Sounding the Pain: Exploring a Feminist Group Music Therapy Approach for Women with Contested Chronic Pain Conditions

Ingrid Wissink

A Thesis
in
The Department
of
Creative Arts Therapies

Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts
Concordia University
Montreal, Quebec, Canada

September 2020

© Ingrid Wissink, 2020

CONCORDIA UNIVERSITY

School of Graduate Studies

This is to certify that the thesis prepared

By: Ingrid Wissink

Entitled: Sounding the Pain: Exploring a Feminist Group Music Therapy Approach for Women with Contested Chronic Pain Conditions

and submitted in partial fulfillment of the requirements for the degree of

Master of Arts (Creative Arts Therapies, Music Therapy - Research with Thesis option)

complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

Signed by the final Examining Committee:

______________________________________ Chair
Laurel Young

______________________________________ Examiner
Guylaine Vaillancourt

______________________________________ Examiner
Laurel Young

______________________________________ Supervisor
Charles-Antoine Thibeault

Approved by ______________________________________
Guylaine Vaillancourt, Chair, Department of Creative Arts

SEPTEMBER 8 2020 ______________________________________
Annie Gérrin, Dean, Faculty of Fine Arts

ABSTRACT

Sounding the Pain: A Feminist Group Music Therapy Approach for Women with Contested Chronic Pain Conditions

Ingrid Wissink

There is an identified need for non-pharmacological approaches to address the unique psychosocial needs of women suffering from contested chronic pain conditions. Although music therapy interventions hold potential to address these needs, very little is written about how a music therapy treatment approach might be conceptualized for this population. Therefore, the purpose of this study was to make a case as to why group music therapy realized within a feminist approach is an ideal way to address the unique psychosocial needs of women with contested chronic pain conditions. A philosophical inquiry methodology situated within a feminist intersectional perspective used scholarly literature as the primary source of data to address this purpose. This involved a critical analysis where three overarching concepts contained in the subsidiary research questions were explored, conceptualized, and clarified: (a) unique psychosocial needs of women with contested chronic pain conditions; (b) music therapy interventions that can used to treat the psychosocial components of chronic pain conditions; and (c) advantages of group music therapy realized within a feminist approach for women with contested chronic pain conditions. Cumulatively, the information outlined in these overarching concepts created a cogent argument aimed at answering the purpose (i.e., primary research question) of this study. Limitations of the study as well as implications for music therapy practice, research, and advocacy are presented.

ACKNOWLEDGEMENTS

This thesis would not have been possible without the help of many people whom I would like to acknowledge and thank:

To my advisor, Dr. Laurel Young for your expertise, guidance, and rapid feedback throughout.

To Charles-Antoine Thibeault, who helped me through the first stages of this paper with kindness and open-mindedness.

To my former professor Sandi Curtis for sparking my initial interest in feminist music therapy and for inspiring me with your courage, positivity and devotion to the cause of women's emancipation.

To my friends who were always listened to me, no matter how many times I repeated myself.

To my wonderful mother Anne who supported me throughout and never lost faith in me.

And a special thanks to my late father Ron. You left this world just as I started my research journey, but I felt you with me all along the way. You instilled in me the joy of music in its endlessly fascinating diversity, and I will always carry that with me.

Table of Contents

CHAPTER 1. INTRODUCTION **1**

SIGNIFICANCE AND NEED 1

PERSONAL RELATIONSHIP TO THE TOPIC 3

STATEMENT OF PURPOSE 4

RESEARCH QUESTIONS 4

KEY TERMS 5

CHAPTERS SUMMARY 6

CHAPTER 2. METHODOLOGY **2**

DESIGN 2

MATERIALS 2

DATA COLLECTION 2

DATA ANALYSIS 3

CHAPTER 3: A CRITICAL ANALYSIS OF THE LITERATURE **4**

THE UNIQUE PSYCHOSOCIAL NEEDS OF WOMEN WITH CONTESTED CHRONIC PAIN 4

Developing an Ability to Live with the Pain ***4***

Need for Diagnosis and Professional Guidance 5

The Need for a Sense of Control 7

Need to Care for Self 7

Need to Find Meaning in Their Pain 8

Need for Support, Caring and Connection with Others ***9***

Personal Support 9

Coping with Isolation and Loneliness 10

Caring for Others 11

Need for a Sense of Normalcy ***11***

Avoiding the Sick Role and Reconnecting to the Self 11

RELEVANT GROUP MUSIC THERAPY INTERVENTIONS 14

Developing an Ability to Live with the Pain ***15***

The Need for Diagnosis and Professional Guidance 15

The Need for a Sense of Control 18

The Need to Care for the Self 21

The Need to Find Meaning in Their Pain 22

Need for Support, Caring and Connection with Others ***25***

Personal Support 25

Coping with Isolation and Loneliness 27

Caring for Others ... 29
The Need for a Sense of Normalcy ... ***31***
Avoiding the Sick Role and Reconnecting to a Sense of Self ... 31
REALIZING GROUP MUSIC THERAPY INTERVENTIONS WITHIN A FEMINIST APPROACH ... 35
Centering Empowerment and the Anti-Oppressive Framework ... ***35***
The Importance of Intentional Community ... ***36***
Caring for Others is Caring for Self ... 37
Amplifying Marginalized Voices ... ***38***
Social Transformation and Systemic Change ... 39
CHAPTER 4. DISCUSSION ... **41**
LIMITATIONS ... 41
IMPLICATIONS FOR MUSIC THERAPY PRACTICE ... 42
IMPLICATIONS FOR MUSIC THERAPY RESEARCH ... 43
IMPLICATIONS FOR FEMINIST MUSIC THERAPY ADVOCACY ... 44
REFERENCES ... **45**

Chapter 1. Introduction

Significance and Need

Non-cancer related chronic pain is prevalent in Canada, affecting nearly 20% of adults, and of that group, half have suffered for over 10 years. A third of those suffering for over a decade rated the intensity of their pain as "very severe" (Schopflocher, Taenzer, & Jovey, 2011, p. 445). In the 2017 *Canadian Guideline for Opioids for Chronic Non-Cancer Pain*, Busse reported that impaired functioning due to chronic non-cancer pain is associated with “significant lost work and decreased work effectiveness" (p. 9). The latest *American Federal Pain Research Strategy* (Interagency Pain Research Coordinating Committee, 2017) found that pain severity is also associated with "worsening overall health status” and “greater disability” (p. 2). Due to lost productivity and increased health care expenses, chronic non-cancer pain is associated with substantial taxpayer expense. In Canada, the costs of managing chronic pain, including “direct and indirect expenses, total $43 billion per year.” (Busse, 2017, p. 9). Thus, one can conclude that chronic pain is not only a private, individual problem, but also a public one.

North American physicians frequently treat chronic pain by increasing opioid prescription for chronic pain patients, a risky solution due to the possibility of overdose and the development of substance abuse disorders (Busse, 2017). In a study that examined the relationship between addictions and opioid use, results indicated that chronic pain patients undergoing chronic opioid analgesic therapy may move on to using illicit drugs (Fishbain, Cole, Lewis, Rosomoff, & Rosomoff, 2007). Since 2016, many American states have restricted the legal dosage of opioid prescriptions in response to a guideline published by the Center for Disease Control and Prevention (Davis, Lieberman, Hernandez-Delgado, & Suba, 2019). As Jonas (2017) noted in his editorial *An integrative approach to managing chronic pain can help solve the opioid crisis*:

> Turning off the tap on prescription painkillers will not solve the opioid crisis. More likely, it will just drive it underground - or even increase the use of illegal drugs like heroin. We need to do more, including making integrative health the standard of care. Tackling the opioid crisis will be that much easier if we reduce the legitimate demand for prescription opioids through better pain care, not just fewer pills. (para. 16)

In another initiative toward containing the opioid crisis, the *American Federal Pain Research Strategy* (Interagency Pain Research Coordinating Committee, 2017) included

recommendations for more team-based care, better-educated physicians and the inclusion of evidence-based non-pharmacologic treatments. Furthermore, the use of opioids implies further complications for pregnant women, in which pain management for the mother must be balanced with the needs of her unborn baby (Pritham & Mckay, 2014). Considering the toll of chronic pain on both a private and public level, as well as the lack of evidence supporting long-term opioid therapy, it is important to consider the possibilities of non-pharmacological treatments such as music therapy (Allen, 2013).

Literature also indicates that women report pain more frequently, representing 70% of chronic pain sufferers, and have even been shown to suffer from it more intensely, yet they often end up undiagnosed**,** misdiagnosed**,** or undermedicated for pain (Calderone, 1990; Hoffman & Tarzian, 2003; Smith, 2003, 2011). Women's reported symptoms are far more likely to be interpreted by physicians as psychosomatic (Fillingim, 2017; Smith, 2011; Unruh, 1996). Furthermore, they are more likely to receive prescriptions for sedatives rather than painkillers when reporting pain (Smith, 2011), which may be related to many physicians' discomfort treating "problem patients" (Malterud, 1999, p. 16). whose symptoms have unclear etiology Thus, there is a serious problem of women who suffer physically and emotionally as a result of gendered diagnoses and treatment in the medical system. This effect is compounded for visible minorities (Green, Anderson, Baker, Campbell, & Decker, 2003), as well as a number of other factors such as socioeconomic status, sexual orientation and environment (Baines, 2013). There are also indications that younger women are taken even less seriously in examination rooms, as they are assumed to be in good health because of their age (Bula, 2016).

Furthermore, women living with chronic pain may suffer from a double disconnection from their bodies as a result both of the somatic disassociation caused by chronic pain as well as the disassociation resulting from a *dismembering* enacted by the objectification of the female body in Western consumer culture and the internalization of the outside gaze (Roberts & Waters, 2004). Many women with chronic pain can experience intensified distress as a result of the disconnection from their bodies that is doubly reinforced when they are not considered the experts on their own pain and/or when their personal experience of pain is not believed or treated seriously (Lillrank, 2003; Sylvain & Talbot, 2002). In addition, sufferers of chronic pain conditions who lack diagnostic certainty face poorer pain prognoses as well as higher levels of anxiety, depression and disability (Serbic & Pincus, 2017), leading to a vicious cycle in which

activity engagement is reduced, leading to further discouragement, depression, and pain intensity (Gatchel, 2004). Therefore, as noted by Meana, Cho, and Desmeules (2004), "more comprehensive and gender-sensitive information on pain is needed in Canada so that enhanced interventions can be developed" (p. 187).

Music therapy interventions could play an important role in addressing the psychosocial needs of women who suffer from chronic pain conditions. In a study that examined the use of vocal music therapy techniques with African Americans living with chronic pain, Bradt, Norris, Shim, Gracely, and Gerrity (2016) noted how music therapy can transform underlying emotions and cognitions related to perceptions of pain and its impact on function, quality of life, and identity. Other studies have also shown how music therapy interventions can reduce pain intensity (Allen, 2013) as well as pain related anxiety and depression (Lee, 2016). Further details about these and other relevant studies will be included in Chapter Three.

While the discipline of music therapy has been slow to incorporate feminist practices or women-specific research (Edwards & Hadley, 2007), there has been a growing number of advocates in the last decade publishing work indicating how women experiencing pain can be empowered through music therapy. In a book of essays by prominent music therapists, edited by Hadley (2006) and entitled *Feminist Perspectives in Music Therapy,* a chapter by Bradt (2006), entitled *The Voices of Women Suffering From Pain,* details how guided improvisatory experiences helped clients who were "muted" (p. 295) by their experiences with chronic pain to find their voices once more and adapt to their pain by connecting to it on a physical and emotional level. Furthermore, other publications outline how participation in group music therapy can serve as an empowering experience for women (e.g., Gardstrom, Klemm, & Murphy, 2017) and encourage them to be more active in their own healing processes (Baines, 2013). However, despite the illustrated potential of music therapy intervention for the treatment of chronic pain and its potential facilitate feelings of empowerment and control for women in particular, there is an identified dearth of research on applications of music therapy to address women's health challenges (Dileo, 2016). The present study aimed to make connections among existing scholarly literature to address this identified gap.

Personal Relationship to the Topic

It is relevant to note that while conducting the present inquiry, I served as the music therapy clinician for a university-based research project that was examining the impact of group

music therapy (in a community setting) on the psychosocial needs of isolated men with chronic pain. Furthermore, I have personally experienced chronic pain due to scoliosis and also due to tendonitis which disrupted when my violin performance training and career plans. Similar to what I found in the literature, my individual expressions or complaints of pain that could not be directly seen by others or proven by traditional medical tests tended to solicit skeptical or insensitive responses. These were often followed by unsolicited advice from peers and friends to just "get over it." These experiences motivated my interest in the present study and helped me to conceptualize the results. Although I mostly consider this to be an advantage, the possible limitations that my personal experiences may have inadvertently imposed on the study will be noted in Chapter 4.

Finally, as a person and researcher, I assume a feminist standpoint that acknowledges the historical and ongoing unequal power relationship between men and women. This research seeks not only to answer the research questions but also to instill social change (Brooks, 2007; Curtis, 2007). My standpoint is also intersectional, meaning that oppression can be compounded by the existence of multiple marginalized identities in one individual, for example, a woman of colour who lives with a disability (Curtis, 2016). This perspective implores the researcher to situate themselves in the sociocultural context. To that end, I declare that I am a feminist, cis (gender matches sex assigned at birth) female, white, queer, and of a middle-class background.

Statement of Purpose

In summary, there is an identified need for non-pharmacological approaches to address the unique psychosocial needs of women suffering from contested chronic pain conditions. Although music therapy interventions hold potential to address these needs, very little is written about how a music therapy treatment approach might be conceptualized for this population. Therefore, the purpose of this study was to make a case as to why group music therapy realized within a feminist approach is an ideal way to address the unique psychosocial needs of women with contested chronic pain conditions.

Research Questions

The main question of this study was: Why is group music therapy realized within a feminist approach an ideal way to address the unique psychosocial needs of women with contested chronic pain conditions?

Subsidiary questions included:

- According to the literature, what are the unique psychosocial needs of women with contested chronic pain conditions?
- What is known about how music therapy interventions can be used to treat the psychosocial components of contested chronic pain conditions?
- What are the specific advantages of group music therapy realized within a feminist approach for the targeted population?

A philosophical inquiry methodology that used scholarly literature as the primary source of data was used to answer these questions. Specific methodological procedures will be presented in Chapter 2.

Key Terms

The term *psychosocial* is defined by the *American Psychological Association* as "the intersection and interaction of social, cultural, and environmental influences on the mind and behavior" ("Psychosocial", 2018). Psychosocial factors that protect individuals, (e.g., social supports), are thought to mediate the "effects of social structural factors on individual health outcomes" (Martikainen, Bartley, & Lahelma, 2002). *Contested chronic pain conditions* refer to illnesses with uncertain aetiologies, their status as legitimate illnesses are "highly controversial," their medical, legal, and cultural classifications are "disputed" and treatment protocols are "ambiguous" (Swoboda, 2005, p. 234). Common contested chronic pain conditions experienced by women include fibromyalgia, rheumatoid arthritis, endometriosis, multiple sclerosis, and chronic fatigue, amongst others (Hart, 2014). *Music therapy* involves the safe and ethical use of music by a credentialed music therapist to "address human needs within cognitive, communicative, emotional, musical, physical, social, and spiritual domains… within a therapeutic relationship" ("About Music Therapy", 2020). Within the context of this study *interventions* are considered as intentional actions executed for the purpose of treatment and/or psychosocial health promotion and fall under four main types of music experience: improvisational, re-creative, compositional, and receptive (Bruscia, 2014). *Group music therapy* involves the use of goal-oriented music therapy interventions with groups generally containing no more than 8-10 participants (Yinger, 2018). *Feminist music therapy* incorporates music therapy practices within a philosophical framework that acknowledges the individual within the context of societal power structures and their impact on the individual, and aims to empower the individual to challenge these inequities (Curtis, 1996, 2012). An intersectional stance is implicit

in a feminist music therapy approach, meaning that it recognizes that various markers of social location such as gender, ethnocultural identity, socioeconomic status, sexual orientation, age, and ability are factors that complicate and compound experiences of oppression (Curtis, 2016). Feminist research is grounded in women's perspectives and aims to be "transformative" (Lewis, 2015, p. 26). In the present study, the term *women* includes trans women, as the feminist ideal of inclusiveness is prioritized in this inquiry.

