Bodily practices and the interdisciplinary treatment of people with fibromyalgia: the gift of care

Práticas corporais e o tratamento interdisciplinar de pessoas com fibromialgia: a dádiva do cuidado[1]

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Abstract

Fibromyalgia is a rheumatic syndrome characterized by chronic and diffuse musculoskeletal pain that presents diagnostic and therapeutic challenges to Western medical rationality. Studies highlight the role of interdisciplinary treatment (IT) and corporal practices of health (CPH) in terms of health care and reception. The acts of giving, receiving, and returning symbolic gifts of care provide sociability, recognition, and legitimacy in the health field. The objective of this article is to understand IT and CPH as a system for exchanging health care gifts that is established between people diagnosed with fibromyalgia and health professionals. This is a qualitative study carried out by applying an open interview and carrying out field observation with eight people diagnosed with fibromyalgia and a semi-open questionnaire with nine health professionals. Content Analysis led to the elaboration of a thematic category: "The triple obligation cycle of giving health care." The constitution of the gift in the health care process occurred by an affective-therapeutic displacement to the other, a gift of hospitality, and a gift of recognition. In summary, it was possible to perceive the relevance of IT and CPH as circuits of reciprocity capable of building new social uses of the body in social instances of life.

Keywords: Fibromyalgia; Corporal Practices of Health; Interdisciplinary Treatment; Gift; Health Care.

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Resumo

A fibromialgia é uma síndrome reumática caracterizada por dor musculoesquelética crônica e difusa que apresenta desafios diagnósticos e terapêuticos à racionalidade médica ocidental. Estudos ressaltam o papel do tratamento interdisciplinar (TI) e das práticas corporais de saúde (PCS) em termos de cuidado em saúde e acolhimento. Os atos de dar, receber e retribuir dádivas simbólicas de cuidado fornecem sociabilidade, reconhecimento e legitimidade no campo da saúde. O objetivo deste artigo é compreender o TI e as PCS como um sistema de troca de dádivas de cuidado em saúde que se estabelece entre pessoas diagnosticadas com fibromialgia e profissionais de saúde. Trata-se de um estudo qualitativo realizado mediante aplicação de entrevista aberta e observação em campo com oito pessoas diagnosticadas com fibromialgia e questionário semiaberto com nove profissionais de saúde. A Análise do Conteúdo resultou na construção de uma categoria temática: "O ciclo da tripla obrigação da dádiva do cuidado em saúde". A constituição da dádiva no processo de cuidado em saúde ocorreu mediante um deslocamento afetivo-terapêutico ao próximo, dom da hospitalidade e dom do reconhecimento. Em síntese, foi possível perceber a relevância do TI e das PCS como circuitos de reciprocidade capazes de construir novos usos sociais do corpo nas instâncias sociais da vida.

Palavras-chave: Fibromialgia; Práticas Corporais de Saúde; Tratamento Interdisciplinar; Dádiva; Cuidado em Saúde.

Introduction

Fibromyalgia is a rheumatic syndrome characterized by chronic and diffuse musculoskeletal pain and numerous associated symptoms of unknown origin that predominantly affects women (Able; Robinson; Kroenke, 2016). According to Marcondes et al. (2017), the literature indicates a prevalence of fibromyalgia ranging from 0.2 to 6.6% in the population; from 2.4 to 6.8% in women; from 0.7 to 11.4% in urban areas, from 0.1 to 5.2% in rural areas, and from 0.6 to 15% in populations with special needs.

The syndrome belongs to a class of disorders that offers significant diagnostic and therapeutic challenges to medicine since its etiopathogenesis remains unclear in the light of a clinic hegemonically characterized by excessive objectivity. Despite numerous advances, the biomedical system faces difficulties in the face of a syndrome without an anatomical substrate in its etiology and that somatizes itself as pain (Mattos, 2015).

Thus, chronic pain from fibromyalgia requires a contextual analysis that considers people's life history as its clinical expression varies socially, psychologically, culturally, and environmentally. The increase in the number of cases, the chronicity, the lack of knowledge of its causes, the caused disability, and the embarrassing relationships experienced in various social environments in which the syndrome is delegitimized suggest the need for medical and social relevance in the therapeutic process (Martinez et al., 2017; Souza; Laurenti, 2017).

