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Exploring music therapists' perspectives on clinical goals, practices, and outcomes across different settings in cancer care

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Abstract

This qualitative study explores the use of music therapy in cancer care by examining the perspectives of experienced music therapists. Sixteen semi-structured interviews were conducted with music therapists who work or have worked with cancer patients across various clinical settings and stages of illness. The interviews were analysed by using relational content analysis. The identified themes in the interviews focused on the clinical goals set by the therapists, the music therapy practices used in sessions, the benefits they observed, and the challenges they encountered. The analysis of the interviews provided an in-depth understanding of participants' experiences, highlighting the importance of tailoring music therapy practices to meet the unique needs of cancer patients across different stages of illness and in diverse settings.

Keywords

cancer care,
music therapy practices,
clinical goals,
interviews,
qualitative content analysis

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Introduction

Cancer care

Cancer remains a major cause of death globally. In 2022, nearly 20 million new cases were reported, alongside 9.7 million cancer-related deaths. By 2040, these numbers are projected to increase, with new cases expected to reach 29.9 million per year and cancer-related deaths estimated at 15.3 million annually. Typically, cancer rates are highest in countries with the greatest life expectancy, education levels and living standards. However, for certain cancers, such as cervical cancer, incidence rates are highest in countries where these indicators are comparatively lower (Cancer Statistics - NCI, 2024; The International Agency for Research on Cancer (IARC), n.d.).

Medical experts recognise standard cancer treatments as appropriate for specific cancer types and commonly practice them in healthcare. These treatments include surgery, various types of chemotherapy, radiation therapy, immunotherapy, stem cell or bone marrow transplants and hormone therapy. The type of treatment or combination of treatments an individual receives typically depends on the type and stage of cancer (Types of Cancer Treatment - NCI, n.d.).

However, cancer does not affect only the body. For example, cancer patients are particularly vulnerable to co-existing anxiety and depression (Caruso & Breitbart, 2020; Diaz-Frutos et al., 2016; Pandey et al., 2006). Research has shown that cancer and cancer treatment have significant psychosocial impacts on both patients and their families, underscoring the necessity of incorporating psychosocial care into standard cancer treatment (Adler et al., 2008; Caruso & Breitbart, 2020). In addition, there is an urgent need for a structured approach to designing and implementing multidisciplinary and integrated psychosocial interventions, guided by established standards and supported by rigorous randomised controlled trials (Caruso & Breitbart, 2020).

The International Psycho-Oncology Society (IPOS) was established to advance training, support research and foster the integration of psychosocial principles across all oncology disciplines worldwide to provide the highest standard of patient care in cancer treatment (*International Psycho-Oncology Society - Vision & Mission*, n.d.). IPOS's standards of quality cancer care are:

1. "Psychosocial cancer care should be recognised as a universal human right;
2. Quality cancer care must integrate the psychosocial domain into routine care;
3. Distress should be measured as the sixth vital sign after temperature, blood pressure, pulse, respiratory rate and pain." (*International Psycho-Oncology Society - IPOS Standard of Quality Cancer Care*, n.d.).

In practice, healthcare systems worldwide differ significantly, leading to considerable variation in psychosocial care for cancer patients. Furthermore, there is a considerable lack of awareness of the international development of psychosocial oncology programs among the general public and within the medical community. Consequently, there is limited understanding of the circumstances under which psychosocial oncology is actually applied in everyday clinical practice (Mehnert & Koch, 2005).

The biopsychosocial model of care

Incorporating psychosocial support into standard cancer treatment enhances the biopsychosocial model of care. Developed by George Engel, this model integrates biological, psychological, and social elements to provide a comprehensive understanding of health and illness (Guillemin & Barnard, 2015). The biopsychosocial model has been widely adopted in medical education and practice. It addresses the limitations of the conventional biomedical approach (Guillemin & Barnard, 2015), and offers opportunities to understand and support mental health challenges (Babalola et al., 2017). It represents a significant advancement in medicine by promoting a holistic understanding of health and disease that considers factors beyond biological processes (Engel, 2012).

Clinical psychology and psychotherapy are becoming increasingly rooted in an integrative, evolutionary and contextual biopsychosocial framework (Gilbert, 2019). Psychotherapy in particular has demonstrated promising effects on biopsychosocial health and cancer survival (Spiegel, 2014). Moreover, numerous psychosocial and mind-body interventions have been supported in the literature for their effectiveness, including relaxation techniques, cognitive behavioural therapies, meditation, guided imagery, biofeedback and hypnosis (Astin et al., 2003). Additionally, Shafir et al. (2020) highlight the significant potential of creative arts therapies, which encompass various artistic modalities, in promoting biopsychosocial health across different age groups and settings. These therapies engage physiological responses, emotions and cognition, facilitating expression and meaning-making (Shafir et al., 2020). Music therapy especially can address physical, emotional, cognitive, social and spiritual needs across diverse populations and age groups (O'Callaghan et al., 2016; Scheve, 2004).

Building on this, Bruscia (2014) further emphasises the value of integrative and flexible clinical reasoning through the concept of *integral thinking*, which encourages therapists to draw reflectively from multiple approaches, models and methods in order to meet the complex and individualised needs of each client. This way of thinking aligns with the biopsychosocial framework by promoting holistic, client-centred care.

Music therapy in cancer care

According to the literature, music therapy can has many benefits, such as reduce pain and alleviate other physical symptoms (Alcântara-Silva et al., 2018; Bradt et al., 2023; Lichtl et al., 2022; Rabinowitch et al., 2023; Reimnitz & Silverman, 2020; Rodgers-Melnick et al., 2022; Rossetti, 2021, Tang et al., 2021), reduce anxiety and promote relaxation (Eseadi & Ngwu, 2023; Holloway et al., 2019; Lagattolla et al., 2023; Rodgers-Melnick et al., 2022; Tang et al., 2021), encourage coping with diagnosis and treatment (Mondanaro et al., 2021; Rossetti, 2021), enhance spirituality and meaning-making (Lichtl et al., 2022; Thompson et al., 2017; Tynan et al., 2018), facilitate emotional expression (Mondanaro et al., 2021; Rodríguez-Rodríguez et al., 2023; Thompson et al., 2017; Tynan et al., 2018) and support trauma integration (Rossetti, 2021) in various types and stages of cancer.