Chapters Summary

This introductory chapter outlined the significance and need for the present study, as well as its purpose and research questions. Chapter 2 describes the methodology used and Chapter 3 contains a critical analysis of the literature in response to the research questions. Chapter 4 discusses the implications of the results in regard to future music therapy practice, research and advocacy and presents limitations of the present inquiry.

Chapter 2. Methodology

The current chapter outlines how a philosophical inquiry methodology was conceptualized within the context of the present inquiry.

Design

This study assumed the form of a philosophical inquiry to answer the research questions and propose the main argument. In a chapter on philosophical inquiry, Stige and Strand (2016) cite Deleuze and Guattari (1991) who defined philosophy in opposition to the Anglo-American/analytical school, arguing that philosophical inquiry can represent a force for change.

> Philosophy's most important task is not to clarify existing concepts but to develop and propose new concepts that can give novel perspectives on the world and open up fresh planes of action… philosophy is therefore a creative enterprise that should be in close contact with social and political reality. For example, new concepts can make it easier to discover discrimination, injustice, or suffering that so far has been difficult to put into words and therefore difficult to notice. (Stige & Strand, 2016, Chapter 64, Philosophy and Controversy, para. 3).

Given that this study was situated within a feminist intersectional perspective (defined in Chapter 1) and that its main purpose was to make a case as to why group music therapy is an ideal (and innovative) way to address the unique psychosocial needs of women with contested chronic pain conditions, philosophical inquiry was deemed as the most suitable methodology. Epistemologically, the knowledge obtained via this research represents an integration of theoretical and practical information that cumulatively form a foundation upon which to further develop a new approach to music therapy practice (Aigen, 2005).

Materials

This study had no participants. Scholarly literature published in English within the last 15 years served as the primary source of data. This was organized on an Excel spreadsheet according to concepts contained in the subsidiary research questions. I maintained a literature search log as well as a personal journal to record thoughts and ideas that emerged throughout the research process. All of these materials were stored on my personal password protected computer.

Data Collection

The following databases were searched for relevant literature: ERIC, PsychInfo, Google Scholar, Medline, ProQuest, and the Concordia University library database, Clues. Search terms included: chronic pain, women, music therapy, resource-oriented music therapy, feminist therapy, feminist music therapy, empowerment and therapy, strength-based counselling, medical model, and music therapy approaches. I also reviewed music therapy journals: *Music Therapy Perspectives, Journal of Music Therapy (U.S.), Canadian Journal of Music Therapy, British Journal of Music Therapy, Voices: A World Forum for Music Therapy, Music Therapy Today*, and the *Nordic Journal of Music Therapy*. Publications published within the last 15 years (after 2003) were prioritized. One PhD dissertation, five book chapters, and 55 journal articles were included in the data analysis.

Data Analysis

Relevant literature was organized on an Excel spreadsheet according to concepts contained in the three subsidiary research questions. These concepts included: (a) unique psychosocial needs of women with contested chronic pain conditions; (b) music therapy interventions that may be used to treat these needs (i.e., the psychosocial components of chronic pain conditions within the targeted population or related populations; and (c) potential advantages of group music therapy realized within a feminist approach for women with contested chronic pain conditions. Each one of these concepts was then clarified by organizing related evidence extracted from the literature and conceptualizing it within a feminist theoretical framework. Thoughts and ideas from my personal journal helped to guide how I organized and synthesized the evidence and this also helped me to identify and/or evaluate assumptions contained in the literature (Aigen, 2005). Cumulatively, this information created a strong case as to why group music therapy realized within a feminist approach is an ideal way to address the unique psychosocial needs of women with contested chronic pain conditions. It is important to note that trustworthiness of the present inquiry was addressed through regular academic advisement with my thesis supervisors throughout the data collection and analysis processes.

Chapter 3: A Critical Analysis of the Literature

The purpose of the present chapter is to clarify three overarching concepts contained in the research questions and create an argument as to why group music therapy is an ideal way to address the unique psychosocial needs of women with contested chronic pain conditions: These concepts are: (a) unique psychosocial needs of women with contested chronic pain conditions; (b) music therapy interventions that can used to treat the psychosocial components of chronic pain conditions; and (c) advantages of group music therapy realized within a feminist approach for women with contested chronic pain conditions. The chapter will culminate with a closing argument/summary, to help synthesize and strengthen connections among the presented concepts.

The Unique Psychosocial Needs of Women with Contested Chronic Pain

Surprisingly, there has been scant research investigating women's measured and perceived experiences of chronic pain. However, Icelandic nursing researchers Sigridur Halldorsdottir and Hafdis Skuladottir have conducted several qualitative studies examining the particular challenges of women living with chronic pain (Halldorsdottir, 1996, 1999, 2000; Skuladottir, 2000; Skuladottir & Halldorsdottir, 2008, 2011). In their 2011 inquiry, they identified 12 categories of self-reported needs, which were organized into 3 clusters: (a) the "quest to learn to live with the pain", (b) the "quest for support, caring and connection," and (c) the "quest for normalcy" (p. 84), all corresponding to the desire for well-being across "physical, mental, emotional and social" domains (p. 89). My review of the literature indicated that these clusters generally aligned with the perspectives and results of other relevant scholarly writings. In order to account for ideas contained in all of the relevant literature and to clearly align this information with my research questions I have reconceptualized Skuladottir & Halldorsdottir's (2011) three *quests* to into three more general and all-encompassing categories: developing an ability to live with the pain, need for support, caring, and connection with others; and need for a sense of normalcy.

Developing an Ability to Live with the Pain

As women living with chronic pain usually cannot experience full relief from this pain, they need to develop individualized strategies that will help them to live with their pain in constructive and healthy ways, thus helping them to fulfil their personal potential for quality of life (LaChapelle, Lavoie, & Boudreau, 2008; Skuladottir & Halldorsdottir, 2011). My review of

the literature indicates that these strategies can be organized into four subcategories: (a) need for diagnosis and professional guidance, (b) need for a sense of control, (c) need to care for self, and (d) need to find meaning in the pain.

Need for Diagnosis and Professional Guidance. An initial step in developing an ability to live with the pain is for women living with contested chronic pain conditions (CCPC) to have their pain reports taken seriously by health professionals (MacDonald, 2008; Malterud, 1999; Sylvain & Talbot, 2002). Unfortunately, literature indicates that the pain complaints of women with CCPC are often met with skepticism and rejection (Malterud, 1998; Pryma, 2017; Skuladottir & Halldorsdottir, 2008, 2011; Sylvain & Talbot, 2002) and they may even struggle to obtain a preliminary appointment (Lillrank, 2003). Assumptions about women and their bodies are based on historically sexist attitudes (Weitz, 2013) and can interfere in the assessment process, where women's reports of pain are interpreted as a psychological or emotional issue, rather than a physiological one (Armentor, 2017; Barker, 2005; Malterud, 1999; Sylvain & Talbot, 2002) which may subsequently lead them to be labelled as *hysterical* or *hypochondriacal* (Lillrank, 2003; Werner & Malterud, 2003). Literature indicates that some physicians ignore biopsychosocial models of pain that show the impact of several internal and external domains of human experience on vulnerability to pain and the pain experience itself (Gatchel, 2004; Trout, 2004). Furthermore, women of colour face additional challenges, being dismissed as opioid chasers or opportunistic "welfare queens" (Pryma, 2017, p. 68). In order to help women accept and live with CCPC, health professionals must first and foremost believe and respect the subjective reports of these women's experiences of pain (McCaffery & Moss, 1968; Pasero, 2018).

Once belief and acceptance on the part of health professionals is established, the next step is to work toward obtaining an official diagnosis, which the literature clearly indicates is strongly desired by women with CCPC (Lillrank, 2003; Sylvain & Talbot, 2002). A medical diagnosis assigns a name, and therefore gives meaning to one's suffering, and legitimizes their pain experience (Kenny & Faunce, 2004; Skuladottir & Halldorsdottir, 2011; Swoboda, 2005). Furthermore, this may lead to better management in the healthcare system (Malterud, 1998) and may open up access to treatment options, disability insurance, or other crucial financial supports which in turn may help women with CCPC to live with less pain or lower pain intensity (Gatchel, 2004; Lillrank, 2003; Pryma, 2017; Skuladottir & Halldorsdottir, 2011). This

progression further enables psychological coping as their condition becomes more *real* and therefore easier to face (LaChapelle et al., 2008), potentially reducing the risk of developing associated depression (Honkasalo, 1999). However, it important to note that persons who are diagnosed with fibromyalgia (FM), a disorder accompanied by unpredictable musculoskeletal pain as well as problems with insomnia, fatigue, memory and mood (Sylvain & Talbot, 2002), may continue to face challenges even after a diagnosis. The condition's etiology remains unclear and therefore its legitimacy as a condition continues to be questioned (Trout, 2004), thereby making it more challenging to obtain crucial governmental supports (Pryma, 2017). Nonetheless, naming the pain in this instance can still enable persons with CCPC to begin the process of accepting their pain and learning to live with it. Professional validation of illness can furthermore help women with CCPC integrate their condition into their sense of identity and restore their "social status as ordinary citizens" (Lillrank, 2003, p. 1053).

Women with CCPC have also expressed the desire for more support, constructive communication and advice (i.e., professional guidance) from health professionals regarding diagnosis, treatment, and best practices for self-management (Pryma, 2017; Skuladottir & Halldorsdottir, 2011). Literature indicates that doctor-patient communication is frequently brief and characterized by conflict (Kenny & Faunce, 2004: Swoboda, 2005). Yet, good communication between doctors and patients can be empowering for patients and lead to more active coping solutions (Kenny & Faunce, 2004; Sylvain & Talbot; 2002). Information sharing can also "establish hopeful yet realistic expectations" and prevent the urge to waste time consulting multiple doctors in search of a "cure" (Meana, Cho, & DesMeules, 2004, p. 17).

The professional guidance offered may also depend on the diagnosis. For example, in a study conducted by LaChapelle et al. (2008) that analyzed focus group data from 45 women with arthritis and fibromyalgia, the 20 participants with a diagnosis of arthritis indicated that they felt more or less satisfied by the level of support received. In contrast, the seven participants with fibromyalgia surveyed in Sylvain and Talbot (2002) reported a sharp drop-off in professional support following diagnosis, causing them to feel abandoned and left to their own devices. Fibromyalgia is a far more misunderstood condition and is considered a diagnosis of exclusion (Pryma, 2017). Persons with fibromyalgia might therefore have additional need for the professional caring and guidance that is commonly denied to them (Trout, 2004).

Finally, the literature shows that obtaining professional guidance (i.e., knowledge) and support can be another important step not only toward developing an ability to *live with* the pain, but also the perception that one has *control over* it (Lillrank, 2003; Skuladottir & Halldorsdottir, 2011). As the next section shows, perceiving a lack of control over pain is a key cause of women's distress and discomfort.

The Need for a Sense of Control. In the literature, women with CCPC describe their experience as a chaotic, disorienting and unpredictable struggle characterized by loss of ability (Bullington et al., 2003; Hovey, Khayat, & Feig, 2017). Furthermore, feelings of disempowerment can be magnified in women with CCPC, many of whom struggle to be taken seriously (Lillrank, 2003; Malterud, 1998; Skuladottir & Halldorsdottir, 2008; Werner & Malterud, 2003). Feeling a sense of control may help these women to live with their pain in more constructive ways.

Paradoxically, finding a sense of control requires accepting the unpredictability of the pain (Bradt, 2006), although obtaining a diagnosis and professional guidance can also help, as previously discussed. Sylvain and Talbot (2002) found that participating in the decision-making process regarding one's own care improved one's sense of control, and various authors have suggested that healthcare professionals consider a partnership approach to treatment planning in order to foster patient empowerment (Kenny & Faunce, 2004; MacDonald, 2008; Sylvain & Talbot, 2002). Although some chronic pain patients want to be equal partners in managing their own care, or to move toward self-care, some would rather not bear this level of responsibility. Sylvain & Talbot (2002) found that some individuals "simply long to be recognized as human beings who, at times, are overwhelmed by their situation and (as indicated in the first subcategory) need the expertise and skills of a professional to guide them in their progression towards health" (p. 270). It may be the case that these individuals feel that things are more under control when a trusted professional is leading the way. Regardless of how it is manifested, women living with CCPC need to experience a sense of control in order to feel empowered and/or supported in developing an ability to live with their pain.

Need to Care for Self. As women often assume the role of caregiver to others, they may deprioritize their own needs, and women with contested chronic pain conditions are no exception (Shakhshir, 2008). Women with CCPC can manage their pain by learning to care for themselves. For participants in Skuladottir and Halldorsdottir (2011) study, caring for themselves meant

respecting their own limits by setting boundaries, which helped to keep their pain tolerable. For some women, self-care activities that are often labelled as alternative or complementary, such as such as relaxation exercise, positive leisure distractions, social support, and cognitive coping strategies can be helpful and in fact, the literature indicates that women are more likely than men to pursue active self-care strategies like these (Berkley, 1997; Hoffman & Tarzian, 2001; Unruh, 1996, 1997; Vingrhoets & Van Heck, 1990). Some women with CCPC subscribe to cognitive behavioural approaches which encourage them to observe and transform their emotional reactions to pain in order to reinforce psychological coping techniques such as acceptance and mindfulness (Sullivan et al., 2005). Some women may turn toward their own instincts when biomedical treatment and/or professional guidance have failed or are lacking. Participants in Swoboda's (2006) study which included 18 American women who self-identified as having had Chronic Fatigue Syndrome (CFS), Fibromyalgia (FM), Multiple Chemical Sensitivities (MCS), and Gulf War Syndrome (GWS) for at least five years, described how they adapted to their uncertain illness status by turning toward an "embodied practical knowledge of illness-management," using techniques such as bodily attunement to prevent pain triggers (p. 85). Active self-care strategies can also reinforce a sense of control, as mobilizing individual resources can lead to an increased sense of empowerment (Werner et al., 2003), thus contributing to women's ability to live with their pain.

Need to Find Meaning in Their Pain. Obtaining a diagnosis, while helpful, does not adequately describe or respond to the full spectrum of individuals' experience of pain both in terms of cause and effect. For example, in the case of fibromyalgia, a diagnosis can still represent an uncertain, "empty promise" that "fails to provide definitive answers or confer meaning" (Boulton, 2019, p. 809). Furthermore, denial of women's pain complaints represents a phenomenon in which the "continuation of inaccurate mind–body dichotomies…nullifie[s] their subjective experience" (Lillrank, 2003, p. 1053). The brief and narrowly focused nature of traditional physician consultation may obscure key factors in understanding pain. For example, in Malterud's (1998) study that examined the experiences of 20 women with unexplained pain symptoms, 11 out of the 20 female participants suspected their pain was due in part to years of stress from enduring frequent domestic violence, yet this subject was not explored or addressed in medical contexts. Women with CCPC may also need to explore the meaning of their lived experience of pain outside of the boundaries of biomedical structures in order to more deeply

understand their struggles with pain and explore their stories of suffering (Bullington et al., 2003; Swoboda, 2005). Here, they may embark on a "parallel search for meaning and explanation, involving a process of narrative reconstruction" (Bendelow & Williams, 1995, p. 99). Finding meaningful ways to connect the dots of their pain experience can allow women with CCPC to recover a sense of order and create a personal narrative of complex suffering, which in turn can help them understand and heighten their ability to live with their particular pain experience (Malterud, 1998).

