebermos nossos corpos, como a competência cultural pode ser relevante para o desenvolvimento da habilidade de escuta e da ação do profissional e como convívio e a ação coletiva entre as mulheres durante o trabalho em uma cooperativa pode contribuir para o enfrentamento da dor neste contexto rural. Concluímos que apreender de forma mais qualificada o contexto de vida de pacientes com dor lombar crônica ajuda a compreender os limites da formação em Fisioterapia, bem como repensar as necessidades e possibilidades de tratamento em diferentes contextos.

Palavras chaves: Dor; Dor Crônica; Fisioterapia; Competência Cultural; Antropologia do Corpo e da Saúde.

Introduction

> *Sat in her living room, Lídia begins by telling me about her life trajectory. The house is spacious, comfortable, simple and with a bed of roses at the front door—which Lídia says belong to her husband. With an impeccable yerba mate gourd in hand, without a leaf out of place, she welcomes me into her home to sweetly and calmly tell me the story of a hard life, but which she is very proud of.* (Lídia, 46)

This field diary description recorded as part of the research[1] conducted with six women at a Landless Workers' Movement (MST) settlement depicts the shift in perspective of a physiotherapist throughout a long and in-depth fieldwork on the phenomenon of chronic pain. From the contact with this unusual space for Physiotherapy and the perspectives experienced therein, different from those encountered in a clinical outpatient or hospital setting, we chose to address issues related to integrality in healthcare and the need for a contextualized and comprehensive care articulated with other fields of knowledge. This is because, as we intend to explain throughout this article, although chronic pain is present in everyday life and permeates all activities of those affected by it, this is solely one aspect of their lived experience. In the case of the research participants, this pain is intertwined with work to maintain life and pride in everyday achievements, as reported in the field diary and, thus, challenges the physiotherapist's viewpoint. Although some publications in Physiotherapy discuss health care, the topic receives limited attention when compared to the literature based on biomechanics and biomedicine.

Certain authors (Damasceno; Silva, 2018) have argued in favor of developing patient-centered health care strategies that consider their beliefs and are sensitive to particular life situations, proposing a greater rapprochement between professionals and the philosophical, subjective, social, and anthropological dimensions of the body.

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[1] Experience of chronic low back pain among women living at the rural settlement "Filhos de Sepé," research approved by the Universidade Federal do Rio Grande do Sul's Ethics Committee under opinion No. 050810/2015

This way of thinking about care has been discussed mainly within Primary Care, which has invested in new forms of action towards multidimensional and low-complexity health problems, such as chronic musculoskeletal pain (Mata et al., 2011). Physiotherapists having historically had little insertion in Primary Care may explain the difficulty in incorporating, both in education and in professional practice, a broader view of health and comprehensive care regarding chronic pain (Fernandes et al., 2022). But as Baena and Soares (2011) suggest, the subjective context of care, dialogue as its foundation in any sphere, and the refusal of reductionism are key aspects of good health professional practice, regardless of their core education and training and the level of care at which health care is provided.

For Joseph R. Betancourt et al. (2016), without developing a "cultural competence"[2] we are unable to understand how social and cultural issues influence health beliefs and behaviors and consequently become insensitive to their contextualization within care and therapeutic practices. Physiotherapy has as its main object of study and intervention the action upon the body and, despite recognizing the biopsychosocial model as relevant to its practice, it still leaves out the cultural, sociopolitical aspects and other spheres of life involved in corporeity, thus limiting its understanding of the health-disease process (Mescouto et al., 2020). In lacking cultural competence, we make decisions and prescribe therapies considering only knowledge derived from universalist perspectives, paying little attention to the individual and their experience of life and illness, crucial elements for comprehensive care (Helman, 2003). It thus becomes paramount to reflect on how technical and cultural competences interact in health care.