Music therapists employ a wide range of practices to achieve their clinical goals with cancer patients. One common practice documented in the literature involves playing live music selected by the patient (Alcântara-Silva et al., 2018; Reimnitz & Silverman, 2020; Rodríguez-Rodríguez et al., 2023; Rossetti, 2021). In some cases, this live music is improvisational (Rossetti et al., 2017, Rossetti, 2021). Music therapists often prefer live music, as it provides flexibility to incorporate or change musical elements, thus enhancing the therapeutic process (Rossetti, 2021). In other instances, pre-composed music (either chosen by the patient or therapist) can be played on a music device (Rabinowitch et al., 2023, Thompson et al., 2017). Music therapists may also employ other practices to address individual needs. These practices can range from music and imagery and music-guided breathing exercises (Holloway et al., 2019; Rabinowitch et al., 2023; Rodgers-Melnick et al., 2022; Tang et al., 2021), to co-created musical improvisation (Mondanaro et al., 2021; Rodgers-Melnick et al., 2022; Rodríguez-Rodríguez et al., 2023; Tang et al., 2021) or songwriting (Hanser, 2017; Rodgers-Melnick et al., 2022; Thompson et al., 2017). Lastly, another practice is the "Song of Life," which involves conducting a

biographical interview followed by a live performance of a song with significant biographical meaning, presented in a lullaby style (Warth et al., 2018).

In a systematic review and meta-analysis, Köhler et al. (2020) examined the effectiveness of music therapy in adult cancer patients by synthesising evidence from 30 studies. They focused on music therapy's impact on patients' psychological well-being, quality of life, and physical symptom distress. The purpose of this study was to offer both a narrative and quantitative overview of the impact of music therapy on adult cancer patients across all stages of the disease. The findings showed that music therapy can positively affect cancer patients' health and help reduce anxiety, depression, and manage pain. Additionally, according to the literature used in the review, music therapy can be implemented in diverse clinical settings and can employ a variety of practices to achieve different clinical goals.

However, the review also identified gaps in the literature, including limited evidence about which cancer patients benefit most from specific types of music therapy, as well as a need for further research into its long-term effects (Köhler et al., 2020). Building on these findings and limitations, this study explores how tailored music therapy practices can better meet the individual needs of cancer patients and examines their potential benefits.

This study

The present study consists of sixteen interviews with experienced music therapists who work or have worked with cancer patients across different settings and stages of illness. We aim to explore their perspectives on how clinical settings, goals, music therapy practices, and patient outcomes interrelate in cancer care, and to identify patterns that could enhance the quality and impact of music therapy. Additionally, we investigate the challenges music therapists face in their clinical work with cancer patients and examine whether these challenges influence the selection of clinical goals and therapy practices. Insights from these interviews highlight how tailored music therapy practices can enhance effectiveness in addressing the unique needs of cancer patients across different stages of illness and settings.

This research addresses the following questions:

1. What recurring themes emerge from the perspectives of experienced music therapists regarding their clinical work with cancer patients?
2. How are clinical setting, treatment duration, and patient outcomes in music therapy for cancer patients related to one another, and how do these factors influence the choice of clinical goals and practices?
3. How do music therapists adapt their practices to meet the individual needs of cancer patients?

By identifying key patterns in clinical practice, this research presents findings that could support efforts to enhance the quality and impact of music therapy in oncology care.

Method

Recruitment

Music therapists with a minimum of five years of experience were recruited for this study. The researcher personally emailed therapists renowned for their work in the field, as well as those recommended by some interviewees (snowball recruitment) and others identified via internet searches. Additionally, an announcement was posted in music therapy-related Facebook groups, and a recruitment notice was also sent to the European Music Therapy Confederation (EMTC) Research Action Team, with a request for distribution to music therapy associations across Europe.

Recruitment continued over an eight-month period, resulting in sixteen participants. At this point, and despite further efforts to recruit additional participants, no further music therapists responded to the study's call.

Demographics

Of the sixteen music therapists, eleven were working in the USA, four in Europe, and one had experience in both Europe and Australia. Three participants had 5–10 years of experience, five had 11–15 years, three had 16–20 years and five had over 20 years of experience. Nine participants held a PhD and eight of them also taught at a university. Fourteen had worked in hospitals, five in hospice centres, five in cancer centres/institutes, one in a private clinic, and one in private practice (some participants had worked in more than one setting). One participant was credentialed as NMT (neurologic music therapist) and MT-NICU, two were BMGIM (Bonny Method of Guided Imagery and Music) trainees and one was a certified BMGIM therapist.

Process of the interview

Prior to the interviews, the researcher sent a Privacy Notice and an Informed Consent form for electronic signing to all participants via Webropol software. The signed consent forms were securely stored in a locked folder on NextCloud software, accessible only to the researcher. Each interview lasted 60 minutes and was conducted in English.

According to the ethical guidelines of the University of Jyväskylä and national regulations, this study did not require ethics committee review as it involved only informed-consent interviews with adult professionals and did not pose risks to participants' physical or psychological well-being. The interview consisted of twelve questions, covering the following main topics:

1. Background and work settings of the music therapist
2. Duration and frequency of sessions
3. Length of the music therapy process with their longest-term patient
4. Therapeutic need
5. Clinical goals
6. Clinical interventions
7. Improvements observed

8. Special benefits of music therapy
9. Challenges encountered
10. Factors influencing the effectiveness of music therapy
11. Collaborations with other healthcare professionals
12. Thoughts on future research

These interview topics were chosen to provide comprehensive insights into the clinical practices of music therapists, supporting the research questions.

The interviews were recorded and stored in ResearchVideo, a secure content management system developed at the University of Jyväskylä for managing media material during research. The interviews were then transcribed into text using the same platform and archived in a pseudonymised manner.

Analysing the data

The data was analysed using relational content analysis. This method of analysis explores how the themes and concepts identified in the interviews are interconnected (Wilson, 2016). The interview transcripts were examined to uncover patterns and meanings within the data. This process involves immersing oneself in the findings, developing concepts, and organising the material into coherent themes (Gerson & Damaske, 2020). This method of analysis aligns with the study's objective of gaining an in-depth understanding of music therapists' perspectives. Given the complexity of music therapy, with its diverse clinical goals and practices, this approach enabled a nuanced analysis that captured the relationships between these elements.

The study used an inductive approach. Although there are pre-determined questions that categorise themes, such as music therapy practices and clinical goals, this approach allowed for more precise labels to arise naturally from the responses to those and follow-up questions. This leads to the discovery of fresh perspectives and revelations (Hsieh & Shannon, 2005).

The primary focus of the analysis was on clinical settings, duration and frequency of sessions, clinical goals, music therapy practices, improvements, and challenges. The interview also included questions on topics that were outside of these specific areas, but contributed to a broader understanding. Moreover, responses to these additional questions also revealed insights related to the main themes. Lastly, all research data were stored for possible further analysis.

To ensure credibility and accuracy, member check was conducted. This technique, commonly used in qualitative research, enhances the trustworthiness of results by allowing participants to review and validate the researcher's interpretations (Birt et al., 2016; Koelsch, 2013). Participants had the opportunity to comment on the results and the relevance of the findings.

Trustworthiness

Several strategies were applied to ensure trustworthiness (Lincoln & Guba, 1985). Credibility was supported by prolonged engagement with the data and by member check, as participants were invited to review the findings. It was further strengthened by recruiting participants with a minimum of five

years of experience in music therapy in cancer care, with thirteen of them having more than ten years of experience. Transferability was enhanced by providing descriptions of participants and the clinical settings in which they worked. Dependability and confirmability were supported by documenting analysis decisions (through a transparent description of the analytic process) and by engaging in regular peer debriefing with the co-author.