Need for Support, Caring and Connection with Others

An initial step to supporting women in chronic pain is to believe them (as noted above), which in turn can pave the way to receiving further support, caring and connection with others. Chronic pain can be an isolating experience, as it can be hard for outsiders who have not had this experience to truly understand what it is like (Pryma, 2017). Research shows that as their experience of pain is often questioned by others, women with contested chronic pain conditions can often feel disconnected from or even rejected by others, including family, friends, and medical professionals (Lillrank, 2003). Even supportive allies may not truly recognize the extent of their suffering (Pryma, 2017; Swoboda, 2005). From a psychosocial perspective, the need for support, caring and connection falls under the innate human need for love, belongingness, and community (Baumeister & Leary, 1995; Maslow, 1968) My review of the literature revealed that this overarching category can be organized into three subcategories: (a) personal support, (b) coping with isolation and loneliness, and (c) caring for others.

Personal Support. The women in Skuladottir and Halldorsdottir's (2011) study indicated that they needed "someone close who cares" (p. 81) and connection with others in order to cope and help them navigate the psychosocial impact of pain. Women are more likely than men to turn to social support as a means of coping (Shakhshir, 2008), although many women with CCPC still find authentic support to be scarce (Pryma, 2017). Many women struggle with social stigma when they are accused of cheating the system, which can engender a self-imposed social exile (Goffman, 1963; Malterud, 2003). Women are more prone to psychological stress as a result of managing multiple caretaking roles (Spitzer, 2005; U.S. Department of Health and Human Services, 2017) and may need to set boundaries and seek out support in order to respect their own limits and address their needs (Skuladottir & Halldorsdottir, 2008).

Participants in Skuladottir & Halldorsdottir's (2011) study also named the need for *practical* personal support in terms of domestic help from live-in partners, such as childcare and household management, to reduce strain, allow more time for healing, and reduce the risk of work disability (Unruh, 1996). It is known that women tend to do more housework than men, and many women who suffer from chronic pain and illnesses speak of having to undertake a *second shift* comprised of domestic duties in addition to their paid work (Frejka, Goldscheider, & Lappegård, 2018; Moss & Dyck, 1996;) For this reason, spousal support constituted a fundamental pillar of Sylvain and Talbot's (2002) consensus-based nursing intervention model for women living with fibromyalgia. They observed that their participants were able to "move on with their lives...when the various sources of help pulled together towards the same goal" (p. 267). Finally, Skuladottir and Halldorsdottir (2011) discovered the imperative for families to reorganize around the needs of loved ones living with chronic pain, and while this is challenging, it represented a positive and perhaps needed opportunity for growth in family relations. Women with CCPC need personal support as a means of fostering their rehabilitation within loving and supportive relationships.

Coping with Isolation and Loneliness. Women living with CCPC need to retain social connections as their world is changed by pain. Chronic pain patients often become isolated as their ability and energy to participate in various social activities naturally becomes more restricted (Hovey, Khayat, & Feig, 2017; Pryma, 2017). Many women with CCPC end up losing various social supports as their pain is questioned by friends (Armentor, 2017; Lillrank, 2003; Swoboda, 2005) and even family members (Pryma, 2017). Thus, for some, the disbelief or stigma attached to a contested condition can also result in either externally or internally imposed social exile (Lillrank, 2003; Werner & Malterud, 2003). This "banishment from the human community" (Swoboda, 2005, p. 81) can be quite troubling, as women are especially concerned by interpersonal stressors that relate to or negatively affect their relationships (Davis, Matthews, & Twamley, 1999; Zautra, Johnson, & Davis, 2005). Individually or cumulatively, these factors make pain a fundamentally solitary experience (Frank, 1995) which can negatively impact one's personal and social identity (Goffman, 1963; Malterud, 2003).

However, women with CCPC can create new alliances by creating an intentional community with like-minded others. For example, Swoboda (2006) started an advocacy group for women suffering from similar pain conditions and challenges. Participants indicated that this

group fulfilled their need for belongingness and empowerment, as well as their need to take care of others, which will be discussed in the next subcategory.

Caring for Others. Participants in Skuladottir and Halldorsdottir's (2011) study discussed the personal importance they ascribed to continuing to care for others. They cited this as a crucial pillar of their social well-being and identity, feeling that they needed to "someone to care for" just as much as "someone close who cares" (p. 86). Generally, women with CCPC want to fulfill their roles as friends, wives, and mothers (Malterud, 1998; Pryma, 2017; Unruh, 1996) and contribute to the world. However, as previously mentioned, an excessive drive to take care of others can worsen pain intensity and disability (Unruh, 1996), either by physical strain from performing the bulk of domestic work (Shakhshir, 2008; Skuladottir & Halldorsdottir, 2011; Spitzer, 2005) or from the emotional stress of trying (Malterud, 1998; Pryma, 2017). Finding the right balance is crucial, as caring for others is a fulfilling aspect of the need for connection and belongingness in this population, representing an important component to consider in their rehabilitation.

Need for a Sense of Normalcy

The last of Skuladottir & Halldorsdottir's (2011) three 'quests' encompasses the need for a sense of normalcy in daily life. In the present study, the name of the category was slightly adjusted in order to integrate perspectives from other literature and to align with the wording of the research questions. According to Skuladottir and Halldorsdottir (2011) the need for a sense of normalcy stems the need to feel socially 'normal' and participate in regular life, even as their lives have been changed by the pain. Concepts identified by Skuladottir and Halldorsdottir (2011) will be combined into one subcategory and used to organize relevant literature: avoiding the sick role and reconnecting to personal strengths.

Avoiding the Sick Role and Reconnecting to the Self. The 'sick role' describes a phenomenon in which societal norms dictate what being sick should look like and what behaviours are socially acceptable for the ill (Kasl & Cobb,1966; Parsons, 1951). This phenomenon can be intensified for women, whose bodies and behaviours have frequently been the object of public scrutiny (Weitz, 2013; Whitehead, 2006). Women in chronic pain may feel the need to avoid the sick role in order to maintain a sense of normalcy, dignity, and personhood. These individuals may experience stress and stigma if they further challenge the sick role, for example, by not getting better fast enough or by defying medical expectations for diagnosis. In

Skuladottir and Halldorsdottir's (2011) study, participants related the need to avoid the sick role as a means to maintain a sense of dignity, as to them, this role implies the undesirable position of victim. Similarly, the women with chronic unexplained muscular pain in Werner et al. (2004) felt compelled to perform an image of strength, in part by attempting to distance themselves from stigmatized images of the "crazy, lazy…weak," woman (p. 1043). However, attempts to maintain dignity, for example by wearing makeup or attempting to fulfil expectations of domestic work and childcare (Johansson et al., 1999) can backfire, as they can be misperceived as too pretty (Skuladottir & Halldorsdottir, 2011) or too functional (Johansson et al., 1999) to be disabled. By avoiding the sick role and the appearance of victimhood through demonstrating strength in one way or another, many women with CCPC attempt to access the sense of dignity and personhood that they enjoyed in their pre-pain lives (Skuladottir & Halldorsdottir, 2011).

In turning away from the constraints and performativity imposed by sick role. expectations, women with CCPC also demonstrate the need to reconnect to an authentic sense of self and identity outside of illness, even as they learn to accept the imposition of often lifelong conditions (Bullington et al., 2003; Skuladottir & Halldorsdottir, 2011; Swoboda, 2005). They can experience multiple threats to their sense of identity and individuality as they face changes in physical capabilities, personal and professional role loss, and frequently depersonalizing experiences in clinics and hospitals. Depersonalization and disempowerment can ensue over time as the ill person is frequently reduced to a set of symptoms and dysfunction within the medical model (Hovey, Khayat, & Feig, 2017; Jackson, 2000; Kenny & Faunce, 2004), and this demoralization can result in rigidity in affect, behavior, and self-concept (Bullington et al., 2003; Crombez, 2012). For some, fulfilling their regular tasks corresponding to their roles as wives and mothers constitutes part of their identity as a woman, and experience guilt when their pain inhibits them for fulfilling these roles. Furthermore, since women with CCPC frequently have their reports of pain and disability doubted by others, and their psychological state questioned, they may begin to doubt their own self-knowledge and sense of reality, causing psychological turmoil (Lillrank, 2003; Werner, 2004). Thus, many women with CCPC feel the need to reconnect to a sense of personal identity and self-knowledge in personally meaningful ways in order to maintain a sense of normalcy (Kenny & Faunce, 2004; Swoboda, 2005).

Women living with CCPC can also maintain dignity and reconnect to a sense of personal identity by rediscovering personal strengths, or by discovering new ones. In addition, positive

morale can be improved or maintained when persons with chronic conditions achieve a sense of independence through relying on personal strengths, as when the women in Skuladottir and Halldorsdottir (2011) named traits such as “serenity” or “optimism” and the “desire for achievement” as crucial to coping ability and positive morale (p. 87). Similarly, the women with fibromyalgia in Risdon et al.’s study named personal, spiritual resolve as an important path to pain acceptance. The validation of these strengths by a helping professional can be a powerful experience (Carniol, 2003; MacDonald, 2008).Furthermore, validating strengths through participating in familiar or valuable activities can improve physical and psychosocial well-being (Gatchel, 2004; Serbic & Pincus, 2014), lead to empowerment and increased self-management of pain (LaChapelle, Lavoie, & Boudreau, 2008), and help build reserves of positive affect that reduce the emotional impact of especially bad pain days (Zautra et al., 2005).

However, the impositions of pain and disability may make engaging in regular activities more difficult and it may be necessary for women with CCPC to create a “new life pattern” that balances their limitations while allowing for growth in self-concept (Skuladottir & Halldorsdottir, 2011, p. 88). Therefore, reconnecting to the self involves focusing on what they can now achieve despite the pain (LaChapelle et al., 2008), which requires acceptance as well as self-knowledge of limitations and strengths. In this way, women with CCPC may seek to find new outlets for social connection and validation outside of gendered expectations and illness narratives (Sylvain & Talbot, 2002; Swoboda, 2005). Therefore, it may be necessary to channel strengths into new outlets or discover new strengths in novel activities in order to experience the self-efficacy they may have previously only attained via professional or personal roles. For example, a group of women with various CCPC in Swoboda (2005) found new roles as “truth-tellers” by starting a healthcare advocacy group for women with similar pain challenges, leading to “new forms of identity and service” (p. 84). Finally, women with CCPC can experience a sense of normalcy and dignity by relying on and validating her personal strengths, as they are demonstrated through psychological resilience or valued activities. However, they may need to reconceptualize what normal looks like in a life lived with an oft-incurable chronic illness, and seek out new roles and outlets for meaning, self-efficacy and identity-building. In this way she may accept a relationship with pain even as she seeks to integrate markers of identity and personhood that lie outside of illness.

Finally, it is important to note that all of the categories and subcategories above are linked to this final category (Need for a Sense of Normalcy) as each woman's identified needs in context determines how she learn to cope with her chronic pain and realize the full potential of living her own uniquely defined normal life.

Relevant Group Music Therapy Interventions

Literature indicates that music therapy interventions can be used to address psychosocial needs associated with CCPS. This paper takes the position that group music therapy interventions are particularly useful or effective because music therapy provides a variety of means by which women with CCPC can address and explore familiar and unfamiliar coping strategies associated with the multifaceted impacts of chronic pain. The purpose of this section is to integrate relevant findings and perspectives from the literature and make clear connections between the unique psychosocial needs outlined above and specific group music therapy interventions that may be used to address these needs.

Generally, as a certain type of service, music therapy can be utilized to meet goals such as the reduction of perceived pain, anxiety and depression, as well as to enhance mood enhancement and improve overall quality of life (Allen, 2013; Bradt et al., 2011; Hanser, 2013; Kamioka et al., 2014; Lee, 2016; Magill, 2001). Alternatively, music therapy can guide participants toward deeper emotional exploration and facilitate insight on conscious or unconscious conflicts that may contribute to their perceptions, and acceptance of, pain (Ahonen-Eerikainen, 2002). Music therapists, whether intentionally or unintentionally, act within various service parameters simultaneously as a function of the complexity of interactive musical engagement (Allen, 2013; Dileo, 2007).

As noted in Chapter 1, music therapy methods can be organized into four broad categories: receptive, recreative, improvisational and compositional—each one containing multiple variations (Bruscia, 2014). Receptive methods involve experiences where the client listens to live or recorded music and responds to the experience silently, verbally, or in another modality, such as artmaking or movement (Bruscia, 2014). Improvisational methods involve spontaneous, unscripted music-making using voice, instruments, and/or other sounds, in which clients participate directly (Bruscia, 2014). These improvisations may be based on a theme (referential) or remain open (Dimaio, 2010). In recreative methods, clients learn, sing, play, or perform (i.e., recreate) familiar or pre-composed music using their voice and/or instruments

(Bruscia, 2014). In compositional methods, clients create their own musical products, such as songs, lyrics, or instrumental melodies (Bruscia, 2014). Within all these methods, each having myriad variations, the music therapist provides whatever support is needed in the moment to help clients engage in music experiences targeting musical or non-musical therapeutic goals.

In the following sections, connections are made between the unique psychosocial needs of women with contested chronic pain conditions and variations of the four main music therapy methods that may be used to address these needs.

Developing an Ability to Live with the Pain

Group music therapy interventions can help women living with CCPC to explore ways to accept their conditions and learn to cope with physical and psychological pain using approaches that are unique to music therapy, as well as reinforce recommended approaches to pain management from other modalities, such as cognitive behavioral therapies (Espí-López, 2016) or psychotherapeutic approaches (Tuinmann, 2017).

The Need for Diagnosis and Professional Guidance. While music therapists cannot provide a medical diagnosis, they may validate the subjective pain experience of an individual, or even a group as a whole, by taking participants' pain reports seriously and using their personal experiences as a starting point for therapy (Kwan, 2010). Music therapists can establish trust from the start of intervention with women with CCPC by using holistic assessment methods. While medical music therapy approaches may involve measuring individual pain levels as part of the initial assessment, music therapists working on psychosocial treatment goals with this population can bypass this tactic in order to avoid replicating participants' frustrating experiences of rejection and denial in traditional medical environments (Pryma, 2017). Kwan's study (2010) of music therapists working with women in chronic pain found that a pain assessment bypassing numerical pain scales was a "validating component of the treatment process" (p. 63), and they further described using a "non-judgmental stance…and not imposing any expectation…to the relationship until it had been developed" (p. 53). This approach was described as a crucial means to building trust with women with CCPC, who typically experience a significant amount of adversity and conflict in encounters with health professionals (Kenny, 2004). Music therapists conduct their own assessments over several domains (e.g., cognitive, physical, musical, emotional and social) in order to gain an understanding of the whole person and create personalized individual or group goals, or both (Allen, 2013; Bruscia, 2014).

Furthermore, music therapists can provide professional guidance on how women with CCPC can use music to address their unique psychosocial needs. The music therapy group format offers the opportunity for knowledge-sharing between therapist and group members, and between the group members themselves, where the therapist can help reinforce various coping strategies using both music-based interventions and verbal processing techniques (Bradt et al., 2016; Torres et al., 2018).

Receptive Interventions. While there is very little music therapy literature examining women with CCPC in particular, literature shows chronic pain of varying etiology is frequently treated using receptive music therapy interventions (Bruscia, 2000), especially in oncology (Allen, 2013; Bradt et al., 2011; Stark, 2012) and palliative care (Aldridge, 2003; Groen, 2007). Music therapists use their professional judgement in order to guide participants toward healing and greater well-being (Allen, 2013) and by structuring receptive interventions based on participants' personal preferences and needs (Allen, 2013). Fundamentally, the music therapist offers support and guidance as a function of a carefully constructed therapeutic alliance based on trust, caring, and empathy (Bruscia, 2014; DiMaio, 2010). From this empathetic point of view, the music therapist, can guide participants toward inner exploration, self-generated insights, and healing using interventions that are carefully selected based on participant needs and preferences (Kwan, 2010; DiMaio, 2010). This responds to the expressed need of women with CCPC for greater trust, caring, and communication from professionals (Skuladottir & Halldorsdottir, 2011). Receptive interventions can also be approached from a psychoeducational perspective, where the therapist offers practical guidance on coping with pain challenges in addition to the information sharing between participants (Torres et al., 2018).