This six-hands article, written by two physiotherapists and one anthropologist, presents some of the reflections developed by the first author—a white, middle-class female physiotherapist—who, after working 15 years in an Industry Worker's Health Rehabilitation Center, took interest in investigating how women from a rural settlement living with chronic low back pain understood their bodies and their pain, and the coping strategies adopted. The project started from the first author's contact with the rural settlement community, under a university outreach project focused on reading to children. Even if not acting as a physiotherapist, this interaction unearthed elements related to the scarcity of health resources and the difficulties in coping with chronic pain—especially chronic lower back pain—, which sparked the interest in developing a field study based on medical anthropology and body culture studies. A choice that proved to be quite challenging from the start, as it invited us to analyze the studied phenomenon through very different lenses from those considered foundational in physiotherapy education and professional practice. Thus, during fieldwork, several situations generated strangeness—more than was first imagined—, leading to reflections on how Physiotherapy education delimits health care.

The qualitative ethnographic research followed six women with chronic low back pain (age range from 43 to 67 years) who worked in the bakery and vegetable processing cooperative at the rural settlement "Filhos de Sepé," located in the municipality of Viamão, near the urban area of Porto Alegre, in Rio Grande do Sul, Brazil. To preserve their identity, all participants are referred to by fictitious names. The settlement was divided into four residential sectors and the study participants lived in the sector where the Cooperative was allocated. We investigated how these women experienced chronic low back pain to understand how they identified and gave meaning to its causes, the duration of pain, the therapies used, and how physical therapy could contribute to this context. Data collection lasted one year and included weekly visits to the Cooperative, and three interviews with each participant. The interviews, recorded and

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[2] Health-related cultural competence implies the ability to understand the importance of social and cultural influences on patients' health beliefs and behaviors. It is paramount to understand how these factors interact with the various levels of health care, and therefore it is necessary to plan interventions that consider these issues, which are adapted to and incorporate different populations' realities and cultural needs. (Betancourt et al., 2016)

transcribed in full, were combined using the body map narrative technique (Quijano, 2016).

During the visits, we noticed that their life trajectories were heavily marked by hard work in the fields, financial difficulties, and excessive bodily effort since childhood. They had little formal education and got married at a young age. Five of the six women actively participated in the MST; they lived for months or years in settlements, in canvas tents, before acquiring definitive land possession. Life at the campsite was hard. According to their accounts, there were several occupations, constant moving, long walks, and working on farms for little money. Facing the cold, the fear of living near the roadside, and the rationed food were part of their daily lives; but the feeling of sharing the same struggle and the proximity of the tents made things less difficult. That is how they lived, until they were selected and moved to the current settlement.

In 1998, after several evaluations, the settlement area was considered for land reform purposes and the Viamão Settlement Project was created. Soon afterwards, 376 families drawn by lot began to arrive at the site, an area of 9,450 hectares organized into four residential sectors, and the settlement was named "Filhos de Sepé."

Arriving at the settlement was a step forward in the struggle process, representing the consummation of access to land ownership. A remarkable moment of great happiness, but also of many "lacks" for the women and their families—lack of housing, lack of electricity, lack of water, besides the initial impossibility of cultivating the land. Since the soil was sandy with little vegetation, they first needed to improve land conditions for planting.

Faced with this setback, they sought other work fronts in the settlement surroundings and even in the urban area. They had no choice but face fatiguing work situations again, long working days and endless distances traveled on foot. This reality lasted for approximately two years, until the soil could be fertilized and the plots demarcated and legalized by the National Institute of Colonization and Agrarian Reform (INCRA).

At that moment things started to change and their livelihoods began to come from what they produced on the plot. Some families engaged in rice planting or livestock raising, but the study participants predominantly engaged in small-scale planting, both for self-sufficiency and to sell, and cattle raising to produce milk and cheese.

Currently, the settlement houses—mostly made of masonry and built very close to each other—are close to the Cooperative and can be accessed via dirt roads. The plots are large and some are difficult to access, especially in dry weather, when the soil becomes sandy. Nearby there is a place for leisure activities such as soccer, bocce, card games, dance classes that happen sporadically, and other scheduled activities.