The authors are trained music therapists and researchers. This background provided insight into the clinical context while also requiring conscious reflection to avoid assumptions and remain open to participants' perspectives. Reflexivity was enhanced through regular discussions between the authors to challenge interpretations and minimise potential bias.

Results

The results are organised into themes that capture the main patterns identified through relational content analysis. This approach allowed for the identification of not only discrete themes, but also the ways in which clinical goals, music therapy practices, and patient engagement patterns are interconnected, reflecting therapists' perspectives and decision-making processes. These interrelated themes correspond to the research questions by highlighting recurring patterns (RQ1), relationships between clinical setting, treatment duration and outcomes, as well as their influence on the choice of clinical goals and practices (RQ2) and the ways therapists adapt their practice to individual needs (RQ3).

Patient engagement patterns: short-term vs. long-term

This theme captures how patterns of duration and frequency of the sessions, and therapeutic continuity emerge as a central factor influencing clinical goals, music therapy practices and outcomes (RQ2). The results are presented in two groups: Short-term (Table 1a) and long-term patients (Table 1b). This division reflects notable differences between the two groups and similarities within each group, including shared clinical goals and practices among therapists.

During the interviews, participants were not asked to define their interpretations of short- and long-term patients, nor to specify whether they work with either group. Instead, the necessity for these definitions arose post hoc during the analysis phase, based on patterns of session duration, frequency, and continuity. Short-term patients typically engaged in music therapy briefly or intermittently, for a few days up to a few weeks. Long-term patients engage in consistent, ongoing sessions, typically spanning several months to years.

To illustrate how these groupings emerged, participants' responses provided insights into typical engagement patterns:

1. I have to work in the moment because, for inpatients, treatment periods are predominantly short-term.
2. I have short-term patients because, once they are discharged from the hospital, I don't see them again.
3. I consider my short-term patients to be those who stay at the hospital for a few days to perhaps two weeks, while my long-term patients stay for several weeks to a few months.

4. I have long-term patients whom I know I'll see for a series of sessions. Our sessions are more psychotherapeutic in nature and the work has more depth.
5. Most of our outpatient appointments are expected to be long-term. On average, I would say we see patients for about a year and a half to two years.
6. I had about 15 sessions in a series of GIM (Guided Imagery and Music) with him (describing a specific "long-term patient" as they called him).
7. With long-term clients, I like to check in every couple of weeks or once a month and ask them "Where are we at?" and if they would like to reevaluate.
8. I had different sorts of relationships. Some patients I only saw for a few days or a few weeks while they were in treatment, while with others we had relationships over many years with regular frequency.
9. I used the long GIM programs with long-term patients who would come to us regularly as outpatients and were stable enough to engage in these extended sessions.

These statements reveal practical considerations within clinical settings that shape the approach to patient care. The music therapists' work is highly influenced by the patient's status as an inpatient or outpatient and the expected length of their hospital stay. Consequently, the definition of a patient as short- or long-term might not be determined by the therapist, but rather by external factors beyond their control. This, in turn, influences the clinical goals and music therapy practices chosen by the therapist.

Additionally, the label "*short-term patients*" also includes individuals who may engage in music therapy intermittently. These patients might leave the hospital or conclude their outpatient treatments and return after a long period, a pattern that can last for several years. Despite the extended period of their involvement, their engagement in therapy is not consistent, which prevents them from being seen as long-term patients. Intermittent therapeutic engagement is usually not considered long-term music therapy, where continuous or regular therapeutic engagement is more characteristic.

Given these differences in engagement patterns, framing the results around session duration, frequency and continuity highlights how the length and consistency of therapeutic engagement influence clinical decisions and outcomes. These pragmatic terms (short-term and long-term) help communicate the realities of music therapy practice while reflecting the main aspect of time in the therapeutic process.

Based on the distinction outlined above, of the sixteen interviewees, seven work or have worked exclusively with short-term patients, four work or have worked exclusively with long-term patients, while the remaining five have experience working with both short- and long-term patients. The group "Short-term patients" (Table 1a) includes settings where the duration and frequency of the sessions depend on factors such as medical procedures, the type and stage of cancer, the length of the patient's hospital stay and other relevant considerations. Consequently, a session can last from five minutes to one hour or even longer. Additionally, sessions can be one-time events, occur two or three times per week for a limited period (even for one week), or follow another inconsistent pattern (e.g., having a few sessions and then resuming after several months). This design is commonly observed in hospitals and other medical settings.

Clinical setting of music therapy (S-T)	Duration of music therapy(S-T)	Frequency of music therapy (S-T)
- Hospital / Cancer Centre: - Inpatient (surgery, procedural support, other treatments/tests/scans) - Outpatient (radiation, infusion unit) - Hospice Centre	It is influenced by several factors, including: - The medical procedure - The type and stage of cancer - If it is a single session - The patient's stamina - The hospital's policy It can be from 5 minutes if the patient manages to fall asleep or a medical staff member interrupts for a procedure, to 2 hours usually (but not only) for a single session that involves songwriting.	It is influenced by several factors, including: - The patient's needs (priority is given to those with severe physical symptoms) - The medical procedure - Whether it is inpatient or outpatient - The hospital's policy (length of stay in the hospital) - The size of the hospital and the number of music therapists working there - Sometimes, it can be a single session. - If there are too many inpatients and there is only one music therapist, they do not have time to see patients frequently. - Some inpatients stay in the hospital for a week. In such cases, the music therapist might see them multiple times during that week if time allows. - Outpatients receive music therapy each time they come for treatment, but this is not on a steady basis and can be unpredictable.

Table 1a: Short-term (S-T) patients in music therapy

In contrast, the group “Long-term patients” (Table 1b) includes settings where the duration and frequency of the sessions are more consistent. These typically involve weekly sessions lasting 45 minutes to one hour. This design is common in private practice but is also evident in other mental health settings (e.g., private clinics where appointments can be booked).

Clinical setting of music therapy (L-T)	Duration of music therapy (L-T)	Frequency of music therapy (L-T)
- Hospital / Cancer Centre: - Inpatient (longer stay e.g., for bone marrow transplants) - Outpatient (regular long-term treatments) - Hospital's clinic (where appointments specifically for music therapy are booked) - Private practice - Long-stay nursing home - Hospice Centre	- Usually 45-60 minutes - Depending on the practice, it can go up to 90 minutes (BMGIM or songwriting)	- Twice a week - Once a week - Once every two weeks over an extended period

Table 1b: Long-term (L-T) patients in music therapy

Clinical goals: from immediate symptom relief to deeper psychosocial processes (Table 2)

This theme highlights recurring goals and how therapists adapt them according to patient engagement patterns (RQ1, RQ3). It also illustrates how clinical setting, session duration and frequency, as well as patient physical condition, influence the selection and prioritisation of clinical goals (RQ2).