This complex sociodemographic and clinical context suggests the relevance of anthropological studies on the subject. Firstly, the basic investigative exercise of the anthropological field of alterity can provide other understandings about the symptomatic framework causing functional disability, negative impact on quality of life, and difficulty in social reintegration (Beyazal et al., 2018). Secondly, anthropological research can show how people are sometimes disrespected for their illness, generating a state of outrage toward the health of their bodies (Mattos, 2019). Thirdly (still on the importance of anthropological understanding), it is argued that, although chronic pain is one of the main reasons for seeking medical and therapeutic consultations (Le Breton, 2013), fibromyalgia hinders the relationship of diagnosed people with their bodies and health precisely for the hegemony of logic or explanation based on medical rationality (Mattos, 2019).

In this context, this study is based on Marcel Mauss' (2017) classic work on gift theory, arguing that the acts of giving, receiving, and repaying symbolic care goods can recognize and legitimize to the health-disease process of fibromyalgia, aligning with the assumption of the total social fact, which sustains a symbolic and subjective apprehension of reality in which the social exists when integrated into systems of three-dimensional interpretations, linking the social to the subject, the physical, and the psychological.

Based on Alain Caillé (2002, 2014), a contemporary sociologist who problematizes the gift from the Maussian point of view, this study highlights the possibility of articulating such discussions with physical education and the field of health. For the author, the symbolic dimension of gift theory exceeds the utilitarian and functional dimension of goods, services, and human beings. Mauss (2017) thought about the gift to approach a symbolic perspective of words and gestures against utilitarianism since the traditional societies he studied structured their material and immaterial exchanges on the symbolic cycle of triple obligation rather than on the market.

It is noteworthy, therefore, that the Maussian theoretical assumptions are aligned with or effectively contribute to the interdisciplinary intervention advocated in the biopsychosocial treatment of fibromyalgia. This interdisciplinary intervention aims to approximate/intertwine different knowledge and disciplines (such as physical education, nursing, medicine, and psychology) and emerges as a key factor for controlling the symptomatic framework of fibromyalgia, improving the quality of life of those affected, and enabling patients to better understand the social, physiological, and psychological complexity of their health status (Berardinelli; Brito; Miranda, 2019).

Thus, body health practices include physical exercises within an interdisciplinary collective treatment proposal that deems human movement as endowed with sociocultural significance, needs, desires, bonds, reception, and health care in the wake of values that exceed the biological notion of health and stress the relation between human movement and culture. These strategic social actions are developed by people diagnosed with fibromyalgia to cope with their suffering and illness due to the syndrome (González, 2015; Mattos, 2015; Oliveira et al., 2017).

Thus, we offer the following guiding question: does interdisciplinary treatment for fibromyalgia patients and body health practices constitute a system of exchange of symbolic gifts (health care) between diagnosed patients and healthcare providers? Based on this question, this study aimed to understand interdisciplinary treatment and body health practices for patients with fibromyalgia from this perspective.

Methodology

This qualitative study was developed within the scope of the Project "Interdisciplinary Treatment for Patients with Fibromyalgia" (IFT), which belongs to the "Body Health Practices" extension Program. IFT was founded in 2000 to offer free non-drug therapy to patients with fibromyalgia. It has currently served more than 500 women. In addition to its proposal, IFT includes other specific intentions: to contribute to the reduction of the limitations due to fibromyalgia, to improve physical skills and functional capacity, to reduce muscle tension, to create and/or consolidate habits of regular physical activity, and to collaborate to increasing self-esteem.

The Project has three phases, each lasting three months: Adaptation, Transition, and Coexistence, in which people participate in two weekly sessions of aerobic, strength, and flexibility physical exercises supervised by physical education teachers (all phases), fortnightly nutritional guidance (all phases), weekly group psychological therapy (Transition and Coexistence), and in a weekly health education "Interdisciplinary Group" with physical education, nutrition, psychology, medicine, and nursing professionals (Adaptation).

Patients diagnosed with fibromyalgia (P) and healthcare providers (HP) were chosen from 2019 and 2020 for our empirical universe. Inclusion criteria referred to patients with fibromyalgia joining and participating in the IFT Adaptation and Transition groups in 2019 and healthcare providers' involvement in the interdisciplinary actions of the Project. The study group was composed of eight people diagnosed with fibromyalgia and nine healthcare providers. Research subjects' profiles (age, gender, education, professional activity, marital status, and occupation/profession) are shown in the tables below.