Receptive interventions consist of music listening, relaxation, meditation and music and imagery activities and are frequently paired with a discussion component (Bruscia, 2014). In music and imagery (MI) interventions, the participant is led through a short relaxation induction and invited to explore mental imagery freely while listening to recorded or live improvised music (Grocke & Wigram, 2006). If providing live improvised music, the therapist can adjust their playing to reflect or highlight particular themes or moods (Allen, 2013). This technique focusses on the role of music, as opposed to the verbal guidance of the therapist, to transform mood states, relax the body and stimulate imagery. Music and imagery (MI) interventions do not require specialized certification on the part of the leader, whereas Guided Imagery and Music (GIM) is a

form of psychotherapeutic intervention requiring specialized training on the part of the guide (Grocke & Wigram, 2006). The Bonny Method of GIM (BMGIM) is the original form of GIM in which the therapist makes selections within structured sets of classical music that are grouped based on various psychosocial themes and selected in the moment by the therapist according to participant goals and needs (Bonny, 2000). Musical selections carefully chosen for various stages of the process may enhance the production and intensity of personally generated imagery (Burns, 2001; Sanfi & Christensen, 2017). These sessions include a preliminary discussion in order to determine relevant topics or themes to explore, induction into a deeply relaxed or altered state of consciousness, guided imaging to music, return to normal alertness, and a post-imaging discussion where the participants can reflect on the images or associations generated and make relevant connections to their daily lives (Warja & Bonde, 2014). Participants may also be invited to draw mandalas in order to explore any symbolism generated during the session. The combination of relaxation, verbal guidance from the therapist and the careful selection of relevant music is used to maximize the sensory, emotive, reminiscent and transformative possibilities in the participant while targeting emotional, existential and spiritual needs (Allen, 2013). Emotionally intense experiences, such as those encountered during GIM sessions, can increase motivation to participate in a variety of pain coping strategies (Staats, 1986; Staats & Eifert, 1990). These experiences can promote the development and use of personal coping methods, enhancing participants' ability to accept and live with oft-incurable pain (Hanser, 2010; Potvin et al., 2015). In Dileo's "transformational" level of music therapy pain treatment, the person "enters into the pain or dialogues with the pain, intending to form a relationship" with it (Sanfi & Christensen, 2017, p. 240).

Improvisational Interventions. The music therapist can also validate and guide women with CCPC using group improvisational experiences. Music therapists are trained to facilitate improvisational experiences that musically support participants in such a way that they feel able to express or explore their suffering without judgement (Thompson et al., 2017). Improvisational activities can be structured around a theme, mood or feeling or revolve around more abstract concepts such as "sounding the unsayable" (Rykov, 2008, p. 193) in referential improvisation, or participants may be encouraged to play freely without a theme (non-referential). In Bradt's (2016) study on 55 men and women with various chronic pain conditions, free vocal music therapy techniques such as toning helped participants gain control over their own pain

perception. In toning exercises, participants are encouraged to sing using only vowel sounds unbound by rhythmic structure. Using this intervention, Bradt guided participants to use their voices to locate pain, helping them to find those vocal tones that resonated in the most affected areas and to actively soothe these sensations. Toning was especially effective for those whose pain had not changed much over time and was seemingly *stuck* inside of them.

The Need for a Sense of Control. Literature indicates that a variety of group music therapy interventions can help individuals to feel a sense of control over their lives and how they perceive and manage their pain (Allen, 2013; Mitchell & MacDonald, 2006). The need for a sense of control is a crucial goal in the treatment of women with CCPC, who are often overwhelmed by disempowering experiences in many spheres of their lives following the onset of pain and disability. Since the music therapist prioritizes client engagement within a collaborative and trusting therapeutic relationship, intervention goals are most often set in partnership with the participant, promoting a sense of control and empowerment at the onset of the relationship (Baines, 2003; Dileo, 2016).

Receptive Interventions. Receptive interventions can foster a sense of control in participants in a number of ways. On a practical level, music therapists can afford a sense of control by inviting participants to choose the musical material used in listening sessions (Baines, 2003; Bradt et al., 2011, 2015; Koenig et al., 2013; Siedlecki, 2005). Bradt et al. (2015) concluded that familiar music can provide a crucial sense of security in her review of music therapy with cancer populations, since “self-selected music presents predictable musical and emotional content and may therefore provide a much-needed holding environment for the patient” (p. 1269). Participant-selected music provides a feeling of safety from which to explore difficult emotions, providing a powerful basis for emotional exploration during music and imagery interventions (Bonde, 2005; Heiderscheit & Jackson, 2018; McKinney & Honig, 2016; Torres et al., 2018). Receptive music therapy interventions can help participants to access inner resources and resilience, leading to enhanced feelings of control over pain (Allen, 2010).

Music therapists also combine listening experiences with movement activities in order to foster a sense of empowerment via attunement to the body. Torres (2015) described using a group music and imagery (GrpMI) method in order to increase pain acceptance, amongst other goals, in eight women with fibromyalgia by helping them learn to “integrate and understand messages from the body” (p. 269). Participants enhanced their sense of bodily awareness as they

attuned to inner sensation, memories, and deeply held tensions while in a state of altered consciousness during the intervention, comprising a powerful group experience. Thompson et al. (2017) also used group movement and music activities with a group of women in various stages of breast cancer treatment in order to afford a sense of control while interacting with others in different roles. Participants engaged in a "mirroring" activity, in which partners take turns leading while the other mirrors their partner's movements, affording a sense of control to the leader (p. 325).

Improvisational Interventions. Group music improvisation represents a powerful experience of agency affording a sense of control to group members (Curtis & York, 2015; Rykov, 2008) during a time of little control due to the limitations imposed by chronic pain. Participants experience empowerment within improvisational experiences by making artistic choices, for example by choosing which instrument to play, when to play and when to listen, and the volume, tempo or speed of the sounds used (Meadows & Wimpenny, 2017). Improvisational experiences are structured for participant success by the music therapist, who provides personal and musical support in such a way that the musical end product is generally satisfying and aesthetic, no matter how the participants choose to express themselves (Aldridge, 2003; Bruscia, 2014). Reflecting on their experience in post-improvisation discussions, participants can reach insights on their own behaviours and choices, thus becoming the agent of their own transformations (Ahonen-Eerikainen, 2002) and avoiding the sense of passivity or dependency that can stem from relying on medical intervention to fix the pain (Lawendowski & Bieleninik, 2017; Meadows & Wimpenny, 2017). Bullington et al. (2003) attributed their participants' growth to the creation of new experiences in music and movement therapy, which replaced feelings of uncertainty and chaos as a result of the disruptive impacts of pain on their lives. These experiences can bolster participants' self-esteem and sense of self-efficacy, culminating in a sense of agency, as they enjoy the product of both their personal engagement with creativity and productive collaboration with others (Rykov, 2006, 2008; Thompson et al., 2017). Creating music in the presence of others taking similar creative risks is powerful, as "in the face of existential uncertainty, [it] is experienced as affirmation that fosters resilience and empowerment" (Rykov, 2006, p. 194). Finally, the group can achieve a rare and powerful sense of flow as they becomes engaged and synchronized within the act of communal creation (Hanser, 2013; Rykov, 2006, 2008; Thompson et al., 2017).

Recreative Interventions. The use of familiar music within recreative music therapy experiences can enhance a sense of control in participants, as they interact with familiar and meaningful material that valorizes previous experience and connections to the music. As Young (2009) wrote, people with no prior musical experience or skill can experience feelings of self-efficacy while participating in song recreation with in therapeutic group singing activities. In Baines (2003), members of a community mental health group took further control within the therapeutic process by creating their own songbook of selections with personal significance corresponding to a wide variety of psychosocial needs, resulting in a much-needed sense of empowerment for an isolated population. Singing familiar songs can also disable individuals' learned defense mechanisms, as participants' preferred music can heighten emotional connection and increase vulnerability (Baker & Uhlig, 2011; Bradt et al., 2015), thus increasing the potential for deeper emotional exploration, acceptance and control over the pain.

Compositional Interventions. While no research on song-writing interventions with women with CCPC was found, song-writing interventions are used in other therapeutic contexts to increase self-esteem and provide opportunities for decision-making individually and as a group (Anderson, 2012; Baker et al., 2008). Baker (2005) described how the act of self-expression via song writing can comprise an empowering "emotion-focused coping strategy that allows clients opportunities to verbalize and thereby acknowledge situations that they are not necessarily able to control" (p. 117). The music therapist may also offer compositional interventions in order to help participants to deconstruct "irrational belief systems" inhibiting pain acceptance and begin to change their perceptions (Dileo, 2007, p. 533). Through compositional methods, clients can enhance the understanding and acceptance of their pain experience as they voice their experiences and insights in musical or lyrical creations (Baker, 2009; Dileo & Magill, 2005). Options for song-writing interventions can include word substitution, adding verses to existing songs, and original song compositions, and group members can collectively make decisions about elements of the composition including lyrical content, tempo, musical key, and tone (Anderson, 2012; Baker, 2005). Songwriting also offers opportunities to express difficult, painful feelings that are not generally available in everyday social exchanges (Baker, 2005). For example, a group of women with various types of cancer in Tobias et al (1999) wrote lyrics illustrating both "positive and negative aspects" of the multiple changes that their illness imposed on their lives (p. 119) as a means of catharsis. Finally, making

recordings of the songs composed in session can provide "evidence of creativity and mastery" (Thompson et al., 2017, p. 324) for the group, creating a lasting memento of their experiences of agency and success in group songwriting.

The Need to Care for the Self. Various publications indicate how music therapy interventions may be used as a form of self-nurturance in sessions as well as an independent self-care strategy. The natural appeal self-selected music (Bradt, 2016) can result in increased motivation to employ music as an independent self-care strategy (as guided by the music therapist), a coping method which carries no social stigma as opposed to the use of painkillers (Dileo, 2007). In the group setting, participants can share musical materials and practices in order to maximize the benefits of music-based self-care in independent use at home (Batt-Rawden & Tellnes, 2011).

Receptive Interventions. In group music and imagery interventions, participants can practice self-regulation skills to help distract them from pain and replace negative thoughts or feelings with positive ones. Participants in Thompson et al. (2017) described using images and visualization skills developed within group music therapy experiences as they were undergoing medical interventions for breast cancer, and Curtis & York (2015) described how the use of music and imagery was effective as a form of self-nurture for a group of women survivors of domestic abuse. These aesthetic experiences offer the opportunity to disconnect from the pain and experience beauty in its place (Aldridge, 2003; Shakhshir, 2008). Music therapists can also reinforce the understanding and use of breathing and muscle relaxation exercises as part of self-care practices (Bradt, 2016; DeNora, 2005), as well as aid in the creation and recording of personalized playlists that reflect the listener's preferences and needs (Dimaio, 2010; Summer, 2009, 2015). The combination of music with other treatment modalities, such as mindfulness, increases motivation to maintain other healthy self-care practices (Batt-Rawden & Tellnes, 2011).

Receptive interventions can also be used to help persons with chronic pain to become more independent in their coping strategies (Allen, 2013; Bradt et al., 2016; Dileo, 2007). The literature emphasized the importance of encouraging an active patient role in healing and the self-management of chronic pain symptoms, with listening to music frequently identified as an effective coping method (Baker, 2010; Crone et al., 2013; Midcalf, 2017). Participants in several studies learned how they might use music independently as a coping mechanism, to induce

relaxation and comfort (Hanser et al., 2006; Lawendowski & Bieleninik, 2017; Shakhshir, 2008) and to attain a sense of peace (Bradt et al., 2016). In this way, participants can enact self-monitoring rituals in their use of music at home in order to examine their own reactions to the music and discover potential trigger points (Batt-Rawden et al., 2005).

Improvisational Interventions. Active music therapy experiences can also be a stepping-off point for participants to explore the possibilities of using music for themselves, by themselves (Hanser et al., 2006; Young & Pringle, 2018), thus experiencing a sense of control and empowerment in the context of pain and uncertainty (Potvin et al., 2015). Bradt et al. (2016) recorded songs learned in weekly sessions and vocal improvisation guides to CDs to enable adult music therapy participants to transfer these interventions to their daily lives to practice at home. In this study, Bradt et al. (2016) promoted the self-regulation of stress and pain in participants by humming or toning, techniques that encourage deep, mindful breathing. Participants learned to "use music more purposively to enhance breathing, release stress, and manage pain" (Bradt, 2016, p. 202). The participation of others in the group normalized the use of such novel experiences, and members were motivated by the positive feelings of others. Bradt concluded that these gains in self-efficacy, self-respect, motivation, and empowerment might transfer into increased motivation for other treatment components, such as other therapies or strategies to care of themselves. She also employed a psychoeducational approach to pain management by instructing or reminding participants of self-healing strategies such as breathing, vocal work and relaxation techniques. Improvisational activities, as with other methods, provide an opportunity for women with CCPC to act as the agents of their own healing. Learning to care for oneself is a crucial step toward empowering self-reliance and a sense of independence (Allen, 2013) in women who have been disappointed by traditional sources of medical help.

The Need to Find Meaning in Their Pain. The group music therapy setting represents a space in which participants can experience a sense of meaning while sharing oneself with others (Aldridge, 2003) as a counter to the senseless pain and chaos of chronic pain (Rykov, 2006, 2008). The aesthetic power and profound non-verbal expression facilitated by musical experiences can facilitate the exploration of difficult feelings, helping participants to perceive various emotional triggers of physical pain and make connections between their life experiences and their illness experiences (Bullington et al., 2003). Finally, group music therapy can offer opportunities to transcend the pain and experience aesthetic beauty, as the presence of the group

creates the potential for powerful, shared emotional experiences (Ahonen-Eerikainen, 2002; Allen, 2010; Baines, 2003; Bradt et al., 2016; Thompson et al., 2017). The safety of the therapeutic relationship holds the space for these experiences (Bruscia, 2014; Kwan, 2010), enhanced by the witnessing of understanding peers (Bradt, 2016; Rykov, 2008).

Receptive Interventions. Group GIM interventions can be an effective means to find an individual sense of meaning and purpose (Allen, 2013; Grocke & Moe, 2015) for those whose lives have been torn apart by illness and disability. As previously described, the element of transcendence demonstrates the possibility to engage in experiences focussed on beauty as opposed to pathology and sensory experiences outside of pain (Aldridge, 2003). Furthermore, sharing music and imagery experiences with others can enhance the emotional salience of the experience (Ahonen-Eerikainen, 2002), which has been associated with experiences of catharsis (Brown et al., 1989; Kenny & Faunce, 2004). These experiences were rejuvenating to exhausted women living with breast cancer in Thompson (2017). The transcendental potential of group (music and imagery) interventions to elevate experience beyond the mundane "facilitates the process of connecting to that which is spiritually significant for the patient" (Aldridge, 2003, para. 2), transcending daily life and existential suffering. Music therapy can "promote reminiscence" (Allen, 2010, p. 9), allowing participants to get in touch with powerful memories and associations, and engage with the therapeutic process on a deeper level, revealing potential triggers of physical and emotional pain. During the postlude discussion portion of the GIM experiences in Torres et al. (2018), exchanges within the group helped women with fibromyalgia to understand their personal relationship with their symptoms as they explored the associations generated during the imaging, similar to the healing trajectories of individuals with chronic pain elaborated in Sanfi and Christensen (2017).

Through dynamic group interaction, participants can construct narratives connecting their experiences of suffering, which promotes a deeper understanding of their relationship to the pain and its triggers (Bonde, 2005). Ahonen-Eerikainen (2002) describes how group members further co-created a matrix of meaning within a psychoanalytical music therapy framework, as they examined how the images or symbols created either in listening experiences or using other artistic media revealed various projections, transference, and shared unconscious concerns.