ID 1 (short-term patients) divides clinical goals into three levels of care: physical symptom management, emotional expression and transformation. While the rest of the music therapists working with short-term patients do not classify goals in the same way, they have set similar clinical goals encompassing the entire biopsychosocial spectrum, prioritising however the relief of any physical discomfort, especially pain. If patients do not feel well physically, they are unlikely to agree to participate in music therapy for any other reason. As ID 1 stated, “If the patient is in pain, there is nothing we can do.” Another participant similarly noted that “[...] if my patients are in pain, nothing else matters.”

When patients feel physically well, music therapists can focus on addressing psychosocial needs. Common clinical goals include alleviating anxiety, improving coping mechanisms, strengthening family relationships, and providing emotional processing and support. It is worth noting that, although there are clinical goals targeting emotional issues, the inconsistency in the duration and frequency of the sessions means these issues are explored gently, with a focus on helping the patient feel better at that moment. As ID 3 (short-term patients) stated “[...] I may not see them again, so I'm not going to rip open band-aids that we can't sew up.”, while ID 16 (both groups) pointed out that,

When we felt that something had arisen in the sessions in the hospital that we could not continue to support further because the patients [...] couldn't come back on a regular basis, then we would highly encourage them to seek an outside support [...]. We were highly aware of the difficulties of opening up a traumatic experience and not be able to support the treatment through.

Music therapists working with long-term patients can have multiple and steady sessions with a patient. This increases the likelihood of meeting with them even when patients are not experiencing physical discomfort, thus providing more opportunities to address emotional and spiritual issues. They might also have longer-term goals aimed at more profound work, such as work with trauma, supported by the stability in session duration and frequency, as well as the long-term therapeutic relationship. In fact, two music therapists (long-term patients) specifically described clinical goals as “psychotherapy-oriented,” while ID 16 (both groups) stated “If I have someone for months and I develop a stronger therapeutic relationship, we can explore deeper issues.”

Additionally, music therapists working with long-term patients witnessed past trauma that was reopened or triggered by the current cancer-related trauma. This provided patients with a significant opportunity to work on unresolved past issues.

It is important to highlight the holistic approach music therapists take toward both categories. More specifically, ID 6 (short-term patients) and ID 7 (long-term patients) referred to the multidimensional nature of pain, noting that physical pain can simultaneously have emotional, spiritual, social, and/or existential components. Additionally, ID 11 (long-term patients) stated

“I see patients with a lot of what we call total pain. You have the anxiety and the psychosocial distress component that feeds the physical pain.” Lastly, ID 14 (both groups) emphasises the importance of grounding psychosomatic symptoms such as emotional pain manifesting as physical pain.

		Short-term patients in music therapy	Long-term patients in music therapy
Immediate goals	Physical symptoms	• Provide comfort • Symptom management (e.g., alleviate pain, reduce blood pressure, reduce heart rate, etc.) • Improve sleep • Get more energy • Promoting relaxation	• Symptom management when is needed
	Environment	• Adjust to the illness and hospitalisation • Procedural support (e.g., during blood draws, IV-line placement) • Assist with phobic reaction to treatment or an aspect of it (e.g., panic attacks) • Provide a sense of control over the overwhelming medical environment	
Psychological goals	Emotions	• Alleviate depressive state • Reduce anxiety • Process the emotions and idea of death • Process the emotions related to diagnosis, treatment • Support the expression and processing of emotions • Facilitate meaning-making • Facilitate safe self-expression • Improve mood • Provide comfort	• Alleviate depression • Reduce anxiety • Process the emotions and idea of death • Facilitate safe emotional expression, processing and support • Process and work through the emotions around the trauma (cancer-related and other) • Facilitate meaning-making Address the mental health issues they had before cancer, which are now triggered or amplified by the disease
	Coping	• Improve coping skills • Build resilience • Empowerment	• Support and develop ego-strength • Improve coping skills • Ability to move on without fear of recurrence • Provide a sense of control over the illness • Empowerment
Social goals	Relationship with self	• Improve self-perception and physical perception • Provide spiritual support and promote spiritual growth (develop a deeper sense of meaning, purpose and connection) • Reduce existential distress • Gain self-worth • Foster a stronger sense of self	• Improve self-perception and physical perception • Provide spiritual support and promote spiritual growth • Reduce existential distress • Work on their identity after cancer and sense of self

Relationship with others	• Improve relationship and communication with family and loved ones • Develop the skills to advocate for themselves with medical staff, insurance companies and others. • Support legacy work (creation of meaningful musical material for loved ones) and relationship completion (facilitate emotional closure and resolution for patients and loved ones) • Address social needs (e.g., strengthening relationships or building social skills)	• Improve relationship and communication with family and loved ones • Support legacy work
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Table 2: Clinical goals in music therapy

Music therapy practices: adapting interventions to patient needs and engagement patterns (Table 3)

This theme describes the practices used by the participants, showing how music therapists adapt them to patient needs and engagement patterns (RQ1, RQ3). It also illustrates how session duration and frequency, as well as patients' physical and emotional conditions, influence the selection of therapeutic practices (RQ2).

Initially, the researcher asked interviewees about the techniques or methods they use in clinical practice to gain a broader understanding of their work. However, the terms still seemed limited, even though their responses encompassed a wider range of practices. Terms such as "approach," "technique," "model," "intervention," "orientation," "practice," and "method" appear to vary depending on the music therapist's training, theoretical background, or even cultural and linguistic background, and in some cases, these terms are used interchangeably. Additionally, McFerran et al. (2023) identified a variety of distinct music therapy practices around the world and attempted to classify them as "approach," "method," or "model." After conducting several interviews, it was decided that it would be more effective to ask interviewees about their practices or interventions. Bruscia (2014) defines intervention as "a purposeful attempt to mitigate an existing condition in order to effect some kind of change" (p. xxi). However, he admits that this term carries certain negative associations, such as power dynamics, hierarchy and client passivity. Additionally, while it may be suitable for some areas of practice, it is not for others, making its use potentially exclusionary (Bruscia, 2014). Therefore, after consideration, the term "music therapy practices" was selected for the remaining interviews to ensure maximum inclusivity.

Interviewees working with short-term patients often use receptive practices, which involve pre-composed songs chosen by the patient or music and imagery. Receptive practices are preferred because inpatients usually have low energy levels, or they refuse to play/sing. When patients are more energetic or willing to be musically active, the music therapist may incorporate other practices, such as songwriting, having the patients play/sing songs, or interactive improvisation. However, due to the limited time they have, they prefer to work with "various types of song methods" (ID 1) and music and imagery.