Kinship features heavily in conversations at the "Filhos de Sepé" settlement. As they say: "We are all related." Jurema lives close to her three children, each of them with their own plot and house. Lídia's sister-in-law and her children also live nearby. Elis is Rose's neighbor, who is also her sister-in-law, and her parents and siblings live in the lot behind their houses. Rose has daughters who have married and built their own homes. Celia has a niece, a son and a son-in-law who live nearby. Ana, who arrived later, lives with her daughter and husband in the same house. Thus, as several members of the same family live at the settlement, the existing kinship networks allow them to keep family close and kinship ties strong, since they were often apart. It is through it that reciprocity is strengthened, whether by sharing childcare, exchanging products, providing food, showing concern for another's health or by offering mutual help. Such way of collective life creates safety, support, but above all is the only possibility of succeding.

Fieldwork brought about situations that invite us to reflect on the (in)competence of a dominant biomedical knowledge in Physiotherapy, in favor of an approach to the body based on life contexts and experiences. Firstly, we discuss how body and pain can be understood differently by the anatomy laboratory and everyday experience. We then present some interactions with the participating women that, from a Physiotherapy education standpoint, caused strangeness and challenged us to think differently. Our goal here was to bring a more contextualized look at the chronic pain experience of women living in a rural settlement to broaden our understanding of the body, chronic pain, and health in different life contexts.

Body and pain models in the anatomy laboratory

As a student, the physiotherapist's first contact with the human body occurs by manipulating a corpse—a previously living body belonging to the realm of people that is explored as an object, depersonalized and universal, enabling the student to scrutinize its structural details (Neves, 2016). Such an appropriation of the body as a nameless, skinless, and inert object on a table at anatomy laboratories of higher education institutions remains a common thread throughout the course, even if permeated by moments in which the need to "see the person as a whole" is highlighted.

Similarly, pain is perceived as a physiological event, a symptom that must be justified, clarified, and located in that anatomical body. The need to establish a relation between signs, symptoms, and the pathological condition persists, as this is the path to legitimize pain as an illness process. The hegemonic biomedical model in physiotherapy education, as well as in other health fields, offers, from a mechanistic and dualistic view of scientific rationality, recognized approaches for elaborating methods to relieve suffering and treatments for different pains and illnesses (Victora, 2011; Luz et al., 2019). Although such abilities are still highly valued by most health professionals and much of Western society, they bring harm or even hinder recognizing alternatives, i. e., theories and concepts adverse to the reductionism of anatomical pathology and mechanical physiology (Luz et al., 2019).

Therapeutic knowledge remained focused on combating and controlling diseases, moving away from the patient and their life, gradually becoming standardized in a process of "erasure and de-individualization of biomedical action in relation to real individuals [...] seen increasingly as homogeneous units" (Tesser; Luz, 2008, p. 200). This perspective, focused only on structural aspects of the body and pain, although questioned when addressing chronic pain (Engel, 1977), predominates in the clinical approach.

Since its inception, physiotherapy has shown little interest in other theoretical perspectives on body and health, reinforcing a view of the body as a neutral, depersonalized element and consequently easily grasped and treated as universal. This understanding also supports the presumption of defining what is normal or abnormal, as well as establishing certain prescriptions common to all, even if completely decontextualized. Nicholls and Gibson (2010), however, reinforce that these actions are at odds with a social perspective of the body, which values diversity, inclusion, and the need to review our concepts of normality. They also argue that the social sciences criticize biomedical disciplines for their resistance to go beyond the limits of the biological body, and that physiotherapy, as a profession aligned with medicine and its strong affinity to the physical body, needs to engage in this discussion.

Even the biopsychosocial model, recommended in controlled studies of chronic low back pain treatment (Schmidt, 2021), has been questioned and, to some extent, criticized. Mescouto et al. (2020), for example, question how physiotherapists appropriate this model, both in research and in practice, by considering that, despite attempts to integrate these different dimensions in the chronic pain process, the biomedical perspective and the positivist paradigm remain central. This results in the maintenance of a reductionist practice that, besides fragmenting the patient into these three aspects, finds it difficult to apprehend chronic pain in all its complexity (Mescouto et. al., 2020). Despite discussions about a more comprehensive and humanized model, society continues to prioritize biological etiology, a fragmented health logic, and the "imposing and normative character of positivist science" (Traverso-Yépez, 2001, p. 53), ignoring the importance of other spheres of life as mediators in the health-disease process (Lima; Trad, 2007; Traverso-Yépez, 2001).