Improvisational Interventions. Improvised activities create space for emotional exploration and catharsis as a result of profound, meaningful self-expression (Bradt, 2006),

Rykov, 2006, 2008). Through improvisational methods, participants sound their pain, using various expressive parameters in order to reflect psychological states that may be difficult to articulate verbally (Bruscia, 2014; Meadows & Wimpenny, 2017). The freedom of improvisational experiences offer opportunities to share narratives or express the emotional impact of life experiences in ways that may have been previously inaccessible to participants or seemingly inappropriate for everyday social exchanges (Ahonen-Eerikainen, 2002). Co-created explorations of mood states, thoughts and emotions can provoke thoughtful engagement with the past, allowing participants to connect the dots in their lives and integrate changes based on insights gained (Ahonen-Eerikainen, 2002; Bullington et al., 2003) as they are witnessed by others (Stark, 2012). Allen (2013) noted that the freedom of improvisation is particularly appropriate for clients who need to dig deeper into a sensation or feeling in order to process it and confront internal tensions that may contribute to their pain. Furthermore, instrumental exchanges within groups can offer opportunities for meaningful communication unbounded by any constraints of language (Rykov, 2008; Kwan, 2010) and the externalization of visceral emotions in front of understanding witnesses was described as liberating by participants in Rykov (2008).

Instrumental and vocal improvisation also offer opportunities for catharsis, releasing deeply held emotion or tension that may influence anxiety and pain perception (Bradt, 2006). Toning represents a powerful means to connect with pain on a physical and emotional level, since the natural resonance and vibration created in the body from singing has powerful potential to liberate deeply held emotion (Austin, 2008). Vocal interventions such as toning and melodic improvisations, can be structured around the idea of the primal scream, promoting the release of deeply held tension (Bradt, 2006; Dileo, 2013; Kwan, 2010).

Recreative Interventions. Recreative interventions can permit powerful experiences in which familiar music can connect individuals and groups to a sense of transcendence, as well as to themselves, in meaningful ways. Music is strongly connected to the limbic system, and thus familiar music has strong associations with memory, pleasure, and narrative (Wilkins et al., 2014). Creating familiar or preferred music in a group may resonate with different members of the group in different ways, yet still unite the group through the spirit of performance and communion in song (Jones, 2006). When an individual member of the group chooses a song for the group to sing, it can result in a deep sense of being understood (Amir, 2012), in feelings of

catharsis and well-being (Kenny & Faunce, 2004), as well as feeling connected to the greater whole (Rykov, 2006, 2008; Thompson et al., 2017). Therapeutic singing groups and music therapy support groups are frequently used with persons living with cancer who have psychosocial needs similar to those of women with CCPC (Rykov, 2008) and for persons who find themselves needing to adjust to multiple physical and personal challenges. Recreating familiar music connects participants to a sense of personal meaning and self-understanding, as well as an opportunity to transcend illness in order to share joy with understanding others.

Compositional Interventions. Song-writing is a powerful technique that can tell the story of one's life, as well as explore and express a range of emotions (Baker, 2005) related to pain triggers, as participants convert their thoughts and emotions into lyrics or melodies addressing various aspects of pain, including emotional, social, and spiritual components (Allen, 2013; Saunders et al., 1995). An overview of individual song-writing interventions by Baker (2005) showed that lyric writing was an important outlet for self-expression and meaning making for a group of men and women recovering adjusting to changes in their lives caused by traumatic brain injuries (TBI). Similar to women living with CCPC, those with TBI need to cope with, and plan for, a future lived with a disability. The process brought forth challenging, repressed thoughts and emotions to light, helping participants process them and help construct an inner narrative that validated their lived experiences. Their songs expressed memories, reflections, insights on dealing with adversity, concern for the future, and imagery or spiritual themes. In verbally processing the song-writing experience with a music therapist, participants can gain insights into their creative choices and reflect on their meanings (Allen, 2013).

Need for Support, Caring and Connection with Others

Since decreases in social support are associated with increases in loneliness and isolation, as previously described, participation in regularly scheduled music therapy group is an ideal format for preserving or enhancing psychosocial well-being in women with CCPC. In this format, participants find themselves regularly surrounded by others who are experiencing similar illness trajectories and understand the seriousness of each other's conditions (Thompson et al., 2017).

Personal Support. Group music therapy interventions can be utilized to provide personal support within a group music therapy context, providing a supportive atmosphere that encourages both verbal and non-verbal forms of expression (Allen, 2008c; Bailey, 1984; Rykov,

2006). While the need for personal support from romantic partners or friends cannot be replaced, the need for "someone close who cares," (Skuladottir & Halldorsdottir (2011, p. 84), could be met in part by both the music therapist and the group (Bradt et al., 2016). The music therapist is trained to develop empathetic, caring and trusting relationships with their participants, both on the individual and group level (Bruscia, 2014). Thus, music therapists can act as a form of personal support who create the therapeutic space for individuals to express themselves freely together, carefully monitoring individual well-being while considering the functioning of the group (Ahonen-Eerikainen, 2002; Lawendowski & Bieleninik, 2017). Furthermore, interaction between group participants generates dynamic energy, connecting people living with similar challenges and facilitating supportive exchanges.

Receptive Interventions. Receptive interventions are used to facilitate supportive exchanges between group members, for example, as sparked by post-imaging discussions (Torres, 2015). Participants can experience a feeling of support within the music therapy group that they may not encounter elsewhere (Stark, 2012). Allen (2010) used a group music psychotherapy approach in order to facilitate **supportive** exchanges between women living with breast cancer, drawing on Spira & Reed's (2003) psychotherapeutic ideals for that population, where participants learned to accept **support** and to share and grow in the company of understanding others. Ahonen-Eerikainen (2002) noted this growth in some participants in her group-analytic MI program, as group members provided vital context to the participants' struggles with previously unconscious material that emerged during imaging or postludes.

The growth made within these receptive music therapy experiences can also enhance participants' personal relationships and improve the level of personal support available to them outside of the music therapy group (Thompson, 2017). As personal relationships with significant others and important memories are evoked by emotional or memory-inducing musical selections in receptive experiences, participants also generate associations or images that symbolize these relationships and can work through issues using visualization, amongst other techniques (Thompson et al., 2017; Torres et al., 2015). In group discussion and post-MI verbal processing, participants can also practice communicative skills such as requesting and receiving support (Koenig et al., 2013) as well as setting boundaries (Torres, 2015). Finally, receptive interventions can also be used to support and connect participants with their family and caregivers in the moment, when significant others are invited to listening sessions to enjoy mutually enjoyable or significant musical selections together (O'Callaghan & Magill, 2016; Thompson et al., 2017).

Improvisational Interventions. Group improvisation interventions provide other opportunities to experience support in "creative and meaningful ways" (Bradt et al., 2016, p.

184; see also Allen, 2008, 2010; Stark, 2012). Group members can offer feelings of support to others as they support each other's musical exploration and bravery (Rykov, 2008). The communion of the group enhances the ability to fully engage in these experiences: a participant in Rykov (2008) described the importance of group bonding on disinhibition and emotional exploration, finding it "easier to talk about your fears once you've bonded through the music" (p. 195). Ahonen-Eerikainen's (2002) analysis of the group improvisation process found that it operates on several levels: within each individual's internal world, in terms of the interaction between group members, and within the group as a whole, with the music acting as a mediating agent. Individuals can experience a sense of caring support, for example, as they play a solo while being musically supported by members of the group, who might reduce the volume of their playing or repeat motifs in order to highlight the playing of the soloist (Ahonen-Eerikainen, 2002; Gardstrom et al., 2017). This sense of support can transfer to everyday life, as when a participant in Rykov (2008) described how the encouragement offered by the music therapy group left her feeling motivated in everyday challenges. As described previously, these experiences can be seen as a metaphor for communication in personal relationships and can be practiced or developed within group improvisational experiences (Koenig et al., 2013; Stark, 2012). Literature also showed improved communication skills as a function of group improvisation experiences (Baines, 2003; Kamioka et al., 2014; Koenig et al., 2013; Torres et al., 2018).

Coping with Isolation and Loneliness. Literature indicates how particular group music therapy interventions can help persons suffering from chronic pain feel less isolated or alone. Group music therapy creates a community around musical enjoyment, fostering a sense of togetherness in the moment while reducing social isolation in the longer term (Bradt, 2016; DeNora, 2005; Dimaio, 2019; Thompson, 2017; Young & Pringle, 2018). Interaction between participants in a group generates dynamic energy, connecting people living with similar challenges (Ahonen-Eerikainen, 2002; Thompson et al., 2017). Thus, women with CCPC can fight isolation and by engaging in regular, motivating social activities such as group music therapy (Bradt et al., 2016; Torres et al., 2018).

Improvisational Interventions. Collective improvisational music-making can provide an appealing and supportive outlet for isolated individuals to join in musical experimentation, reduce feelings of isolation, and experience shared joy (Bradt et al., 2016, Torres, 2018; Rykov,

2008). This social enjoyment can motivate individuals to re-emerge from their isolation: participants in Bradt et al. (2016) reported an increased desire for social engagement following engagement in group music therapy, including improvisational experiences, as they reconnected to the "joy of being with others" (p. 198) through vocal improvisation. Improvisation also represents a powerful to share emotion that may be otherwise inexpressible (Stark, 2012), giving participants the opportunity to generate insights and move through repressed problems. A participant in Ahonen-Eerikainen's (2002) study reported feeling less alone after sharing new reflections on his fear of risk-taking and conflict in relationships during a post-group improvisation discussion. The discussion was spurred by an intra-group conflict during the improvisation which conjured traumatic childhood memories of the participant hiding from his parents as they fought. Group discussions, centred around the multiple elements of shared musical experiences, can help participants to deconstruct these automatic self-defence mechanisms and explore alternatives, either verbally or non-verbally in the safety of the supportive therapeutic space (Meadows & Wimpenny, 2017). Participants across the literature reported experiencing a profound sense of universality (Gardstrom et al., 2017), connectedness (Rykov, 2008) and sense of belonging (Bradt et al., 2016) while engaging in musicmaking with others that "taps into a whole realm of perception and communication that is often neglected" (Rykov, 2008, p. 194). Gardstrom et al. (2017) discussed the impact of a sense of universal experience in group music therapy for women recovering from substance abuse, as commiserating and experimenting with peers reduced their perception that they were "unique in their disease and that no one can understand, relate to, or help them (p. 348).

Recreative Interventions. Recreative interventions, as previously mentioned, provide a pleasurable way to create community and increase social participation in women with CCPC (Bradt, 2006, Bradt et al., 2016). Participants in group recreative experiences can find safety and celebrate commonalities in musical taste and experience, connected by passionate interest as opposed to their diagnoses or similar conditions (Baines, 2003; Thompson et al., 2017). Participants in Baines's study (2003) not only found solidarity within their community singing group, but also participated more in the community at large post-treatment, rallying around music activities such as concerts, jam sessions, and more. They were surprised by their ability to socialize after long periods of isolation, discovering more about group members and connecting on a deeper basis. They also found it much easier to develop singing skills together rather than

alone (Baines, 2003). Whether the music is performed in public or not, the act of recreating beloved or significant songs together promotes a strong sense of community (Baines 2003; Bradt et al., 2016; Thompson et al., 2017), and a non-judgemental atmosphere promotes profound group bonding (Rykov, 2008).

Compositional Interventions. Group song writing interventions can unite members around the common purpose of creating a piece of music that corresponds to the experience of individual group members, as well as the group as a whole, reducing feelings of isolation (Baker, 2005; Lawendowski & Bieleninik, 2017; Thompson et al., 2017). Frankl (1984) noted that the idea of a collective goal or group *work*, in this case songwriting, has a powerful bonding effect that increases feelings of social connection and meaningfulness. The 18 clinically depressed, HIV-positive participants in Cordobes' study (1997) formed distinct intra-group relationships through writing songs together over a three-day-period at an adult day care centre. The song writing process also allowed the group to express their emotional reactions to their social isolation, providing a safe outlet for difficult emotions such as anger and frustration. Cordobes (1997) concluded that the song writing intervention represented an efficient use of participants' time, as the natural appeal of music quickly pulls people together and the communal goal of songwriting creates further bonding and self-expression, especially between those with common struggles and goals. Collective compositional experiences can culminate in recordings of participant-created songs, thus serving as a collective record of the "therapeutic journey" (Thompson et al., 2017, p. 324) as well as a transitional object after terminating therapy (O'Callaghan & McDermott, 2004).

Caring for Others. Participants in group music therapy treatment can care for others within the musical context, an important strategy to improve wellbeing in isolated individuals (Torres et al., 2018) whose personal relationships have been disrupted as a result of their illness. The intentional community created by those choosing to participate in group music therapy contains great power for healing and a "playful, aesthetic context…conducive to building trust, empathy and intimacy" (Rykov, 2008, p. 198). Participants can also share musical recommendations with each other, for example their own preferred coping music, as a form of interconnected support (Thompson et al., 2017).

Receptive Interventions. Group receptive experiences can be structured to facilitate caring exchanges between members, often using metaphor and symbolic imagery to drive

discussion (Stark, 2012). Ahonen-Eerikainen (2002) used a blend of non-verbal and verbal interventions to enhance group connection on various levels, drawing on a psychoanalytic approach. Her group music and imagery experiences combined modalities such as clay sculpture, in combination with listening to music, where participants were first able to project difficult emotion onto the clay objects in order to determine that the expression of such emotions was acceptable to the group. At that point, they felt comfortable discussing them verbally with each other. Similarly, the women struggling with breast cancer in Thompson et al. (2017) took time to validated the difficult emotions expressed by others, allowing space for individual expression within the group. The intensity of music and imagery experiences can permit quick bonding between group members (Sanfi & Christensen, 2017).

Improvisational Interventions. Music therapy group participants can explore ways to support other group members on a musical level in improvisational experiences, which translates into a feeling of mutual support (Dimaio, 2019; Thompson et al., 2017). Caring for others can be considered one of the major mechanisms of therapeutic change in participants. Gardstrom et al. (2017) identified altruism as one of seven major themes that emerged from the authors' thematic analysis of interviews with participants. For example, one participant gave up her chance to select preferred music in order to allow another group member to hear and sing her favourite song. Another offered to provide support and advice during off-group times to a fellow group member, and another helped a group member learn an instrumental line in order to help her participate in group activities. Finally, group members may relate, encourage, and advise each other either in song or in post-improvisation discussions (Bradt et al., 2016; Gardstrom et al., 2017; Rykov, 2008). In Bradt et al. (2016), group members named salient concepts common to all in song, which were repeated in spontaneous musical call-and-response games.

Recreative Interventions. In group recreative interventions, familiar songs represent an excellent opportunity to express support to others using lyrical or musical material to structure these exchanges. Participants can communicate a sense of feeling "cared about in the music" (Dimaio, 2019, p. 5) as they identify with lyrics sung aloud by the group. After becoming more familiar with each other in the singing group, participants in Baines (2003) offered support to peers and learned to manage interpersonal conflict within various decision-making processes surrounding the performance of music, increasing their sense of connectedness and bonding. While they sometimes fought over musical choices, they learned to resolve these differences in

order to unite toward a common goal of performing in the community. Participants learned to be patient when others requested particular songs or interventions that would respond to their current emotional status and needs through the medium of personally significant songs.

The Need for a Sense of Normalcy

Although some music therapy interventions are conceptualized within a more prescriptive, medical approach focussed on symptom reduction, there are others that focus on identifying and developing each individual's inherent potentials as integral to therapy (Rolvsjord & Halstead, 2013). One could argue that this resource-oriented approach could help persons to feel more connected to their authentic sense of self, which in turn helps them to feel more grounded in their normal, everyday lives. In feeling more connected to personal strengths, women living with CCPC may once again experience a sense of dignity, normalcy, and personhood.

Avoiding the Sick Role and Reconnecting to a Sense of Self. Women with CCPC can reconnect to a sense of authentic self-concept, as well as explore different forms of identity outside of the sick role, through participation in aesthetic, creative group music therapy experiences in the company of understanding peers (Thompson et al., 2017). Music therapy interventions offered within a strength-based perspective offer the opportunity for revitalization following pathologizing experiences around illness, as well as the opportunity to transform self-concept from incapable to capable (Magee, 2002).