Chart 1 – Profile of healthcare providers

HEALTHCARE PROVIDERS	GENDER	AGE	SCHOOLING	PROFESSIONAL ACTIVITY
HP1	F	57	Master's degree	Physical Education Teacher and Project Coordinator
HP2	F	57	Master's degree	Physical Education Teacher
PS3	M	68	PhD degree	Undergraduate professor, physician, and coordinator of the Project
HP4	F	60	Post Doctorate	Nurse and undergraduate professor
HP5	F	47	Master's degree	Nurse
HP6	F	42	Post Doctorate	Nutritionist and undergraduate professor
HP7	F	35	PhD degree	Psychologist and public servant
HP8	F	43	Specialization	Psychologist
HP9	F	63	Specialization	Psychologist and undergraduate professor

Chart 2 – Profile of patients with fibromyalgia

PATIENTS WITH FIBROMYALGIA	AGE	MARITAL STATUS	SCHOOLING	Profession/occupation
P1	59	Married	Incomplete primary education	Seamstress, housekeeper, and hotel maid
P2	44	Single	Specialization	Photographer/unemployed
P3	42	Married	Complete secondary education	Hairdresser
P4	61	Widow	Incomplete primary education	Retired
P5	56	Married	Incomplete primary education	Artisan and micro-entrepreneur

continues...

Chart 2 — Continuation

PATIENTS WITH FIBROMYALGIA	AGE	MARITAL STATUS	SCHOOLING	Profession/occupation
P6	69	Single	Complete higher education	Cosmetics Saleswoman/Retired
P7	70	Widow	Complete secondary education	Housewife
P8	53	Widow	Incomplete primary education	Caregiver for children and older adults/ presser

The empirical material was collected by in-depth open interviews with patients diagnosed with fibromyalgia, a semi-open questionnaire with healthcare providers (physical education teachers, nutritionists, nurses, and psychologists) involved with the interdisciplinary treatment of the Project, and fieldwork observations. These techniques were triangulated based on the open interviews, semi-open questionnaires, field observations, and respondents' data (which can enhance the development of qualitative research) (Farmer et al., 2006).

In total, 16 open-ended interviews were conducted with each patient at two separate times: in the transition from the Adaptation to the Transition class and from the Transition to the Coexistence class. Thus, their reports accurately contextualized the most varied experiences in the interdisciplinary treatment. All interviews lasted from 50 to 60 minutes, were recorded with a smartphone and the consent of all study participants, and transcribed for analysis. This methodological strategy can evaluate interlocutors' reality in their experiential world (Gaskell, 2010).

Healthcare providers answered a semi-open questionnaire (Google Forms) that usually lasted around 12 minutes and consisted of five parts with closed and open questions on their sociodemographic data, interdisciplinary treatment for fibromyalgia patients, professional performance, chronic pain and health, and patients' demands. Instruments with closed and open questions ensure study participants greater objectivity in answers and freedom of response (Goldenberg, 2004).

It is also noteworthy that field observations took place in two one-hour sessions on Tuesdays and Thursdays during the physical education body practices. Field observations were developed by the researcher in a participatory way during the several IFT phases in June and July (adaptation), September and October (transition), and November and December (coexistence) of 2019, interacting and establishing dialogues with patients with fibromyalgia and with local physical education teachers, as per Becker (1997, p. 47):

> He watches the people he is studying to see what situations they ordinarily meet and how they behave in them. He enters into conversation with some or all of the participants in these situations and discovers their interpretations of the events he has observed.

The researcher responsible for the field observations is a physical education teacher, a former IFT intern (from 2011 to 2014), and currently works as a collaborating professor at the IFT laboratory (Laboratory of Physiology Applied to Physical Education). This person has lived with IFT professionals, patients, and coordinators and is involved with previous research in the Project. It was necessary to exercise the process of reflexivity during fieldwork, as per Beaud and Weber (2007).

Content analysis was chosen to address the reports in the in-depth open interviews and semi-open questionnaires (Bardin, 2011). This type of analysis can build categories based on the following steps: pre-analysis, material exploration, and result treatment. Categorical (or thematic) analysis consists of understanding the nuclei of meanings making up the communicative process in which the frequency of enunciations enables the identification of a structure of symbolic chains constituting discursive regularities.