Body and pain from what is at stake

The contextualization of the body, from an anthropological perspective, is very different from what we apprehend in the anatomy laboratory, sometimes almost an alien for those trained mainly by books that deal with anatomy, physiology, and pathology. We are trained to fragment the experience into a physical or mental, biological or psychosocial phenomenon (Uchôa; Vidal, 1994), without realizing its multidimensional characteristic, in which biological, environmental, historical, cultural factors, and even the role of each one in the society, are intertwined. This understanding of the body, nurtured during physiotherapist training, hinders the realization that pain experiences are permeated by interconnections of various spheres of life.

By assuming the multidimensionality of the experience, we must accept it as an indeterminate field of interpretations, which builds slowly and continuously from the experiences in a given context. Therefore, being attentive to the subject's experience means recognizing "what is at stake" in everyday life, understanding how life experiences produce meanings and imprint marks on the body. Such experiences should also be understood in their intersubjectivity, considering they occur in social transactions in moral and local worlds, and are permeated by cultural categories and social structures that support the understanding and perceptions of the body, as well as the situations of illness (Kleinman; Kleinman, 1995).

Thinking pain as an experience in life – more than as a physiological fact – allows health professionals to break dichotomies (health/disease, body/mind) and create space for other forms of understanding and acting. As proposed by Csordas (2008), based on Merleau-Ponty's works on body and perception and Pierre Bourdieu's on habitus, the attention given to body experiences – in the sense of how they value and apprehend their sensations – differs between different cultural contexts. Therefore, the way subjects and their peers relate to pain experiences, since it is an intersubjective phenomenon, may have different repercussions and forms of expression in different communities and historical moments.

Merleau-Ponty argues we access the world through the body, since it is our means of being in such world. He speaks of the simultaneity of existing as a subjective and object body, thus not despising biology, but disagreeing with the Cartesian model that sees it as separate from subjectivity (Merleau-Ponty, 1999; Thornquist, 2001a). Similarly, Pierre Bourdieu seeks to break with dichotomies, based on his understanding of Habitus (Wacquant, 2007); he also understands our apprehension of the world as the result of learning and dispositions we unconsciously incorporate. Such apprehension of the world, which manifests in our practices and forms of expression, is therefore shared in the different uses of the body in everyday life and in different social groups. Likewise, the forms of action in face of the chronic condition will depend on the embodiment of a Habitus that encompasses an entire worldview in a given sociocultural context, thus reverberating on the coping strategies, on the expression of pain or even on the understanding of concepts such as health and disease.

All these interpretations of body/pain/world reveal different possibilities and how much the physiotherapist training still establishes dichotomous patterns, based on ideals of an urban, middle-class, white context that seeks to standardize practices, disregarding the experience of those who look for their services. The physiotherapist's ability to reflect on different perspectives, developing different skills in his or her practice and, therefore, being able to perceive the body from the perspective of the person, breaking with dichotomies, adapting to diversity, valuing the trajectory of life, beliefs, relationships and emotions, would contribute to developing cultural competence and pave the way for a contextualized, realistic practice connected to the patient's daily life (Thornquist, 2001a).

Researching pain, women and lives

Interacting with rural settlement women living with chronic low back pain generated many surprises. Several years of practice in a clinical environment of moderate-complexity care, treating chronic pain patients with devices, exercises, and manual therapeutic resources, ignoring much of their perceptions and life trajectories, gave us the false impression that going into the field the answers would be as easy and objective as they seemed to be in structured anamneses. But by providing these women with a space for telling their stories, their narratives gave voice to a mosaic of pains that did not fit into their anatomical structures; they were pains of life. As much as they knew that the researcher was a physiotherapist, that the study was aimed at better understanding their chronic low back pain experiences, this was not the theme brought up in their narratives. When asked, for example, about their bodily experiences, nothing was said about physical pain, they longed to talk about the silences of the female body, their records recalled the importance given to the body that produced, the body available to fulfill the roles of procreating, taking care of the house, and how much this caused suffering and pain. The need to share the pains of life urged more than talking about physical "low back" pain, which was the topic of the research.