Receptive Interventions. Receptive interventions can provide a variety of opportunities for participants to maintain dignity, reconnect a sense of identity and strength, and experiment with visions for the future in the company of understanding peers (Aldridge, 2003; Allen, 2010; Thompson, 2017). Experiences in which participants select music representing their life story in order to share with the group represent a meaningful way to assert their identity in the presence of others. Amir (2012) described an empowering group music listening intervention called *musical presentation*, in which participants carefully choose and present a selection of songs that are personally meaningful to them, that connect to significant moments in their lives, or that represent their self-concept, creating a musical collage representing their identity. This could also be considered as a compositional intervention. These recordings are shared with the group, where the presenter discusses the importance of the material and members discuss their impressions of the music, its meaning, and its relation to the presenter. In this way, presenters

struggling with visible or invisible illnesses can experience a sense of personhood, wholeness and dignity while being *seen* by the group (Amir, 2012).

Music and imagery interventions also represent opportunities to discover or acknowledge inner strengths and resources, as well as neglected or forgotten aspects of self-image and identity (Allen, 2010; Lawendowski & Bieleninik, 2017). During the final dialogue portion of music and imagery experiences, therapists may reinforce the strengths and resources demonstrated by group members as a means to help them integrate a sense of empowerment and self-knowledge (Torres, 2015, Torres et al., 2018). In Allen's (2010) experimental comparison of a cognitive behavioral-based support group with a music psychotherapy group on the self-concept of breast cancer survivors, participants re-integrated aspects of self-image that were suppressed within the illness experience, finding sources of "inner beauty" while reflecting on the symbolic meaning of the images they generated (p. 50). The support of others in the group helped strengthen individual self-esteem, contributing to the consolidation of self-concept and identity. She describes how several group members progressed from a feeling of being "stuck" in themselves, to exploring multiple aspects of self; "allowing other aspects of self in" and reclaiming previous aspects of their lives; to having the "courage to explore new opportunities" (p. 50). Fundamentally, she observed group members' integration of their illness into their self-concept, yet without being defined by their condition, a crucial step toward pain acceptance (Kranz et al., 2010). Group GIM experiences were found to improve social well-being (Allen, 2010) and social self-concept, a measure of positive self-image in relation to others (Clark & McKinney, 2013).

Furthermore**.** women with CCPC can explore and integrate new identities, dreams, and fantasies within the imaginative space offered by group music and imagery experiences, where associations made during the active listening portions can be discussed in detail within the safety of the therapeutic relationship and the supportive group (Ahonen-Eerikainen, 2002; Larson, 1995; Lawendowski & Bieleninik, 2017). In these types of interventions, group members can learn about themselves both through the music selection process and the group discussion, bringing new light to their own reflections. Hearing others voice similar concerns can also shed new light on aspects of personal identity (Torres, 2015).

Improvisational Interventions. Improvisational experiences offer opportunities to explore aspects of self and connect with valued personal strengths as well as experiment with new elements of self-image (Allen, 2010). Meadows and Wimpenny (2017) determined that, in

some cases, the musical processes in improvisational experiences were "understood as psychological processes, wherein the music was a "symbolic carrier of meaning" (p. 181). Within the supportive, structured space of the group music therapy format, participants can surprise themselves in their abilities to make valuable contributions: while the women in Thompson et al. (2017) felt challenged by some of the group activities, they later recounted that they appreciated the opportunity to confront their own fears. In this way, group improvisational experiences can reconnect with, or discover, personal strengths. These benefits can be transferred onto perspectives and behaviours in everyday life and relationships. Within the group, participants can experiment with different roles such as musical leader or supporter in collaborative improvisations (Ahonen-Eerikainen, 2002; Dimaio, 2019). Spontaneous musicmaking can also help participants let go of the emotional rigidity that often accompanies the physical rigidities imposed by chronic pain and disability, enhancing their emotional flexibility and ability to expand self-concept in the moment (Bullington et al., 2003; Koenig et al., 2013; Lawendowski & Bieleninik, 2016). These experiences offer unique opportunities to seize the moment and act freely, helping them to create shifts in sense of self and self-efficacy (Lawendowski & Bieleninik, 2017).

In terms of group dynamics, uncertainty in the music can bring anxiety, tension, and risk-taking, fertile grounds representing the potential for individual and collective change. This sense of movement or unrest can foster bonding within a group, as they work out collectively approved artistic elements in the music (Bruscia, 1987). In a supportive ambiance, the group partakes in "a co-created narrative of known and unknown moments - familiar and unfamiliar" in order to "affirm and…create" the individual and collective self (p. 170). Supportive holding techniques within toning exercises also create space for both the complex, emotionally intense process of grieving pre-pain identities, as well as moving on to the exploration of new modes of expression and being. Group improvisational experiences, whether free or guided (referential to a theme), represent the opportunity to "sound oneself, and then sound oneself anew" (Meadows and Wimpenny, 2017, p.177) with the affirmation of understanding witnesses.

Recreative Interventions. Recreative interventions present opportunities for participants to connect with memories as they share and relate to songs from a particular era or place, reconnecting them to possibly happier times, significant personal relationships, culminating in reconnection to a sense of personhood and dignity (Bradt et al., 2006; Thompson et al., 2017).

As Young (2009) notes, referencing community singing groups for adults with cancer, familiar songs contain moods, characters or lyrical themes that represent accessible ideas with which participants can identify as a jumping off point to connect with the group and "re-affirm their sense of identity" while feeling a "strong sense of acceptance" (p. 19). These parts of themselves can then represent part of a collective identity revolving around strength in the group (Rykov, 2008).

Collective singing experiences in particular represent the opportunity to feel a "sense of being" (Bradt et al., 2016, p. 198), in other words, an active agent with a full identity outside of illness. These experiences can represent a crucial remoralizing mechanism for isolated and stigmatized women living with CCPC (Bradt, 2006). Paradoxically, for some participants in a music therapy group for women living with various stages of breast cancer in Thompson et al. (2017), singing together helped forget about having cancer and feel *like themselves.* Furthermore**,** within the safety of familiar or pre-composed songs, participants can develop an enhanced sense of self-efficacy as they improve their skills in singing or playing instruments (Baines, 2003; Dileo, 2007), even if the quality produced is less than ideal (Bailey & Davidson, 2005). Performing familiar songs represents performing identity, both private and personal, as well as the journey of the group as they bond and learn together (Meadows & Wimpenny, 2017).

Compositional Interventions. The need to create a new life pattern around chronic illness, in order to cope with the pain and avoid the sick role, can also be addressed with song-writing interventions. The process of lyrical creation offers the opportunity to engage with one's own ideas about internal impacts of illness as well as contemplate those of others (Stark, 2012), allowing for the consideration of new perspectives on one's individual situation. Contemplating the future, however, first requires grieving a past that was untroubled by pain and illness (Lachappelle et al., 2008). This process can be aided by the creation of lyrics, melodies, or songs within a compositional process, in collaboration with a music therapist and the music therapy group (Stark, 2012). For example, HIV-positive music therapy group members in Cordobes (1997) commemorated their trajectory from anger to release to acceptance in a collaboratively written songwriting process that revealed both commonalities and differences in members' illness experience. Participants in these interventions may discover unknown strengths such as being skilled with words, creating melodies, or telling stories (Thompson et al., 2017). In addition, compositional interventions represent an ideal space in which participants can explore

potential for a self-image outside of the illness experience. Songwriting as a group in Stark (2012) helped participants to move beyond the "survivor identity," where the imaginative, transformative space of the music therapy group helped space for the contemplation of possible futures lived with chronic pain (p. 42).

Realizing Group Music Therapy Interventions within a Feminist Approach

Although research, theory, and anecdotal evidence indicates that the above music therapy interventions may help meet the psychosocial needs of women with contested chronic pain conditions, this philosophical inquiry also takes the position that the explicit realization of these interventions within a feminist approach would enhance the experience of these intervention thus increasing their effectiveness with women who are living with CCPC.

Feminist music therapy research demonstrates that there is value in taking a feminist or anti-oppressive approach in work with women in groups (Curtis & York, 2015; Hadley, 2006). Feminism is a vast and complex social movement, academic discipline and epistemological framework that can be integrated with, and into, a number of different perspectives and theories. Nevertheless, as Dileo (2006) has argued, there are some unifying principles that are common to most feminisms and which can be used as an organizing framework for a discussion of feminist group music therapy interventions. Possibilities for framing group music therapy within a feminist perspective were based on these principles and organized into three concepts: (a) centering empowerment and the anti-oppressive framework (Baines, 2003, 2013), (b)the importance of intentional community (Swoboda, 2005), and (c) amplifying marginalized voices (Bradt, 2006).

Centering Empowerment and the Anti-Oppressive Framework

Group music therapy work conducted from a feminist perspective can be structured around empowerment in order to fulfill some of the psychosocial needs of women living with CCPC. This process of empowerment may begin with the therapeutic relationship. While traditionally, the therapeutic relationship has been based around a top-down, authoritarian model, placing the therapist as the expert and the participant as the passive receiver of knowledge (Rolvsjord, 2004), feminist counselling frameworks emphasize a collaborative, participatory process where participants/consumers and therapists have horizontal, egalitarian relationships (Dileo, 2006). Curtis describes how the music therapist can model the "effective sharing of power" as well as the "give and take to egalitarian relationships" prioritized in feminist

counselling frameworks, as when she collaborated with a social worker while facilitating group work with survivors of domestic abuse (Curtis & York, 2015, p. 382). Similarly, in the study described previously, Baines (2003) described her role as being less a therapist and more a *facilitator* using music therapy concepts to support a self-help group, a fundamentally empowering approach that placed participants at the center of their own rehabilitation process while connecting them to each other. Working in this horizontal, participatory manner represents an important strategy to respond to the need for women with CCPC to feel heard and respected while honouring their own self-knowledge and expertise.

An anti-oppressive practice may further complement group music therapy work with women with CCPC. The anti-oppressive approach prioritizes empowerment by centering the needs and preferences of the participant at every level (Baines, 2013), responding to the need to feel believed and heard in this population. Baines (2013) describes using this approach with a community mental health music group in tandem with the psychosocial rehabilitation model, a person-centered, rights-based perspective in which *consumers* or *service users* make decisions on every aspect of the treatment process. In this way, the anti-oppressive approach acknowledges the participant as the expert on their own needs and goals (Baines, 2003; MacDonald, 2008). This approach furthermore responds to the need for a sense of control by offering opportunities for partnership between therapists and participants/consumer. As the participant/consumer grows to respect their own expertise on their experience and needs, the reliance on a sometimes-inaccessible validation from healthcare professionals, is reduced. In this way, empowerment can be both a "process and a goal" (Rykov, 2008, p. 198), and respond to the need for validation of subjective experience in women with CCPC by placing participants/consumers at the center of their own experience.

The Importance of Intentional Community

The creation of intentional community amongst women with similar struggles and goals represents a powerful strategy to mobilize feminist consciousness and can be approached from the collaborative spirit of feminist therapy (Rykov, 2008; Swoboda, 2006). The connecting capacity of music has been described in this paper as a means of reducing isolation (see page 32). It is important to note that the need to fight isolation in women and connect with others is a crucial step in helping them feel less alone in their struggles, a powerful feminist strategy in working toward awareness and change, since connecting with those undergoing similar struggles

offers the potential to recognize and fight oppression and silencing experiences (Adrienne, 2006; Curtis, 2007). As Bradt (2006) observes, the "marginalization and tabooing of illnesses and pain complaints that cannot be explained medically makes talking about the pain and discomfort a forbidden subject for most chronic pain sufferers "(Bradt, 2006, Strengthening the Muted Voice, para. 1). As a counter force, the music therapy group can provide a space where the expression of pain is normalized, bypassing the need to worry about appearing as strong or complying with the sick role and to be *enough* as they are, with the pain (Allen, 2010). In Curtis & York (2015), this sense of affirmation and transparency was exemplified in the use of affirming chants that rallied participants around empowering goals, which were combined with percussion playing for emphasis. The creation of a sense of safety in the group also opens up the possibility to normalize discussions around other issues, such as domestic violence or sexual abuse (Adrienne, 2006), which may contribute to the development and experience of chronic pain and illness, according to the biopsychosocial model (Gatchel, 2004). The careful use of relevant female-produced music and collective song-writing experiences can be crucial in work with women survivors of male violence, as it helps them see they are not alone in their suffering as they observe commonalities with other the experiences of other group members and in thematically relevant listening selections (Curtis, 2007; Curtis & York, 2015). This is an important consideration in therapeutic work with women, 1 in 4 of whom experience physical, emotional and sexual abuse in the home (Adrienne, 2006; Curtis, 2007). Exposing and expressing different types of oppression also gives others the opportunity to speak about their own experiences and share insights, for example, within the postlude discussion of a GIM intervention. This normalization can empower the individual to recognize injustices in their own lives and in turn help others to recognize their own.

Caring for Others is Caring for Self. Supportive interaction within the intentional community provides opportunities for psychosocial rehabilitation through the empowering and healing potential of altruistic behaviour (Gardstrom et al., 2017; Yalom and Leszcz, 2005). Self-esteem and self-efficacy are enhanced in participants who support and empower others in the music therapy group (Allen, 2010). Gardstrom et al. (2017) related the appearance of altruism within a music therapy group of women in recovery to Yalom and Leszcz's (2005) theory on the processes of change in traditional group psychotherapy, where the individual emerges from withdrawal and considers their interconnected roles in relationship to the other, expanding self-

concept and promoting growth. Therefore, as women learn to offer themselves more nurturance and compassion within the intentional community, they may become empowered to offer it to others, creating a dynamic flow of empathetic values (Worell & Remer, 2003). In this way, caring for others is also caring for oneself, mirroring the collaborative, horizontal relationships idealized in the feminist approach, where caring for others is both a treatment goal and process, providing a sense of fulfillment and meaning to the experience of illness. Furthermore, a feminist approach centering altruism as a therapeutic process and goal places value on personal strengths such as empathy that are typically attributed to women and dismissed as *soft skills* in individualistic societies, yet which can be prioritized in the relationship-based values that are valorized within feminist thought (Brabeck & Ting, 2000b). Music therapy group work can emphasize mutual aid and empowerment simultaneously by facilitating supportive exchanges between members. From this perspective, music therapy approaches with women with CCPC can prioritize an anti-oppressive strategy that models group music therapy on self-help models stressing "collective support and response" (Adrienne, 2006, Gender research in sociology, para. 3; Baines, 2003). The participant, or "learner," acts as a co-therapist, healing themselves in collaboration with others.

Amplifying Marginalized Voices

A feminist approach to group music therapy can focus on amplifying and facilitating the use of the voice, both in the literal and figurative sense. For women with CCPC, honouring and liberating their voices conveys a crucial understanding that the therapist takes their subjective experiences of pain seriously by offering opportunities for them to be heard on many levels, while mobilizing the voice as an important tool for self-care as well as self-advocacy (Bradt, 2006; 2016). The individual use of the voice imparts an important feeling of strength and self-efficacy (Rykov, 2006; Thompson et al., 2017). Some individuals' voices have been muted by medications and sedatives, more broadly, many women have "forfeited their own voices in order to survive the emotional turmoil caused by their chronic pain and society's insensitive reactions to their condition…the voice of the storyteller is silenced, especially when the storyteller is a woman," (Bradt, 2006, "Strengthening the Muted Voice, para. 1). Finally, in the symbolic sense, using voice to *speak up* represents an important tool for positive social change, which will be illustrated in the next section.

Social Transformation and Systemic Change. Therapy with disenfranchised women can be conceived as a journey toward becoming a force for change in the community, which aligns with the ideals of feminist consciousness-raising and social change as important therapeutic processes in feminist therapy ethics (Curtis, 2013b; Hadley, 2006). These principles can be targeted by liberating the individual and collective voice in group music therapy, empowering members to fight for change and transformation benefitting themselves and others. In this lens, self-advocacy becomes an important therapeutic process and goal. This process may begin at the personal level when, as described previously, participants can practice communicative skills and focus on setting boundaries in order to center their own well-being and avoid taking on too many tasks (Curtis & York, 2015; Torres, 2015), where some might previously have felt guilty and insufficient for failing to perform (Allen, 2010). In doing so, the personal is political (Worell & Remer, 2003), as when women confront gendered role expectations surrounding domestic work that they are understandably unable to fulfil due to illness, they carve out a space for negotiation around gender, unpaid or *invisible* domestic labour, and respect (Werner & Malterud, 2003).