This study was approved by the Research Ethics Committee at the Pedro Ernesto University Hospital with the following certificate of presentation for Ethical Appraisal (CAAE): 25727419.0.0000.5259.

Results and discussion

This study will develop its results and discussion section based on a category that emerged from the process of analysis: "the triple obligation cycle of the gift of health care" from the perspective of patients with fibromyalgia and IFT professionals below.

The triple obligation cycle of the gift of health care

The act of giving, receiving, and repaying a gift involves a paradox that includes freedom and obligation. First, giving a gift promotes an asymmetrical relationship as it establishes a debt owed by the recipient to the donor. Such a debt provides a repayment of the received gift and involves obligation as nothing is given to any person at any random time or way since the times and forms of the gift are socially instituted. However, exchanges acquire meaning in the spontaneity and freedom of the act. Thus, the triple obligation cycle determines acts as freedom in the movements of giving, receiving, and reciprocating (Caillé, 2002).

It is noteworthy that care understood as a gift means promoting a mediation that distances itself from stereotyped, verticalized, and hospital relationships between healthcare providers and users. It refers to the need to understand that the field of health requires trained professionals' engagement toward effectively establishing the care process with others. Thus, it is understood that the relational perspective of the gift becomes present in the circulation of symbolic exchanges acting in the interactive process with users (Martins, 2011).

Thus, IFT health actions occurred by a displacement toward others based on the act of giving or providing health care gifts, as, for example, in the case below:

> *The first thing I received when I stepped here in the Program was affection. In fact, this was already happening even before I entered on the part of the teacher in charge, she called me several times. I told my daughter! It's not possible, there's a place where the person calls you, who knows your name… I need to meet them. Then, my daughter made the appointment perfectly.* (P1)

What does a simple phone conversation have to do with giving and receiving gifts? Knowing the social situation of patients' families, their clinical evolution, and even the served person's name offer possibilities for entering the circuit of symbolic gifts in which reciprocity acts as an opportunity to generate social bonds.

Based on Moreira (2010), basic aspects in a care relationship are deemed symbolic gifts when they reactivate sociability, rebuild bonds, and reduce distances between healthcare providers and users in socially frayed environments (such as those in which patients with fibromyalgia receive treatment), building social bonds in the care process as gift theory deems reciprocity the foundation of sociability (Lopes, 2021). Reciprocity enables healthcare providers to move toward patients with fibromyalgia and repay (countergift) them at their entry into the IFT actions and services.

Repayments/countergifts occurred as the IFT professional insisted on the importance of admitting patients with fibromyalgia:

> *I couldn't believe it, because of the calls and also because of the affection, how this treatment is… Because if I don't go to the doctor, he doesn't care about me, screw it! She didn't, she stayed with me and continued insisting. I called her and she was writing everything down even on her vacation. Then, she said that the day she was going to come*

> *back she would call me. So, that's how I got here, with the strength she gave me.* (P1)

> *From the initial contact by phone or in person to enroll in the project, offering attentive and respectful listening, solving doubts, and offering guidance bring the person closer to treatment. I think that the seriousness of the service is already perceived from that moment on. The bonds of trust, belonging, security, and respect that are woven in the admission interview also favor admission, adherence, and maintenance of treatment. These bonds are consolidated in an environment of harmony in which joyful and relaxed conviviality encourages participation with pleasure.* (HP1)

These observations show that health care circulates between IFT admission and patients with fibromyalgia as dialogue, attention, and reception. As health care is gifted, received, and reciprocated in the relationships built between healthcare providers and patients with fibromyalgia, it actualizes the triple obligation cycle. The Project deems it a mandatory and free action since something is not given to just anyone; rather, the spontaneity of gestures and dialogues translate reciprocity into sociability, as per Lopes (2021).

Our addressal of a specific situation in a certain micro-reality shows the power of giving-receiving-reciprocating in the IFT. Beyond patients with fibromyalgia, this datum shows how the expanded notion of health can be extrapolated to different realities of "being with" or "being among" professionals and people with other chronic diseases.