> *Ah, it was like that, as the child was growing up, they didn't care to talk about the body, especially with the girls, the concern wasn't teaching them about the first time of that lady business and then they will have a sexual relation, nothing was like that. The concern was: the girl was growing up 'ah, you gotta learn making bread, you gotta learn washing clothes, you gotta learn how to do this, to do that.' But they never cared about the most important* [things]. (Lídia, 46)

Lídia understands that talking about the experience of the body is talking about the women's roles in this rural context, not about pain or physical suffering. The pain of the body seems linked to inescapable gender-role activities and, therefore, these women seemly never gave much thought to the pain experience. The researcher assumed, as a physiotherapist, that the impediments generated by physical pain would play a central role in these women's narratives, feeling surprised not to get the answers she expected, which revealed a reality quite different from that idealized from the articles and training books. The feeling was that these women did not want to remain silent about the pain, since it was present in their daily lives, but rather it appeared in a diffuse, confused way, as well as in the background of their narratives.

During fieldwork, it became clear that they did not problematize body care, in order to prevent, treat or manage physical pain as defined in professional training. Body discomfort was perceived as part of the life process, which every worker will experience and, therefore, was not questioned by them, by the family and by the surroundings. Despite associating chronic pain with the heavy work that accompanied them since childhood, they did not question it as they did when reporting life events related to their condition as a woman, such as pregnancy or early marriage, which they had already talked about to each other and considered it as possible to have lived differently. In this sense, we questioned: would there be room for these reports in the clinical environment? How do professionals receive narratives that move away from the problem of "physical pain"? How to provide care when the perception and concerns with the body are so different between the professional and the person looking for a solution to her problem? How does the professional deal with people who, when questioned, cannot be clear and delimit their complaints? How to access this pain that seems to be in the background; does it exist in the same way for the person and for the physiotherapist? Is it possible for the physiotherapist to access this mosaic of pain with a training that is not aware of different possibilities of expression and perceptions of the body?

This process of looking at different contexts of life, unusual for a physiotherapist, gave rise to many questions about the consequences of adopting the dominant model, which is reflected in a dichotomous view of the body and pain. This partially justifies the difficulty of realizing that, despite the temporal and spatial proximity, there was an abyss between the body perceptions of the research participants – who grew up in rural areas, worked since they were children and were at the forefront of a movement for their right to land – and of the researcher trained in Physiotherapy, an urban and middle-class woman from a cultural context in which the body has been constituted as an element that requires attention and care, minimizes unnecessary efforts, has standards of rigorous feminine aesthetics, is entitled to sick leave and undergoes therapeutic procedures in the face of adverse conditions and which, therefore, seeks and values an idealized model of a healthy body. Such reality was not similar to those shared by women during fieldwork.

Reflection on these aspects of education and different living conditions is pertinent and was very present in this study, mainly because it revealed the difficulty of perceiving, in different situations during contact with women, peculiarities of the experience of the body and pain, in a context of struggle for the right to land and rural settlement. The narratives, as suggested by Kleinman and Kleinman (1995), portrayed experiences as products of culture and social arrangements and their convictions. Worlds where these women's personal and collective commitments are revealed in relation to what is important, therefore the moral essence (values) of the flow of social experience. Then, interpreting the experience of the body, in any circumstance, involves considering everyday life, apprehending what is relevant and what is possible. For them, the marks on the body related to gender issues and the women's role are more relevant themes than the history of physical pain. In the face of diversity, one should be able to retain the "complexity, uncertainty and ordinariness of the world of experience" (Kleinman; Kleinman, 1995, p. 275). Therefore, experience cannot be understood as universal. Although plural, it is also unique.

Another situation that caught our attention was one of the women's approach during the researcher's presence at the settlement, according to this episode recorded in the field diary:

> *One day, upon arriving at the settlement, she came towards me, wearing Hawaianas flip-flops, to tell me about the pain she felt in her feet. She described a burning sensation in the calcaneal region, a morning pain, which from a biomedical perspective seemed to be what we call plantar fasciitis. I immediately told her about the importance of wearing shoes, about the possibility of wearing insoles, of resting, and for a while I kept talking. She looked at me like she wasn't listening. Empty look. At the end of that "physiotherapy" speech, she simply didn't ask me anything and went back to work. I realized my speech made no sense from her perspective. I imagined what she would be thinking: 'What do you mean with wearing insoles? I've walked barefoot most of my life! No one wears closed shoes here!'*