As women living with CCPC break out of isolation, find their voices and learn to trust their subjective experience, they can experience further growth by engaging in peer advocacy and social activism. York observed a trajectory in a music therapy group for female survivors of male violence, in which members transitioned from "victim" to "community advocate" (Curtis & York, 2015, p. 388). She described their progress in stages, beginning by telling their stories in therapy, moving on to recordings and music performances as their confidence and engagement grew, and finally arriving at social activism as a final treatment outcome. The recordings produced by participant-written songs also effected real world change when group members shared recordings of songs they wrote or performed with people in their lives, including their abusers, representing an important milestone in their personal growth. In the historical context, where the voices and experiences of women and other marginalized populations have frequently been devalued and subsumed under more powerful discourses (Andersen & Collins, 2016; Hadley, 2006), these visible demonstrations of personhood and strength represent crucially empowering, powerful moments for muted individuals facing private struggles (Curtis & York, 2015). The social changes brought about by such efforts within an anti-oppressive framework can provoke more positive developments over time, as when Baines (2003) observed an increase

in empowering interactions following successful group advocacy for better treatment in an inpatient mental health care facility.

Combining the feminist principles of centering empowerment, intentional community, and amplifying marginalized voices in group music therapy treatment can mobilize a feminist consciousness in individuals and groups that may lead to permanent, positive changes for those who struggle to be heard in the society at large.

Chapter 4. Discussion

The primary research question of this inquiry was: Why is group music therapy realized within a feminist approach an ideal way to address the unique psychosocial needs of women with contested chronic pain conditions?

This primary question was broken down into three subsidiary questions: (a) According to the literature, what are the unique psychosocial needs of women with contested chronic pain conditions? (b) What is known about how music therapy interventions can be used to treat the psychosocial components of contested chronic pain conditions (c) What are the specific advantages of group music therapy realized within a feminist approach for the targeted population? A philosophical inquiry methodology situated within a feminist intersectional perspective was used to clarify the main concepts contained in the subsidiary questions which cumulatively created a cogent argument aimed at answering the primary research question.

The purpose of the present chapter is to present implications of the study findings for music therapy practice, research and advocacy. Limitations of the study are also presented.

Limitations

As the researcher I held some assumptions coming into this research which may have imposed some limitations on the inquiry. I assumed that music therapy can affect psychosocial well-being in women living with chronic pain conditions that are generally not well understood by the medical field. I also assumed that gender affects one's social context and experience of a world that is affected by patriarchal structures resulting in the differential treatment of women following centuries of second-class status for women in Western culture. I also assumed that some commonalities can be found in the experience of women living with CCPC and those with other medical diagnoses such as cancer, as well as between various contested chronic pain conditions, and within the experiences of women in Western societies living with chronic pain.

Finally, I have limited clinical experience with this population so my interpretations and conclusions are based on my theoretical understandings of the literature as well as personal understandings gained via my own experiences. Finally, I am a novice researcher who continues to strive toward increased understanding of the epistemological underpinnings of philosophical inquiry methodology.

Implications for Music Therapy Practice

The findings of this inquiry indicate some fundamental directions for group music therapy work with women living with CCPC. Music therapists who work with women living with CCPC need to engage with them in a collaborative manner, fostering their sense of empowerment, control and partnership. These women may take the lead in the design their own therapeutic experience in a manner that places them as the expert of their own needs and desires, thus putting into practice feminist ideals of horizontal, collaborative frameworks. Music therapists should consider how they may foster feminist collaborative acts, such as helping others, demonstrating empathy, and facilitating supportive exchanges between group members. The use of vocal interventions emerged a powerful means to facilitate women's use of their voices, representing an important metaphor for speaking up in their own lives. Relatedly, there is potential for significant impact when using listening experiences that feature female artists with varying lyrical messages regarding empowerment. Feelings of empowerment can also be facilitated via opportunities for choice in music therapy sessions (e.g., choosing songs, instruments, etc.). Music therapists may also wish to critically consider what certain music therapy experiences may be reflecting about gender, and change their practices accordingly. Finally, the music therapist working within a feminist lens must recognise that the *personal is political*: empowerment involves consideration of individual struggles as a function of larger power struggles. Conceptualizing these struggles as individual challenges could have the unintended effect of normalizing inequalities instead of facilitating the individual's capacity to situate their suffering within larger systems where multiple environmental and social stressors can result in further pain and disability.

On a personal level, I have gained a deeper understanding of the potential psychosocial implications for women living with contested chronic pain conditions, particularly in terms of lesser understood needs, such as the impact of intentional community and the need to care for others. This may impact my future practice in that terms of how I might further consider participants' input in the creation and implementation of therapeutic programs, as well as how to center empowerment and facilitate supportive exchanges at every level of therapeutic work with this population. I will also aim for increased coherence between my personal life and my practice, implicating myself further in social justice work to drive social change. I plan to engage in the continuous self-monitoring recommended by Dileo (2006) in order to enhance my

awareness of the evolution of various identities and their intersection with social, cultural, racial and economic locations and how my own locations influence my assumptions and biases. This research process has enhanced my comprehension of the potential complexity of needs of persons dealing with the multiple consequences of invisible illnesses, which has direct implications for my future practice with this population. I plan to do further research and exploration in order to understand how a feminist perspective affects my work as a music therapist, and how I may evolve my practice in order to incorporate a larger diversity of perspectives.

Implications for Music Therapy Research

This study found that in theory, group music therapy experiences could be underpinned by feminist principles and organized in meaningful ways in order to meet the psychosocial needs with women with contested chronic pain illnesses. A gap in music therapy research on this population was found, demonstrating the need for more qualitative research illustrating the gender-specific impacts of CCPC. In this light, and in keeping with the feminist principle of considering the individual within their sociopolitical locations, those researching this topic might also include more demographic detail in the description and analysis of participant data in order to contribute to the increasing body of knowledge considering the impacts of various oppressions on health (Spitzer, 2005). Researchers should also examine epistemology and consider how some methodologies prioritize the knowledge and voices of those affected, validating alternative ways of knowing and telling that reflect the total pain experience more fully, especially for women who confound current medical understanding. Investigating these group music therapy experiences in practice, within a participatory action feminist research framework would be a logical next step.

Future research could further incorporate an understanding of the biopsychosocial model of pain, which recognizes the multitude of personal, social and environmental factors affecting vulnerability to chronic illness and pain, including various oppressions and traumas, and examine how a holistic, anti-oppressive music therapy approach might help to reduce the impact of these factors, while continuing to situate them within the larger sociopolitical context in accordance with a feminist perspective. Thus, future research could contribute toward the creation of a holistic, anti-oppressive program model for women with CCPC that considers the complex and varied needs of this population.

Implications for Feminist Music Therapy Advocacy

This inquiry pointed to the strong potential for group music therapy, realized from an intersectional feminist approach, to address a variety of psychosocial needs in women with CCPC. Advocacy efforts could illustrate how group music therapy with this population can fill the gaps left by traditional medicine in pain care and help women struggling with invisible illnesses to be heard, whether they have obtained an official medical diagnosis or not, while making room for other needs that may accompany the experience of physical pain. This study's findings support Edwards' (2006) position, who maintains that music therapists should avoid the temptation of relying uniquely on medical models to advocate for music therapy in response to the push for evidence-based practice, as to do so would neglect its unique capacity to hold space for uncertainty or challenging ideas, as well as its powerful potential to holistically address several needs simultaneously. A holistic, feminist approach could be connected to growing models of preventive and integrative models of healthcare, where the individual in pain is considered in the larger context in which they live, and where overall health and wellness play an important part in the prevention of pain and illness. In this perspective, group music therapy could represent an important part of a multimodality, multidisciplinary pain treatment program that offers personally meaningful modalities to the community, where musical engagement comprises part of a preventive healthcare strategy.

The impact of group work on social isolation and community in women with CCPC represents another strong point for advocacy. Group music therapy facilitates the social reintegration of isolated individuals, and can create and strengthen community, providing a gathering hub for positive health behaviours. Approaching this work from an intersectional feminist perspective can connect isolated individuals to themselves, to their peers, and to the community at large while provoking crucial social change. Finally, group music therapy practiced within an anti-oppressive framework supports the implementation of user-led treatment programs with the community, focusing on accessibility and horizontal power dynamics that lead to sharing, caring, supportive communities.

References

Canadian Association of Music Therapists. (June, 2016). *About Music Therapy*. https://www.musictherapy.ca/about-camt-music-therapy/about-music-therapy/.

Adrienne, J. (2006). A feminist sociology of professional issues in music therapy. In S. Hadley (Ed.), *Feminist perspectives in music therapy* (pp. 41-62). Gilson, NH: Barcelona.

Aigen, K. (2005). Philosophical inquiry. In B. L. Wheeler (Ed.), *Music therapy research* (2nd ed., pp. 526-539). Barcelona.

Aldridge, D. (2003). Music therapy references relating to cancer and palliative care. *British Journal of Music Therapy, 17*(1), 17–25.

Allen, J. (2008a). A struggle within: The case study of Kenneth. Unpublished manuscript.

Allen, J. (2008c). Life with Cancer: Music therapy Program Proposal. Unpublished manuscript.

Allen, (2010). The effectiveness of group music psychotherapy in improving the self-concept of breast cancer survivors. Temple University.

Allen, J. (2013). Pain management with adults. In J. Allen (Ed.), *Guidelines for music therapy practice in adult medical care* (pp. 35–61). Barcelona.

Andersen, M., & Hill, C. (2016). *Race, class, and gender: An anthology*. Cengage.

Ardener, S. (2005). Ardener's "muted groups": The genesis of an idea and its praxis. *Women and Language*, *28*(2), 50-54,72.

Armentor, J. L. (2017). Living with a contested, stigmatized illness: Experiences of managing relationships among women with fibromyalgia. *Qualitative Health Research, 27*(4), 462-473.

Austin, D. (2008). *The theory and practice of vocal psychotherapy: Songs of the self.* Kingsley.

Bailey, B. A., & Davidson, J. W. (2005). Effects of group singing and performance for marginalized and middle-class singers. *Psychology of music, 33*(3), 269-303.

Baines, S. (2013). Music therapy as an anti-oppressive practice. *The Arts in Psychotherapy, 40*(1), 1–5.

Baker, L. M. (2010). Music therapy: Diversity, challenge and impact. *International Journal of Disability, Development and Education, 57*(3), 335–340.

Baker, F., & Uhlig, S. (2011). Diversity in approaches to therapeutic voicework: Developing a model of voicework in music therapy. In F. Baker & S. Uhlig (Eds.), *Voicework in music therapy: Research and practice* (pp. 333-349). Kingsley.

Barral Morán, M.J. (2010). Análisis crítico del discurso biomédico sobre sexos y géneros. (Unpublished doctoral dissertation). University of Barcelona. pp. 105-116.

Batt-Rawden, K. B., & Tellnes, G. (2011). How music may promote healthy behaviour. *Scandinavian Journal of Public Health, 39*(2), 113–120.

Batt-Rawden, K. B., DeNora, T., & Ruud, E. (2005). Music listening and empowerment in health promotion: A study of the role and significance of music in everyday life of the long-term ill. *Nordic Journal of Music Therapy, 14*(2), 120-136.

Boulton, T. (2019). Nothing and everything: Fibromyalgia as a diagnosis of exclusion and inclusion. *Qualitative Health Research, 29*(6), 809-819.

Brabeck, M. M., & Ting, K. (2000). Feminist ethics: Lenses for examining ethical psychological practice. In M. M. Brabeck (Ed.), *Psychology of women book series. Practicing feminist ethics in psychology,* (pp. 17–35). American Psychological Association.

Bradt, J. (2006). The voices of women suffering from pain. In S. Hadley (Ed.), *Feminist perspectives in music therapy* (pp. 291-310). Barcelona.

Bradt, J., Dileo, C., Grocke, D., & Magill, L. (2011). Music interventions for improving psychological and physical outcomes in cancer patients. *Cochrane Database of Systematic Reviews*, *8*.

Bradt, J., Norris, M., Shim, M., Gracely, E. J., & Gerrity, P. (2016). Vocal music therapy for chronic pain management in inner-city African Americans: A mixed methods feasibility study. *Journal of Music Therapy, 53*(2), 178–208.

Brooks, A. (2007). Feminist standpoint epistemology: Building knowledge and empowerment through women's lived experience. In S. H. Biber (Ed.), *Feminist research practice: A primer* (pp. 53-82). SAGE Publications.

Brown, C. J., Chen, A. C. N., & Dworkin, S. F. (1989). Music in the control of human pain. *Music Therapy, 8*, 47-60.

Bruscia, K. (2014). *Defining music therapy* (3rd ed.). Barcelona.

Bula, A. (2016). *Young, sick, and invisible: A skeptic's journey with chronic illness.* Pitchstone.

Bullington, J., Nordemar, R., Nordemar, K., & Sjöström-Flanagan, C. (2003). Meaning out of chaos: A way to understand chronic pain. *Scandinavian Journal of Caring Sciences, 17*(4), 325–331.

Busse, J. (Ed.). (2017). The 2017 Canadian guideline for opioids for chronic non-cancer pain. *National Pain Centre.*

Carniol, B. (2003). Generalist skills in social work. Unpublished work in progress, Toronto: Ryerson School of Social Work.

Calderone, K. L. (1990). The influence of gender on the frequency of pain and sedative medication administered to postoperative patients. *Sex Roles, 23*(11-12), 713-725.

Chanda, M. L., & Levitin, D. J. (2013). The neurochemistry of music. *Trends in Cognitive Sciences, 17*(4), 179-193.

Choi, A. N., Lee, M. S., & Lim, H. J. (2008). Effects of group music intervention on depression, anxiety, and relationships in psychiatric patients: A pilot study. *The Journal of Alternative and Complementary Medicine, 14*(5), 567–570.

Crombez, G., Eccleston, C., Van Damme, S., Vlaeyen, J., Karoly, P. (2012). The fear avoidance model of chronic pain: the next generation. *The Clinical Journal of Pain*, *28*, 475–483. https://doi.org/10.1097/AJP.0b013e3182385392

Crone, D. M., O'Connell, E. E., Tyson, P. J., Clark-Stone, F., Opher, S., & James, D. V. (2013). 'Art Lift' intervention to improve mental well-being: An observational study from UK general practice. *International Journal of Mental Health Nursing, 22*(3), 279-286.

Curtis, S. (1996). Singing subversion, singing soul: Women's voices in feminist music therapy (Publication No. NQ44871). [Doctoral dissertation, Concordia University]. Spectrum Online Repository.

Curtis, S. (2007). Claiming voice: Music therapy for childhood sexual abuse survivors. The use of creative arts therapies with sexual abuse survivors. In S. Brooke (Ed.), *The use of the creative therapies with sexual abuse survivors* (pp. 196-206). Thomas.

Curtis, S. (2013a). Sorry it has taken so long: Continuing feminist dialogues in music therapy. *Voices: A World Forum for Music Therapy, 13*(1). https://voices.no/index.php/voices/article/view/2090/1837

Curtis, S. L. (2013b). On gender and the creative arts therapies. *Arts in Psychotherapy*, *40*(4), 371–372. https://doi.org/10.1016/j.aip.2013.05.014

Curtis, S. (2016). Music therapy for women who have experienced domestic violence. In J. Edwards (Ed.), *The Oxford handbook of music therapy* (pp. 289-298) Oxford University Press.

Curtis, S. (2017) Intersections of gender and culture. In A. Whitehead-Pleaux & X. Tan (Eds.), *Cultural intersections in music therapy: Music, health, and the person*. Barcelona.

Davis, M., Matthews, K., Twamley, E. (1999). Is life more difficult on Mars or Venus? A meta-analytic review of sex differences in major and minor life events. *Annals of Behavioral Medicine*, *21*(1), 83–97.

Deleuze, G., & Guattari, F. (1991). *What is philosophy?* (H. Tomlinson, Trans.). Columbia University Press.

DeNora, T. (2005). The pebble in the pond: Musicing, therapy, community. *Nordic Journal of Music Therapy, 14*(1), 57-66.