Another interviewee in this group categorises the repertoire as follows:

- a. *Bridge building repertoire*: Songs that the patient chooses or songs from the genre/style that the patient prefers. This helps build the relationship and trust from the beginning.
- b. *Functional repertoire*: Songs that serve a specific function, such as those geared toward down-regulation.
- c. *Shape Shifters*: In some cases, chosen songs can trigger emotions that patients aren't ready to feel. The music therapist can shift the patient's state by selecting a song that is light, playful, or surprising.

In addition, a significant aspect of the receptive practices for these professionals is music-assisted breathing/relaxation and down-regulating in general. Whether playing a familiar song or improvising by themselves, music therapists working with short-term patients usually achieve down-regulating through musical entrainment.

For interviewees working with long-term patients, interactive improvisation is considered essential. They report that, through improvisation, patients can express powerful and sometimes challenging emotions, which can also lead to their sublimation. For example, ID 4 shared regarding a specific patient,

[...] improvisation helped her to express her anger through drums and voice. She was really banging and shouting until she started crying, and then she realised that she actually wanted to die. This way of expressing herself and her anger usually led to crying, which helped her experience her emotions. While experiencing these emotions, they changed and became something else. Sometimes, she started with a small amount of anger, and the anger would build up and become harder and harder to manage. Then it would lead to joy.

Some participants noted that patients may not feel safe expressing certain emotions, and that improvisation, serving as a container for such material, can gently encourage them to open up and share feelings and experiences that would otherwise be inaccessible. Thus, patients are able to communicate their emotions in a creative and non-threatening manner. ID 10 shared their experience regarding this:

Through her improvisation, I understood that she was ready to die, and thus, we prepared for a closure. I also informed the patient's doctor that she was ready to die and that the family should be prepared. The woman indeed died four days later.

It is also stated that improvisation allows patients to select sounds or musical elements that represent specific emotions or relationships, with the therapist providing support throughout the process.

Two of the interviewees use improvisation as their primary tool. Moreover, although ID 5 does not differentiate between interventions for inpatient and outpatient settings, they note that

improvisation plays a larger role for outpatients in the clinic due to the longer therapeutic relationship. Additionally, regarding improvisation, ID 11 stated,

I think it's really up to the music therapist to create trust and rapport, where someone can feel free to explore and be vulnerable without feeling pressured to do something they've never done before, [...] to express themselves in a new way.

Songs chosen by the patient are also important to this group, along with music and imagery practices. In any case, using live music is particularly important for everyone because it allows for control over the musical elements and provides the flexibility to meet the patient's needs.

Table 3 provides a comprehensive list of music therapy practices chosen for sessions with short- or long-term patients. The practices are categorised as pre-composed songs / music, improvisation or other. The asterisk (*) refers to practices used more frequently.

Short-term patients in music therapy	Long-term patients in music therapy
Pre-composed songs: • The therapist plays songs chosen by the patient * • The therapist plays pre-composed songs in the genre or style chosen by the patient • Lyric analysis (exploration of the lyrics of a song to facilitate emotional expression, self-reflection, and insight) • Recreating / adapting a song • Creating playlists * Pre-composed music or improvisation by the music therapist: • Music-assisted breathing and relaxation * • Scripted music and imagery * • Unscripted music and imagery • Short version of GIM (if the music therapist is qualified) • Drawing while or after music listening / imagery • Guided meditation through music Improvisation: • The therapist improvises for the patient * • Progressive muscle relaxation * • Toning (sustaining vowel sounds to create resonant vibrations) • Some interactive improvisation (usually when the patient initiates it) Other: • Songwriting * • Providing patients with resources / techniques they can do themselves * • Heartbeat recordings	Pre-composed songs: • Songs chosen by the patient • Lyric analysis • Recreating / adapting a song • Creating playlists • "Song of Life" Pre-composed music or improvisation by the music therapist: • Scripted music and imagery • Unscripted music and imagery * • Drawing while or after music listening / imagery • Short / adapted version of GIM (if the music therapist is qualified) * • GIM (if the music therapist is qualified) Improvisation: • Interactive improvisation * • The therapist improvises for the patient • Record the improvisation, listen to it and reflect • Music-assisted breathing and relaxation • Toning Other: • Songwriting • Providing patients with resources / techniques they can do themselves *

Table 3: Music therapy practices

Improvements: biopsychosocial outcomes of music therapy (Table 4)

This theme summarises perceived patient outcomes and illustrates the relationship between therapeutic continuity, session duration and frequency and observed benefits (RQ1, RQ2).

Improvements can be seen in all domains: physiological, mental, and social. All three domains are equally important and are observed in both short- and long-term patients. Some common improvements include reduced pain and other physical discomfort, regulated anxiety, emotional expression and processing, increased resilience, better coping, feeling empowered and improved relationships with family and medical staff. Music therapists working with short-term patients observed even more improvements in physical symptoms, as these patients are more likely to experience them. In contrast, therapists working with long-term patients also noted the processing and resolution of past and cancer-related trauma, facilitated by the duration and consistency of sessions.

Although there may be a positive bias in these observations, as therapists were asked primarily about *improvements* rather than *therapeutic change*, something that may have influenced their responses to focus on favourable outcomes, some interviewees also described as improvements the expression of challenging emotions, working through trauma, or the ability to end relationships.

Group	Physical	Psychological	Social
Short-term	• Decreased heart rate • Lower blood pressure • Less tense muscles • Decreased respiratory rate		• Feeling less isolated • Sense of control over the environment and their illness • Feeling of “escape” from the hospital • Relationship completion and legacy work
Both	• Better and deeper breathing • Reduced pain • Better sleep • Increased stamina	Immediate: • Feeling more relaxed • Improved mood • More open and receptive to medical staff and their treatment Functional: • Building resilience • Feeling Empowered • Practicing self-care • Developing coping strategies • Feeling more comfort • Decreased / regulated anxiety • Finding new ways to approach and accept physical symptoms	• Improved relationship with themselves, others and beliefs (e.g., religion) • Interpersonal connection

	Emotional: • Ability to express themselves • Ability to identify and express emotions • Much lighter depressive state • Spiritual experiences and growth • Working on identity issues, and body image (esp. for women)	
Long-term	Complex pre-existed or cancer-related issues and emotional trauma: • Work through that fear for occurrence • Sublimation of painful feelings and use of pain for therapeutic change • Working on and resolving difficult issues that was impossible for them before • Significant changes working on trauma • Identifying childhood trauma as source of emotional and psychosocial issues (e.g., panic attacks) in the present that manifested due to cancer and work on it • Opportunity to seek out therapeutic support and address issues that had been there before in their life but they didn't feel the need to address them with a professional until their cancer treatment	• Finding the strength to end meaningless or harmful relationships with others

Table 4. Improvements in music therapy

Challenges: Barriers that shape therapeutic decisions and adaptations (Table 5)

This theme highlights recurring challenges (RQ1) that influence clinical decisions (RQ2) and require therapists to adapt practices (RQ3).