It was possible to attest to the frequent affective-therapeutic displacement toward others in physical education classes during body health practices, more precisely during the aerobic exercises teachers proposed in a playful and interactive way:

> *From the beginning, together with the physical education teacher and interns, everyone involved pay attention and show care. If they observe us doing something wrong, they talk to us and correct us or give us another exercise. And as time goes by, they make us more comfortable to come to them and ask a question to work on this autonomy in ourselves.* (P3)

> *The teacher and her care is also passed on to us, especially when we are walking. At that moment, we can talk, we can see each other's concern, ask each other how we're doing, and it doesn't stop here for the project because it extends to the WhatsApp group.* (P4)

During fieldwork, the teacher and patients with fibromyalgia cared for the latter during the physical exercises. The teacher paid attention to the movement or the exercise routine and to how patients felt during the classes. This could be noticed when the teacher asked for feedback on the progress of the activities. It was also possible to notice that, when someone preferred to sit for a while due to fatigue or discomfort, other patients approached them or gathered among themselves to ask if everything was okay.

> *The girls and the teacher noticed that I sat down and came to ask me if everything was okay… I said I just needed to rest my legs. This concern for the other here is constant, everyone cares and wishes well for others… At the time of classes, we also notice when the other is not doing well. It's fantastic.* (P7)

> *when it's time to exercise, if one of us is doing something wrong, the teacher always helps. So, everyone is always watching, I always see that but when I can, I help too.* (P6)

This constitutes a displacement toward others immersed in health care, with gestures, perceptions, and dialogues during challenging moments for patients with fibromyalgia who faced difficulties performing body movements. This initiative circulates symbolic gifts of care to promote the participation of patients with fibromyalgia in the proposed practices. During the exercises, for example, patients reciprocated the received care by expressing needs, tastes, and perceptions since they even asked for playful activities, such as dances (which they generally preferred the most).

Understanding human movement as full of symbolism, aiming at caloric expenditure, the development of motor skills, and the control of risk factors. Such construction of a space conducive and inviting to the participation of patients with fibromyalgia in the health-disease process of the syndrome rests on the relational perspective founded on the exchange of symbolic gifts (Mauss, 2017).

The very structuring of body practices based on dances, relays, and games seems to favor the capacity for affection in those involved, as per Ruiz, Santos, and Gerhardt (2016). In other words, considering that the gift is a reciprocal reality that builds sociability between people and physical education teachers, the developed collective activities (physical exercises) seem to favor the continuity of exchanges. The frequent use of dances supports this understanding due to participants' greater social integration and engagement.

From the classic text by Mauss (2017) to Luz (2005), dances circulate values of care that cultivate the diversity of body forms, alliance between groups, and solidary behavior toward others. The exercise (with body movements free of a certain technical requirement and a perfect biomechanical execution), dialogues, games, improvisations, and creativity provide the construction of a collective body practice based on an alliance to cope with fibromyalgia.

González (2015) states that body health practices should be part of a context that seeks to expand and guarantee care comprehensiveness and subjects' empowerment and autonomy. These practices are part of the challenge of promoting healthier life choices from a reflexive bias that considers subjects and collectivities' forgetfulness.

Therefore, the gift of care circulates in the bodily practices of IFT, functioning as a device of reciprocity and integrality that can create a comfortable and sociable environment for the exercises to be carried out. The symbolic relations of gift exchange require the co-participation of health users in the process, whether in clinical care or in body practices. Health care as a gift only materializes itself when the relational symbolism includes mediations between healthcare providers and service users. It refers to the emergence of care as a device for social bond mediation and production (Cerulli, 2018; Martins, 2011).

It should also be added that the field observations found that patients with fibromyalgia participated in the health care process in their relationships with physical education teachers:

> *I was well received by the physical education teacher. I found feedback from my colleagues and my perspective was met. I thought it would be boring and that everyone would be crying, but that's not it, thank God, because it actually lifts our spirits.* (P4)

> *I needed to have contact with other people because of my head, if it was for the physical pain I might not even come, but more for the emotional (the patient started crying) because I needed to make friends and have contact with other people (P7).*

The theory of gift sees social subjects as active and reflective in the health care process and devoid passive or charitable postures. Thus, on the one hand, the IFT group with patients with fibromyalgia and its multidisciplinary team neither conceives itself as a super-organic whole endowed with homogeneous social cohesion (as per the holistic perspective) nor admits that each member of this group constitutes a kind of incommunicable monad impervious to the symbolic, gestural, linguistic, and affective exchanges established from the first meeting – which would characterize an attitude guided by methodological individualism. Rather, bonds, cohesion, and the subsequent affective and symbolic social support are constituted in the process of triadic exchange characterizing the logic of the gift (Mauss, 2017).