Dileo, C. (2013). A Proposed Model For Identifying Practices: A Content Analysis of the First 4 Years of Music and Medicine. *Music & Medicine, 5*(2), 110–118.

Dileo, C. (2015). Advanced Practice in Medical Music Therapy: Case Reports. Jeffrey Books.

Dileo, C. (2016). *The future of medical music therapy for adults. Envisioning the future of music therapy* (pp. 71-80). Temple University.

Dimaio, L. (2010). Music therapy entrainment: A humanistic music therapist's perspective of using music therapy entrainment with hospice clients experiencing pain. *Music Therapy Perspectives, 28*(2), 106–115. Edwards, J., & Hadley, S. (2007). Expanding music therapy practice: Incorporating the feminist frame. *The Arts in Psychotherapy, 34*(2007), 199-207.

Espí-López, G. V., Inglés, M., Ruescas-Nicolau, M. A., & Moreno-Segura, N. (2016). Effect of low-impact aerobic exercise combined with music therapy on patients with fibromyalgia. A pilot study. *Complementary Therapies in Medicine, 28,* 1-7.

Frankl, V. E. (1984). Man's search for meaning: An introduction to logotherapy (3rd ed.). Simon and Schuster.

Ettun, R., Schultz, M., & Bar-Sela, G. (2014). Transforming pain into beauty: On art, healing, and care for the spirit. *Evidence-Based Complementary and Alternative Medicine, 2014*(1), 1-7.

Fillingim, R. B. (2017). Sex, gender, and pain. In M. J. Legato (Ed.), *Principles of gender-specific medicine: Gender in the genomic era* (3rd ed., pp. 481–496). Elsevier.

Fishbain, D. A., Cole, B., Lewis, J., Rosomoff, H. L., & Rosomoff, R. S. (2008). What percentage of chronic non-malignant pain patients exposed to chronic opioid analgesic therapy develop abuse/addiction and/or aberrant drug-related behaviors: A structured evidence-based review. *Pain Medicine, 9*(4), 444–459.

Frejka, T., Goldscheider, F. and Lappegård, T. (2018). The two-part gender revolution, women's second shift and changing cohort fertility. *Comparative Population Studies, 43.*

Gardstrom, S. C., Klemm, A., & Murphy, K. M. (2017). Women's perceptions of the usefulness of group music therapy in addictions recovery. *Nordic Journal of Music Therapy, 26*(4), 338-358.

Gatchel, R. J. (2004). Comorbidity of chronic pain and mental health disorders: The biopsychosocial perspective. *American Psychologist, 59*(8), 795.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* Simon & Schuster.

Green, C. R., Anderson, K. O., Baker, T. A., Campbell, L. C., Decker, S., Fillingim, R. B., & Vallerand, A. H. (2003). The unequal burden of pain: confronting racial and ethnic disparities in pain. *Pain Medicine, 4*(3), 277–295.

Grocke, D., & Wigram, T. (2006). R*eceptive methods in music therapy: Techniques and clinical applications for music therapy clinicians, educators and students*. Kingsley.

Hadley, S. (2006). *Feminist Perspectives in Music Therapy*. Barcelona.

Hanser, S. B., Bauer-Wu, S., Kubicek, L., Healey, M., Manola, J., Hernandez, M., & Bunnell, C. (2006). Effects of a music therapy intervention on quality of life and distress in women with metastatic breast cancer. *Journal of the Society of Integrative Oncology, 4*(3), 116-124.

Hart, J. (2014). Contested illnesses. In T. L. Thompson (Ed.), *Encyclopedia of health communication* (Vol. 1, pp. 257-258). SAGE Publications, Inc.

Hedva, J (2015) Sick woman theory. *Mask Magazine.* http://www.maskmagazine.com/not-again/struggle/sick-woman-theory.

Heiderscheit, A., & Jackson, N. A. (2018). *Introduction to music therapy practice.* Barcelona.

Honkasalo, M.-L. (1999). What is chronic is ambiguity-encountering biomedicine with long-lasting pain. *Suomen Antropologi, 24*(4), 75–92.

Hovey, R. B., Khayat, V. C., & Feig, E. (2017). Listening to and letting pain speak: Poetic reflections. *British Journal of Pain, 1/9*.

Interagency Pain Research Coordinating Committee (2017). *Federal Pain Research Strategy*. https://iprcc.nih.gov/docs/draftfederalpainresearchstrategy.pdf

International Association for the Study of Pain. (2011). *Classification of chronic pain. Descriptions of chronic pain syndromes and definitions of pain terms.* https://www.iasppain.org/PublicationsNews/Content.aspx?ItemNumber=1673.

Jackson, J. (2000). *"Camp pain": Talking with chronic pain patients.* University of Pennsylvania Press.

Johansson, E. E., Hamberg, K., Westman, G., & Lindgren, G. (1999). The meanings of pain: An exploration of women's descriptions of symptoms. *Social Science & Medicine, 48,* 1791-1802.

Jonas, W. (2017, October 31). An integrative approach to managing chronic pain can help solve the opioid crisis. *Stat News.* https://www.statnews.com/2017/10/31/chronic-pain-opioid-crisis/

Kamioka, H., Tsutani, K., Yamada, M., Park, H., Okuizumi, H., Tsuruoka, K., Mutoh, Y. (2014). Effectiveness of music therapy: A summary of systematic reviews based on randomized controlled trials of music interventions. *Patient Preference and Adherence, 8,* 727–754.

Kasl, S. V., & Cobb, S. (1966). Health Behavior, Illness Behavior, and Sick-Role Behavior. *Archives of Environmental Health*, *12*(4), 531–541.

Koenig, J., Warth, M., Oelkers-Ax, R., Wormit, A., Bardenheuer, H. J., Resch, F., Thayer, J. F., & Hillecke, T. K. (2013). I need to hear some sounds that recognize the pain in me: An integrative review of a decade of research in the development of active music therapy outpatient treatment in patients with recurrent or chronic pain. *Music and Medicine*, *5*(3), 150–161. https://doi.org/10.1177/1943862113490739.

Kranz, D., Bollinger, A., & Nilges, P. (2010). Chronic pain acceptance and affective well-being: A coping perspective. *European Journal of Pain*, *14*(10), 1021–1025. https://doi.org/10.1016/j.ejpain.2010.03.010

Kwan, M. (2010). Music therapists' experiences with adults in pain: Implications for clinical practice. *Qualitative Inquiries in Music Therapy, 5*, 43-85.

Kenny, D. T., & Faunce, G. (2004). The impact of group singing on mood, coping, and perceived pain in chronic pain patients attending a multidisciplinary pain clinic. *Journal of Music Therapy, 41*(3), 241–258.

LaChapelle, D., Lavoie, S., & Boudreau, A. (2008). The meaning and process of pain acceptance. Perceptions of women living with arthritis and fibromyalgia. *Health (San Francisco)*, *13*(3).

Lawendowski, R., & Bieleninik, Ł. (2017). Identity and self-esteem in the context of music and music therapy: A review. *Health Psychology Report, 2,* 85–99.

Lee, J. H. (2016). The effects of music on pain: A meta-analysis. *Journal of Music Therapy, 53*(4), 430–477.

Lillrank, A. (2003). Back pain and the resolution of diagnostic uncertainty in illness narratives. *Social Science & Medicine, 57*(6), 1045-1054.

MacDonald, J. E. (2008). Anti-oppressive practices with chronic pain sufferers. *Social Work in Health Care, 47*(2), 135–156.

Magee, W. L. (2002). Identity in clinical music therapy: Shifting self-constructs through the therapeutic process. *Musical Identities,* 179-197.

Magille, L. (2001). The use of music therapy to address the suffering in advanced cancer pain. *Journal of Palliative Care, 17*(3), 167-172.

Malterud, K. (1999). The (gendered) construction of diagnosis interpretation of medical signs in women patients. *Theoretical Medicine and Bioethics, 20*(3), 275-286.

Manzoni, G.M., Pagnini, F., Castelnuovo, G., Molinari, E. (2008). Relaxation training for anxiety: A ten-years systematic review with meta-analysis, *BMC Psychiatry*, *8*(41).

Martikainen, P., Bartley, M., & Lahelma, E. (2002). Psychosocial determinants of health in social epidemiology. *International Journal of Epidemiology*, *31*(6), 1091–1093.

McCaffery, M., & Moss, F. (1967). Nursing intervention for bodily pain. *American Journal of Nursing, 67*(6), 1224-1227.

McKinney, C. H., & Honig, T. J. (2017). Health outcomes of a series of Bonny Method of Guided Imagery and Music sessions: A systematic review. *Journal of Music Therapy, 54*(1), 1-34.

Meadows, A., & Wimpenny, K. (2017). Core themes in music therapy clinical improvisation: An arts-informed qualitative research synthesis. *Journal of Music Therapy, 54*(2), 161–195.

Meana, M., Cho, R., & DesMeules, M. (2004). Chronic pain: The extra burden on Canadian women. *BMC Women's Health, 4*(Suppl 1), S17.

Mitchell, L. A., & MacDonald, R. A. R. (2006). An experimental investigation of the effects of preferred and relaxing music listening on pain perception. *Journal of Music Therapy, XLIII*(4), 295-316.

National Institute of Health. (1994, March 18). Guidelines on the inclusion of women and minorities as subjects in clinical research. *National Institute of Health, 23*(11). https://grants.nih.gov/grants/guide/notice-files/not94-100.html.

Parsons, T. (1951). Illness and the role of the physician: A sociological perspective. *American Journal of Orthopsychiatry, 21*(3), 452.

Potvin, N., Bradt, J., Kesslick, A. (2015). Expanding perspective on music therapy for symptom management in cancer care. *Journal of Music Therapy, 52*(1), 135-167.

Pritham, U. A., & Mckay, L. (2014). Safe management of chronic pain in pregnancy in an era of opioid misuse and abuse. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 43*(5), 554–567.

"Psychosocial". (2018). https://dictionary.apa.org/psychosocial.

Pryma, J. (2017). "Even my sister says I'm acting like a crazy to get a check": Race, gender, and moral boundary-work in women's claims of disabling chronic pain. *Social Science & Medicine, 181*, 66-73.

Roberts, T. & Waters, P. (2004). Self-objectification and that "not so fresh feeling." *Women & Therapy, 27*(3-4), 5-21.

Rolvsjord, R. (2004). Therapy as empowerment: Clinical and political implications of empowerment philosophy in mental health practises of music therapy. *Nordic Journal of Music Therapy, 13*(2), 99-111.

Rolvsjord, R., & Halstead, J. (2013). A woman's voice: The politics of gender identity in music therapy and everyday life. *The Arts in Psychotherapy, 40*(4), 420–427.

Rykov, M. H. (2006). Voicing the song of music therapy cancer support. *Paper presented at the Canadian Association for the Study of Adult Education (CASAE) 25th Annual Conference, 'The Learneds'.* York University, Toronto.

Rykov, M. H. (2008). Experiencing music therapy cancer support. *Journal of Health Psychology, 13*(2), 190-200.

Sanfi, I., & Christensen , E. (2017). Perspectives on Music Imagery and complex chronic pain. *Approaches: An Interdisciplinary Journal of Music Therapy, Special Issue 9*(2), 233-245.

Schopflocher, D., Taenzer, P., & Jovey, R. (2011). The prevalence of chronic pain in Canada. *Pain Research & Management: The Journal of the Canadian Pain Society, 16*(6), 445

Serbic, D., & Pincus, T. (2014). Diagnostic uncertainty and recall bias in chronic low back pain. *Pain, 155*(8), 1540–1546.

Shakhshir, P. S. (2008). The lived experience of Latinas who listen to music for chronic pain. Doctoral dissertation. Azusa Pacific University.

Simon, L. S. (2012). Relieving pain in America: A blueprint for transforming prevention, care, education, and research. *Journal of Pain & Palliative Care Pharmacotherapy, 26*(2), 197-198.

Skuladottir, H., & Halldorsdottir, S. (2011). The quest for well-being: Self-identified needs of women in chronic pain. *Scandinavian Journal of Caring Sciences, 25*(1), 81–91.

Smith, E. C. (2011). Gender-biased diagnosing, the consequences of psychosomatic misdiagnosis and "doing credibility." *Sociology Student Scholarship.* http://scholar.oxy.edu/sociology_student/5

Spitzer, D.L. (2005). Engendering health disparities. *Canadian Journal of Public Health, 96 (April 2005), S78–96.*

Stige, B. & Strand, R. (2016). Philosophical inquiries. In B. L. Wheeler & K. M. Murphy (Eds.), *Music therapy research* (3rd ed). Barcelona.

Sullivan, M. L. J., Feuerstein, M., Gatchel, R., Linton, S. J., & Pransky, G. (2005). Integrating psychosocial and behavioral interventions to achieve optimal rehabilitation outcomes. *Journal of Occupational Rehabilitation, 15*(4).

Swoboda, D. A. (2006). The social construction of contested illness legitimacy: A grounded theory analysis. *Qualitative Research in Psychology, 3*(3), 233–251.

Sylvain, H., & Talbot, L. R. (2002). Synergy towards health: A nursing intervention model for women living with fibromyalgia, and their spouses. *Journal of Advanced Nursing, 38*(3), 264–273.

Swoboda, D. A. (2006). The social construction of contested illness legitimacy: A grounded theory analysis. *Qualitative Research in Psychology, 3*(3), 233–251.

Thompson, S., Grocke, D., & Dileo, C. (2017). The use of group descriptive phenomenology within a mixed methods study to understand the experience of music therapy for women with breast cancer. *Nordic Journal of Music Therapy*, *26*(4), 320–337.

Torres, E. (2015). Group Music and Imagery for treating Fibromyalgia. In D. Grocke, & T. Moe (Eds.), *Guided imagery and music (GIM) and music imagery methods for individual and group therapy* (pp. 267-276). Kingsley.

Torres, E., Pedersen, I. N., & Pérez-Fernández, J. I. (2018). Randomized trial of a group music and imagery method (GrpMI) for women with fibromyalgia. *Journal of Music Therapy, 55*(2), 186–220.

Trout, K. K. (2004). The neuromatrix theory of pain: implications for selected nonpharmacologic methods of pain relief for labor. *Journal of Midwifery & Women's Health, 49*(6), 482-488.

Tuinmann, G. (2017). Combining schema therapy and guided imagery and music. Approaches: An *Interdisciplinary Journal of Music Theory, 9*(2), 246-251.

Unruh, A. M. (1996). Gender variations in clinical pain experience. *Pain, 65*, 123-167.

Weitz, R. (2013). A history of women's bodies. In Weitz, R. & Kwan, S. (Eds.), *The politics of women's bodies* (4th ed.). Oxford University Press.

Werner, A., & Malterud, K. (2003). It is hard work behaving as a credible patient: Encounters between women with chronic pain and their doctors. *Social Science & Medicine, 57*(8), 1409-1419.

Wheeler, B. & Murphy, K. (2016). Music therapy research (3rd ed.). Barcelona.

Whitehead, L. (2006). Toward a trajectory of identity reconstruction in chronic fatigue syndrome/myalgic encephalomyelitis: A longitudinal qualitative study. International *Journal of Nursing Studies, 43*(8), 1023–1031.

Yinger, O. (2018). (Ed.) Overview of the music therapy profession. In *Music Therapy: Research and Evidence-Based Practice* (pp. 1–13). Elsevier.

York, E., & Curtis, S. L. (2016). Music therapy for women survivors of domestic violence. In B. L. Wheeler (Ed.)., *Music therapy handbook.* Guilford.

Young, L. (2009). The potential health benefits of community-based singing groups for adults with cancer. *Canadian Journal of Music Therapy, 15*(1), 11.

Young, L., & Pringle, A. (2018) Lived experiences of singing in a community hospice bereavement support music therapy group. *Bereavement Care, 37*(2), 55-66.

Zautra, A. J., Johnson, L. M., & Davis, M. C. (2005). Positive affect as a source of resilience for women in chronic pain. *Journal of Consulting and Clinical Psychology, 73*(2), 212.