The challenges observed are categorised into three types: those related to the music therapist, those related to the patient and those related to practical or environmental factors. These challenges are varied and usually not specific to any particular setting. Typical challenges are:

- The difficulty music therapists face in adapting and utilising their own countertransference in the process
- Patients' resistances
- Lack of understanding from the medical staff of what music therapy is and what it can offer as a therapeutic intervention
- Patients might refuse music therapy because they don't understand what it is and its benefits.
- Lack of protected space at the hospital. People come in and interrupt the session for a procedure.

Group	Related to the music therapist	Related to the patient	Practical/environmental
Short-term	- Professional grief - Face own mortality - Bearing witness to human vulnerability and suffering - Saying the wrong things - Lack of particular musical skills - Certain music or songs can have one effect on one person and another effect on another person. I have to walk the fine line there.	- Lack of patient's stamina - Lack of understanding from patients of what music therapy is - Patient's deferring or saying "no" to music therapy	- Urgency (we have to do it all in one session) - Sometimes, you have to build a therapeutic relationship in a very short period of time. - Lack of privacy or a soundproof environment - The repertoire - Scheduling and planning (treatment might get cancelled or changed) - Patients might be sleeping, they're in procedures or they have visitors. So, finding a good amount of time with someone can be really difficult. - Provide active music therapy in a hospital bed - Movement restrictions due to the medical treatment
Both	- Being a constant advocate and educating co-workers and medical staff about the benefits of music therapy - Music therapist's countertransference - Not being able to construct a functional therapeutic relationship - The therapist has to figure out, how to gently get around the patient's defences and inspire enough trust so that they will actually let themselves try and do something meaningful. - Learn how to take care of myself - The vacillation of day-to-day goal changing. You're constantly having to adapt and be flexible with the music and meet goals in different ways.	- Patient's receptivity and ability to open up. - Some patients are rigid, they don't let you do anything. - Some patients are resistant to treatment as part of their coping structure. - Some patients have diminished ego strength. - Because patients must pay out of pocket after a certain time, they stop music therapy or reduce sessions - Patient's transference to the music - Some instruments or sounds might have a re-traumatising effect to patients who were physically abused before. - Patient's focus is on survival. So, music therapy support can be secondary for them at that moment.	- Lack of protected space at the hospital. People come in all the time and interrupt the session for a procedure. - Misunderstanding / not knowing what music therapy is from the medical staff - Sometimes, the family takes care of their loved ones and they don't want me to go in the room. - Sometimes, the support system of the family could also have negative impact and discourage the patient to have music therapy. - The lack of equipment - The nature of the music therapist's contract of being time-limited
Long-term	To feel exactly what patients are feeling.	Client's resistances to improvisation, creativity and spontaneity, and their effort to control	

Table 5: Challenges

Discussion

Feedback from interviewees

Conducting member check helped maintain the transparency of the results and ensured an objective reflection of the participants' perspectives. Twelve out of the sixteen interviewees responded to the call for member check. Eight of them had no further comments and approved the researcher's understanding and analysis. Four interviewees provided feedback on the results, suggesting refinements to certain terms or the inclusion of additional elements in the tables. While some comments were incorporated, leading to some final revisions, the request to include certain other terms was deemed unnecessary, as they were considered to fall under a broader category.

Short- and long-term patients

In psychotherapy in general, the distinction between short- and long-term therapy has been addressed variably across theoretical orientations and clinical contexts. Health-system guidelines and trial conventions often define short-term psychotherapy as time-limited, typically comprising 16–20 sessions over 4–6 months for depression and 25–30 sessions over 6–8 months for social anxiety disorder (Ho & Adcock, 2017). Outpatient psychotherapy in naturalistic settings also varies widely, but clinical trials frequently standardise treatment at approximately 16 sessions (Flückiger et al., 2020). Within psychodynamic traditions, short-term psychodynamic psychotherapy is usually scheduled for 20–28 weekly sessions (about 6–7 months) (Malkomsen et al., 2025; Savolainen et al., 2024), whereas long-term psychodynamic psychotherapy is defined as lasting at least 1 year and 40 sessions, often extending to 2–3 sessions weekly over multiple years (Alanne et al., 2021; Woll & Schönbrodt, 2020). Cognitive-behavioural and systemic approaches are generally briefer, typically ranging between 10 and 20 sessions (Orvati Aziz et al., 2020), while solution-focused therapy is often limited to no more than 20 sessions, typically within 8 months (Alanne et al., 2021). Definitions also depend on therapeutic orientation, with psychodynamic and psychoanalytic therapies conceptualised as inherently longer and depth-oriented, while CBT or solution-focused therapy as symptom-focused and briefer.

Overall, the literature highlights the absence of a single universal cutoff. Instead, the boundaries of short- versus long-term psychotherapy depend on frequency and theoretical orientation and are often defined within individual studies (Juul et al., 2019). In this light, our study adopted a post hoc definition of *short- versus long-term patients* based on consistency in the duration and frequency of the sessions, as well as therapeutic continuity rather than rigid cutoffs. The division was further supported by observed differences between the two groups and similarities within each group.

The findings highlight how session consistency and duration shape the scope of clinical goals. Short-term therapeutic relationships often necessitate prioritising physical/physiological, as well as immediate psychosocial and spiritual needs, which may limit opportunities for more profound emotional work. In contrast, longer-term therapeutic relationships provide a foundation for addressing more complex issues, including trauma. In any case, in all kinds of clinical settings, music therapists help cancer patients with any biopsychosocial need they have at that moment. The main difference is

that when sessions are less consistent and brief, it becomes more challenging for music therapists in hospital settings to address deeper emotional issues.

These differences also raise important ethical considerations. As described in the *Results* section, some interviewees working with short-term patients, particularly in hospice, reflected on the responsibility of balancing emotional openness with the limits of a brief therapeutic relationship and emphasised the need to avoid reactivating traumatic material when continuity of care could not be ensured. This underscores the delicate ethical issues involved in working with patients whose future engagement in music therapy is uncertain, such as in end-of-life care. While the emergence of strong emotions related to traumatic experiences cannot always be prevented (e.g., some instruments or sounds might have a re-traumatising effect), music therapists carefully monitor and respond to patients' emotional states, provide support within each session and refer to external resources when ongoing therapy is not possible.

The relationship between clinical goals and music therapy practices

Many studies in adult oncology research refer broadly to *music therapy* as the intervention without specifying the exact practices used. However, some studies provide links between clinical goals, music therapy practices and patient populations. For example, reducing pain and physical symptoms has been targeted with live music selected by the patient in breast or gynaecological cancer (Alcântara-Silva et al., 2018) and in adult oncology patients on a blood and marrow transplant unit (Reimnitz & Silverman, 2020). Pre-composed music, music and imagery, and music-guided breathing exercises have been used with cancer patients under or between active treatments (Rabinowitch et al., 2023). To reduce anxiety and promote relaxation, several practices have been used, such as music and imagery, interactive improvisation and songwriting in patients with small cell lung cancer receiving chemotherapy (Tang et al., 2021) and in hematologic or oncologic patients more broadly (Rodgers-Melnick et al., 2022). Interactive improvisation and songwriting have been used to support coping, emotional expression, trauma integration and spirituality. Examples include patients undergoing infusion (Mondanaro et al., 2021), radiation oncology during CT simulation (Rossetti, 2021) and breast cancer patients (Thompson et al., 2017). These studies illustrate how music therapy practices can be tailored to clinical goals and patient populations.