The care alternatives offered almost automatically on this occasion led us to reflect once again on the lack of cultural competence in professional listening and action. We wonder how often prescriptions and interventions, based solely on the principles of biomedicine, are presented as solutions disconnected from reality. The listening in this episode was not qualified, comprehensive, nor did it take the necessary time for a greater understanding. These actions, which ignore other spheres of life and disregard the principle of integrality, constitute fragmented and restricted practices that will possibly have few responses regarding the demands for treatment and relief of painful conditions. In addition, there is a risk, in the eagerness to impose prescriptions that disregard reality, of removing a possible protective factor or not identifying it.

This reductionist and interventionist perspective places the body as a passive and impersonal object, therefore convenient for the scrutiny of the health professional (Thornquist, 2001b) who positions himself hierarchically asymmetrically in relation to the subject. The physiotherapist, in many situations like this, almost automatically interprets the information according to his references, which transit through the perspective of the dominant structure. Thus, in this context, the subject's body is not perceived as a source of experience of itself, and it is deprived of its meanings and reality. In this perspective, the "power" to establish what is relevant and which world will prevail in practice, during the adoption of therapeutic strategies, is understood as being the professional's attribute (Thornquist, 2001b).

Likewise, we have to ask ourselves whether therapeutic strategies, based on evidence-based practice (EBP), are relevant and easily applicable in the context of life and habitus of a "rural body." Can we disregard the experiences, priorities, meanings, and even the strategies that have been developed over the years to face adversity? How to contemplate the cultural competence, so necessary in this scenario, in training focused on evidence-based practice, expressed in statistics from controlled scenarios and in clinical contexts, which are, in most cases, urban? Medical Anthropology (Kleinman; Eisenberg; Good, 1978) and Phenomenology (Goldenberg, 2006) challenge EBP, seeking to contrast concepts such as "illness" – the disturbance from the patient's perspective – and "disease" – the disease from the physician's perspective –, to account for the various forms of illness (Helman, 2003). Diseases and suffering are not universal entities, they are culturally specific, therefore falling ill and suffering are experienced differently in different societies, cultures, and times (Victora, 2011).

Goldemberg (2006) states that the illness experience also offers a legitimate source of knowledge to health professionals. An approach to the disease, as well as to illness, which disturbs the subject's ability to relate and act in the world, may bring a much deeper understanding of the scientific evidence and perhaps even a new scientific method (Goldenberg, 2006). Therefore, the physiotherapist needs to exercise other ways of responding to the illness and keep in mind that the care of life goes beyond objective therapeutic prescriptions for a limitation of the physical body.

Another experience in the field that raised questions was the understanding that the main coping strategy to deal with pain in that context, in addition to medication, were not stretching exercises, hot baths, or the physiotherapeutic treatments to which some of the participants had access. Even if they reported having pain, these treatments did not seem to be valued and were not carried out, either because of the difficulty of access, when they were far from the settlement, or because of the community's lack of interest in investing in the practices offered (Quijano, 2016). Women's narratives and being close to them at the settlement made us understand how work at the Cooperative occupied an important space in their lives, becoming one of the main strategies, if not the only one, for coping with pain, as reported by Lídia and Jurema:

> *[...] but I still prefer it like this, you know, living with the pain and knowing that even if I take a medicine* [the pain does not go away], *but that I get up in the morning and I can walk, I can go there to the cooperative too, work, coordinate things, right? So, you live with the pain, but you can still move, you can work, you know.* (Lídia, 46)

> *But we who are used to it, we who are used to working hard since we were little, for me that is a piece of cake. It's the only work I can do, besides doing my housework and stuff.* (Jurema, 62)

The work is viable and is a source of forgetting the discomforts that are so present in these women's daily lives. This positive perspective regarding work is also based on observations recorded in the field diary. In the shared context of the Cooperative, women talk and laugh. The meetings I attended showed me that the workers are more than neighbors: they share a history that creates bonds of friendship and even kinship. The close network that has been formed strengthens them and makes it easier to them to deal with pain more lightly or even leaving it as a backdrop. In the meetings we had with them while they were working, we did not identify anything that expressed or was referred to pain. What we did observe is that the work was a kind of relief strategy for them, even if it seemed strenuous in the eyes of the researcher. In their words: *"[...] after I'm in there working, I forget [...] work is a therapy. I can't actually do heavy work [anymore]."* (Jurema, 62)