Another datum on (counter)gift that must be highlighted refers to the relationship of mutual affection between healthcare providers and patients with fibromyalgia:

> *We try to create a relationship of partnership and trust between professionals and patients, and we carry out our approach based on the group's problems.* (HP6)

> *The professional needs to relate in an empathetic way with the patient. It is necessary to establish a bond so that they can learn to deal with fibromyalgia, that their participation is fundamental for the success of the treatment and that it is necessary to daily set goals to be overcome, having an active attitude toward life.* (HP5)

The reports show that the relational process between these social actors offers the possibility of thinking about therapeutic strategies that exceed the technical apparatus and the materiality of the biological body in the gift, i.e., the circulation of the gift of care based on attention, dialogue, acceptance, and gestures produces health, citizenship, and solidarity. For Ruiz, Santos, and Gerhardt (2016), the gift of care can be thought precisely in the sense of understanding how healthcare providers and users affect each other in treatment, achieving the triple obligation cycle.

Patients with fibromyalgia seek possibilities for affection, demands for attention, and encounter with others in their therapeutic journey, evincing active postures. Caillé et al. (2019) understand such social actors' movements and demands in the context of the gift of hospitality, in which the search for lasting relationships in the most diverse social and health institutions is part of the triple obligation to give, receive, and reciprocate admissions, greetings, and receptions in the relationships permeating patients with fibromyalgia and healthcare providers.

Thus, one of the most predominant aspects of care could be seen from the perspective of admission:

> *Attention to that for which I'm looking for answer, then treatment, but what I want again is attention! Because if you've sought that treatment, you want to at least be heard. Even if it is not solved at that moment, I want to realize that the person listened to me and will try to help me in some way.* (P3)

> *Reception, active listening, legitimization of suffering, information, and bonding are fundamental structures for the clinic.* (HP9)

> *Observing over these twenty years of the project, I identify as a great demand the search for admission externalized by more than ninety percent of IFT users.* (HP3)

That space produced healthcare providers' reception of the demands, problems, and anxieties of patients with fibromyalgia from an affective acceptance, inaugurating a relationship of care. The gift of hospitality, which includes a plurality of gifts in contemporary times, also presupposes admission as a symbolic gift in the reception and recognition of people in the most diverse health services.

Thus, the testimonies portray the realization of the triple obligation cycle to give, receive, and reciprocate as the act of receiving patients with fibromyalgia refers to give attention, care, and reception. The gift of hospitality becomes fundamental for therapeutic practices as its reception by patients with fibromyalgia includes recognizing and repaying participation in the health-disease and therapeutic process of the syndrome.

This care scenario can be interpreted in the light of Caillé et al. (2019) as admission actions and even certain gestures make it possible to enter the world of others and obtain a social circle. For Tesser and Luz (2018), admission consitutes the beginning of a therapeutic encounter, the moment in which patients demand attention, legitimacy, and resolution of their health problems. It is possible to perceive the approximation between the proposal of healthcare providers and the way people notice and demand the IFT, evincing the importance of therapeutic relationships based on the other, in which the gift fills a significant space in the lives of people with fibromyalgia (Caillé et al., 2019; Pereira, Magri, 2019).

However, it should be noted that this bond of trust between healthcare providers and patients with fibromyalgia was only made effective by the fact that chronic pain was recognized in that space:

> *A LOT OF DISTRUST. People can't understand, they can't measure what you're feeling. You even want to talk but people DON'T BELIEVE YOU, this is my FIGHT.* (P5)

> *I've seen cases of people who even stop participating in social activities because people only criticize. The family only criticizes. They can't work, few understand what is wrong with you.* (P6)

> *The lack of credibility in their complaints, initially by family members, by some health professionals and colleagues/supervisors. Loss of autonomy in the performance of activities of daily living, contributing to low self-esteem and depression. Therefore, the need for affection, empathy, respect, and listening are extremely relevant.* (HP2)

It can be seen that the starting point for initiating or interrupting IFT is primarily established by the recognition of chronic pain. Such trust/distrust between patients with fibromyalgia and others includes (non)engagement to treatment and their social lives, which can be understood as an identitarian form chronically ill people insert themselves in the world. Thus, the project becomes decisive for patients to (re)construct and re-signify their social place with healthcare providers and other users.