However, Köhler et al. (2020) highlighted the limited evidence regarding which cancer patients benefit most from different types of music therapy, making it difficult to provide music therapy practices tailored to the specific needs of each individual. Our findings expand on this by underscoring how clinical goals shape the choice of music therapy practices, with short-term patients receiving primarily treatment for physical symptoms and long-term patients engaging in deeper psychotherapeutic work, consistent with the broader biopsychosocial framework suggested in prior literature.

Clinical goals related to physical or physiological health are primarily addressed through receptive music therapy. Music therapists use pre-composed songs chosen by patients to help them relax, reduce pain, breathe better, improve sleep, and more. Additionally, musical entrainment is used in songs, music-assisted breathing, music and meditation, or scripted music and imagery and serves as

a key practice for down-regulation. Music and imagery can also help patients “escape” from the hospital setting, cope with medical procedures, and more.

Clinical goals related to psychosocial health are shaped by the duration of the therapeutic relationship. In short-term relationships, the music therapist focuses on providing immediate psychological and emotional support. They may use pre-composed songs or music and imagery to elevate mood, regulate anxiety, provide comfort or facilitate the expression of emotions that can be addressed within a few or even a single session. Incorporating songs – ranging from simply listening to the therapist perform a song, to joining them in singing or playing an instrument, to lyric analysis, to songwriting – remain significant for music therapists working briefly and inconsistently with cancer patients. A song can empower, foster relationships, communicate feelings, and more.

Additionally, music therapists working regularly with cancer patients also use songs. However, having longer therapeutic relationships, they can pursue deeper psychotherapeutic goals. They may use clinical improvisation to encourage the emergence and processing of deeper feelings, conflicts, and fears over time. Music and imagery (usually unscripted) practices are also employed for these purposes. It is important to note that, as mentioned earlier, all music therapists address the biopsychosocial needs of cancer patients at that moment and respect their readiness to engage in a particular therapeutic activity.

Lastly, it seems essential for all music therapists to provide cancer patients with resources they can use outside of music therapy sessions, such as breathing exercises for relaxation or creating a playlist to listen to during infusion treatments.

Improvements

The analysis of the interviews supports previous findings in the literature, indicating that music therapy has an impact across the entire biopsychosocial spectrum of cancer patients' health. Research has shown that music therapy can reduce pain and alleviate other physical symptoms (Alcântara-Silva et al., 2018; Bradt et al., 2023; Lichtl et al., 2022; Rabinowitch et al., 2023; Reimnitz & Silverman, 2020; Rodgers-Melnick et al., 2022; Rossetti, 2021; Tang et al., 2021), reduce anxiety and promote relaxation (Eseadi & Ngwu, 2023; Holloway et al., 2019; Lagattolla et al., 2023; Rodgers-Melnick et al., 2022; Tang et al., 2021), support coping with diagnosis and treatment (Mondanaro et al., 2021; Rossetti, 2021), enhance spirituality and meaning-making (Lichtl et al., 2022; Thompson et al., 2017; Tynan et al., 2018), facilitate emotional expression (Mondanaro et al., 2021; Rodríguez-Rodríguez et al., 2023; Thompson et al., 2017; Tynan et al., 2018), process trauma (Rossetti, 2021), and more.

The improvements reported by music therapists largely align with the clinical goals identified in this study. Although many benefits were mentioned by therapists working with both short- and long-term patients, some appear more characteristic of one group. For example, alleviate physical symptoms were primarily observed in short-term patients, likely because these patients were actively experiencing treatment or illness-related physical discomfort that required immediate attention. In contrast, long-term patients often engage in music therapy after completing treatment and may not present acute physical symptoms. If discomfort occurs, sessions are more likely to be rescheduled. Spiritual benefits also vary. In short-term patients, they may relate more to end-of-life concerns and

meaningful moments, whereas in long-term patients, they often involve personal transformation, reflected in the development of new life meaning and profound changes in values and perspectives.

Additionally, as stated in the *Results* section, although participants were asked about improvements and thus responses may carry a positive bias, they also described outcomes such as the emergence and processing of traumatic material or the development of strength to end relationships. These outcomes reflect emotional processing, resolution of unresolved issues and enhanced agency, even when difficult emotions are involved. Köhler et al. (2020) also emphasised the need for further research to explore the long-term effects of music therapy. The findings of the present study suggest that long-term therapeutic relationships additionally support the integration of past and cancer-related trauma.

Challenges

Common challenges faced by music therapists in their clinical work are rarely discussed in the literature. Bruscia (2014) highlighted the challenge faced by music therapists in determining how responsibilities should be shared between themselves and their clients, as well as the need for them to simultaneously listen to the unfolding music while creating new music, which requires high levels of attention and awareness (Bruscia, 2014). Lacson et al. (2021) identified clients not showing up for sessions as a major challenge, along with music therapists' lack of understanding caused by socioeconomic differences between themselves and their clients. Additionally, finding a balance between the ideal and practical duration of sessions within community healthcare settings was highlighted as another significant challenge (Lacson et al., 2021).

In this study, the exploration of the challenges faced by music therapists in their clinical work aimed to examine whether these challenges differ depending on the setting and how they influence the selection of clinical goals and music therapy practices. Three types of challenges were identified: those related to the music therapist, those related to the patient and those related to practical or environmental factors. The challenges shared by the interviewees complement those reported in previous literature.

Some typical challenges include: the music therapist's difficulty in adapting to and utilising their own countertransference, patients' resistance, patients' reluctance to engage in music therapy due to the lack of knowledge about its benefits, the lack of understanding from medical staff regarding what music therapy can offer as a therapeutic intervention, and the lack of privacy in hospital settings. The documented challenges do not appear to depend on the clinical setting or the type of the therapeutic relationship (short- or long-term). An exception is the significant issue of limited time, which affects those working with inpatients, in hospice care, or in other settings with limited and / or very brief sessions.

Key music therapy practices and their relationship to clinical goals and patient needs

The following sections highlight four central music therapy practices identified in this study: pre-composed songs, clinical improvisation, music and imagery and musical entrainment. These practices consistently emerged across interviews as essential to the clinical work of experienced

music therapists in cancer care. They illustrate how therapists make decisions based on session consistency, patient needs, clinical goals and the therapeutic context. Each subsection describes the rationale for using these practices, the intended outcomes and how they are tailored to support both immediate and longer-term physical, emotional and psychosocial and spiritual goals.