The work at the Cooperative did not seem to be seen as harmful. On the contrary, it was presented as a space capable of "supending" pain. Work means motivation, something that protects and promotes their group identity and their self-esteem. It is, in fact, what makes them feel healthy. As proposed by Nicholls et al. (2016), the positive connections between subjects and their environment contribute to giving meaning to existence, generating feelings of belonging, diverting the focus of attention from suffering. Therefore, work may be understood as an important element of health protection.

However, statements about pain are very different in the private space, when arriving home, as Lídia and Jurema report:

> *Because when I'm working, I walk from side to side, you know. The body is hot and when I get home, I sit down and then I go to rest, the body rests, relaxes, then the pain starts.* (Lídia, 46)

> *But then when I stop, oh my God, everything, everything, everything, everything hurts. There's*

> *nothing that doesn't hurt. I come home and I think I'm going to stretch out on the couch, rest, I've worked a lot. It's the other way around, I can't stop. Then I begin to feel everything, everything.* (Jurema, 62)

This research experience made us question whether, in the face of certain chronic conditions, the best alternative is to recommend total removal from work activities, especially in contexts where there is no labor protection. We have argued earlier that the social interactions in the context of work activities may play an important "protective" role in social identity and self-esteem, especially for those who have had work as their main reference in life. The causal link between work and pain, from the physiotherapist training perspective, directs us to recommend time off to reduce pain or physical disability (Cargnin et al., 2019). On the other hand, based on the women's narratives, we ask ourselves how effective would it be, and what would be the consequences of interrupting work and isolating the subject to ease the discomfort generated by pain.

In the case of this study, pain does not seem to be central in women's experiences, especially when they get involved with work, group activities, and the daily life of the community. We sometimes wondered if refraining from showing pain was a cultural way of keeping up with a work ethics that values strong, healthy, and productive bodies; or, as we suggested earlier, engagement with other dimensions of life does in fact bring about a kind of suspension of pain.

Final considerations

This article brought a few examples among many that led us to recognize the importance of going into the field and developing the ability to observe and listen rather than simply prescribe. The less one knows about individuals' life context, the more necessary this opening is to make room for the other's perspective and to develop cultural competence. Looking back at the original research project, our expectation, at first, when reflecting on possible interventions for those women, was that we needed to provide a solution for that physical pain so prevalent in the rural context. We sought "normalization" (Nicholls et al., 2016), a principle grounded on the dominant interpretive paradigm which differentiates what conforms to socially defined criteria of normality from those who need to be cured, medicated, or rehabilitated. We thus thought of developing activities that are familiar to the physiotherapist, such as postural reeducation and ergonomic changes. But during interactions and interviews, we understood that these recommendations disregarded their demands and life trajectories; there was a mismatch between our propositions and the reality of those women's lives.

Among the possibilities that have emerged within Physiotherapy, we highlight the concept of connectivity discussed in the article *Connectivity: An emerging concept for physiotherapy practice* (Nicholls et al., 2016). From a critique of how health issues and therapeutic proposals are conceived and directed towards the individual's body, the authors invite us to explore the importance of the existing connections between human and non-human entities in health care (people, technology, contexts, ideas, and others). They provoke us to observe how we become embodied through our connections and how this can be reflected in our abilities and in the forms of care we create when facing certain adverse conditions. Researching on chronic pain made us face several questions, such as the possibility of developing activities in the Cooperative, and about the importance of collectivity and play as strategies that go beyond those focused on the individual body and pain. These are some challenges that lead us to emphasize the need to broaden the perspective of health care-related issues in the field of Physiotherapy.

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Authors' contribution

Quijano and Vieira were responsible for the study conception and design, data analysis and manuscript writing. Victora critically reviewed the content. All authors approved the final version submitted.

Received: 6/17/2022
Approved: 10/3/2022