Chronic pain due to fibromyalgia can restrain affective relationships and cause withdrawal, social isolation, and self-forgetfulness (Le Breton, 2013), often associated with depressive and anxious behaviors (Pereira, Magri, 2019). Thus, therapeutic relationships require three-dimensional interpretations, linking the social to the subject, the physical, and the psychological dimensions of a person seeking treatment.

It is difficult to determine when the first gift begins because, in a way, the cycle of reciprocity can place donors in the role of recipients and recipients in the role of donors, i.e., the acts of giving and receiving, rather than working mechanically, configure a complex cycle (Cerulli, 2018). In the case of chronic pain, what is perceived is a gift toward other people in the search for recognition without reciprocity, i.e., the person receives feelings that fail to promote acceptance and recognition and worsen pain and depression.

Mistrust and misunderstanding can be interpreted as ways of dealing and interacting with chronic pain as a poison-gift. Mauss (2017) points out the danger in the thing given or transmitted in Germanic languages as the word "gift" supposes two meanings: that of a present to others and the possibility of reciprocity and that of poison. The dictionaries at the time failed to differentiate gift and poison as what was given could develop into danger and become a poison in reality. Thus, it is understood that patients often deal with and receive these gifts as poison, when in fact they demand care, acceptance, and attention.

Finally, there remains the urgent need to point out how people felt when being (un)recognized in a given fibromyalgia condition and what the possible implications were for healthcare providers:

> *An important point is that you don't need to justify your pain, you are in pain, and no one asks for justification. I think that when you are in pain and the person doesn't question you it's healthy.* (P2)

> *You know that people believe in your pain here. You don't need to justify it, this knowledge leads you to credibility, so you don't have to keep proving to the person that you are feeling bad. This welcoming shows us that we will be well taken care of.* (P5)

In the case of the relationships between patients with fibromyalgia and IFT healthcare providers, this dynamic stressed the movements of the gifts of care as a way of perceiving and recognizing chronic pain (gift of recognition). Recognizing others is an asymmetrical movement, one of the necessary requirements for the movement of giving, in which the act of giving is based on the pleasure of loss and on the built relationship. It refers to the importance of imbalance, the need to think one has received more and thus find oneself indebted to others (Ruiz, Santos, Gerhardt, 2016).

Thus, the way healthcare providers perceive patients; recognize their needs and life histories; expresses their presence in attitudes, gestures, and dialogues; and act in health care belong to the most varied examples of how the asymmetry relationship constitutes the theory of gift. It can be said that the IFT renders health care available in the acts of giving, receiving, and reciprocating; affective-therapeutic displacement; admission/acceptance of demands; and recognition of chronic pain.

Final considerations

In summary, it was possible to perceive the relevance of the interdisciplinary perspective and the IFT body health practices as circuits of reciprocity, hospitality, and recognition in which healthcare providers and patients with fibromyalgia exchanged health care gifts. Healthcare providers' encounter with patients with fibromyalgia developed and bet on new ways of socially using and constructing bodies, health, and chronic pain for the most diverse social instances of life. However, it should be noted that the triple obligation cycle of health care gifting goes beyond professional-patient relationships, which is crossed by other instances or segments, such as involvement with family members, social interactions, etc.

Thus, it is suggested that understanding an interdisciplinary treatment for people with fibromyalgia under the aegis of gift theory means seeking the socialization and reciprocity that guarantee social cohesion, quality of life, and well-being. It is argued, therefore, that the gift achieves alliance, reciprocity, and rivalry at very particular times and circumstances, gathering senses of uniqueness between donors and recipients. Thus, it is worth remembering that always finding or seeking the same relationship in health practices means rejecting the theory in question.

Although this study further developed analytically a certain micro-reality, it also points to its theoretical-empirical potential for future investigative ventures on the relation between body, health-disease, and care (especially in extension programs or health services). This study showed that IFT provided new care for the body and health due to the reciprocal bonds established between social actors, in what can be interpreted as a symbolic investment by the Project, patients, and professionals in the way they deal with chronic pain. In other words, betting on the exchange of symbolic goods in interdisciplinary treatment achieved healthier and more legitimate relationships with the body and pain.

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