The importance of pre-composed songs

Using pre-composed songs appears to be a key practice for inconsistent and shorter therapeutic relationships. Songs serve as a medium for emotional exploration, self-expression, and connection with others, allowing patients to communicate emotions quickly even in brief sessions. They reflect personal beliefs and values, while also preserving memories and offering insights into the past, present, and future (Bruscia, 1998). Their inherent link to human connection makes their use in music therapy particularly significant and meaningful (Bailey, 1984). Whether through active listening, performing with the music therapist, lyric analysis, or any other song method, pre-composed songs chosen by the patient offer an effective way to downregulate physical symptoms, gain trust quickly, access emotions and connect when time is limited.

The importance of clinical improvisation

Clinical improvisation is applied across a range of clinical environments, such as hospitals, clinics, and private practices and it has been implemented with various patient/client groups, including those experiencing pain, medical conditions, or emotional challenges. It also supports psychological development, enhances interpersonal connections, and facilitates relaxation and pain management (Bruscia, 1987). In this study, clinical improvisation appears to be a key practice in consistent and longer therapeutic relationships. It provides a safe space for cancer patients to process and make sense of their traumatic experiences, find support and express their fears, while addressing unrevealed issues and unresolved emotions.

Clinical improvisation facilitates access to emotional experiences linked to symbols and imagery, creating opportunities for exploration and acceptance (Priestley, 2012). This creative process allows individuals to express unconscious material, providing music therapists with a pathway to address profound emotions, underlying drives, and inner conflicts within the therapeutic context (Toomey, 1991).

The importance of music and imagery

Music and imagery practices vary widely depending on the clinical goal, and they appear to be equally important across different settings and therapeutic relationships. When the goal is relaxation, regulating breathing and heart rate, changing the perception of being in a hospital, changing mood, or even reducing pain, these practices typically involve visualising body parts or bodily functions, or imagining a calming and relaxing environment, while following the music therapist's instructions. The music has a steady tempo, predictable structure, and minimal dynamic changes (Grocke & Wigram, 2007).

In contrast, according to the interviewees, when the goal is more spiritual or psychotherapy-oriented, the music and imagery practices focus on encouraging patients to freely connect with more profound feelings, emotions, metaphors, associations, and images and explore and accept them. In these cases, the music exhibits greater variability in instrumentation and dynamic flow, with these changes stimulating imagery by introducing new and engaging musical elements (Grocke & Wigram, 2007).

The importance of musical entrainment

Musical entrainment is incorporated into songs, the therapist's improvisation, or music and imagery. The music therapist utilises the 'iso' principle by matching the music to the patient's mood, breathing rate, heart rate, or other physiological indicators, and then gradually modifies the music to facilitate therapeutic changes (Altschuler, 2001). The music therapist performs it in the way that seems most appropriate at that moment. Its benefits are spread across the biopsychosocial spectrum, more prominently downregulating physical or physiological symptoms, promoting relaxation and improving movement.

Medical music therapy versus music psychotherapy for cancer patients and survivors

Out of the sixteen interviewees, twelve referred to their practice as Music Therapy. One specified that they practice Medical Music Therapy, while three mentioned that they also use Music Psychotherapy. Dileo (2021) defines Medical Music Therapy as the application of music therapy to prevent, treat, and provide ongoing care for individuals at medical risk or those with existing medical conditions. Moreover, Medical Music Therapy utilises evidence-based techniques to address the biopsychosocial needs of patients undergoing medical care (Hillmer et al., 2012).

On the other hand, Bruscia (1998) defines Music Psychotherapy as an interpersonal process, with treatment occurring within and through the client-therapist relationship. In this context, music serves as the primary form of expression within a psychotherapeutic framework (Brabant et al., 2017). While the literature doesn't explicitly state whether Music Psychotherapy is intended for short- or long-term patients, it is evident that developing a strong therapeutic relationship is essential (Bruscia, 1998, 2014), similar to verbal psychotherapy, which requires time and multiple sessions (Pawlak & Kacprzyk-Straszak, 2020; Smith, 2016). Additionally, Rossetti (2021) introduces the concept of Medical Music Psychotherapy (MMPT), described as "an eclectic mix of psychotherapeutic models merge with music experiences as a medium and facilitator of the therapeutic relationship / alliance" (p. 3), which is practised at the Louis Armstrong Music Therapy Department and Center for Music & Medicine at Mount Sinai Beth Israel in New York City.

However, as evidenced by the findings of this study as well, it is common for music therapists to refer to their practice as Music Therapy, even when they focus on a more specific aspect of it for which they may also have received specialised training. Based on the above, the findings suggest that the two groups ("short-term patients" and "long-term patients") can be classified into Medical Music Therapy and Music Psychotherapy respectively.

Limitations

The 16 participants represented a heterogeneous set of theoretical backgrounds, ranging from psychodynamic and humanistic approaches to cognitive-behavioural and integrative orientations. While this diversity enriched the data, it also introduced variability in how concepts, such as “short-term” versus “long-term” therapy or particular practices, were understood and described. Consequently, the findings provide meaningful insights into common patterns and considerations among experienced practitioners, while acknowledging that practices may vary across different contexts.

Additionally, the study was open to music therapists worldwide, most respondents were from United States. Eleven of the participants were based in the United States, four in Europe, and one had experience in both Europe and Australia. Consequently, the findings may primarily reflect practices and healthcare structures as shaped by the U.S. context. Music therapy practices are often influenced by national healthcare systems, cultural attitudes toward therapy and institutional frameworks, which limits the transferability of the results to other regions. Additionally, the majority of participants worked in hospital or institutional settings, including hospices, outpatient clinics and cancer centres, while only one was practicing independently. This institutional bias may have influenced how music therapy goals and practices were described, potentially underrepresenting perspectives from private practice.

Moreover, this study focused exclusively on adult cancer patients and included participants working across various types and stages of illness, such as chemotherapy, radiation, surgery, end-of-life care, and survivorship. Although several participants worked with cancer patients in hospice settings, we did not handle this population as a separate group. This decision was based on the wide variation in session frequency and duration in hospice care, which aligned more closely with the characteristics of the short-term patient group.

As with all qualitative research, the perspectives and interpretations of the researchers may have influenced data collection, analysis, and presentation. In particular, while music therapists described their work in end-of-life care, the interpretation of these narratives may have been shaped by the researchers’ professional background and cultural perspectives. Given the ethical sensitivity of hospice and palliative contexts, such positionality inevitably influenced how practices were understood and presented. Reflexivity was maintained throughout the study by keeping a research diary, documenting reflections, discussing interpretations in research meetings and conducting member check with participants. These steps were intended to minimise the influence of personal or theoretical biases.

Finally, this study did not include patient perspectives or measurable clinical outcomes. While patients could have provided valuable insights, particularly regarding perceived benefits and challenges, they could not address key aspects such as clinical goals or therapists’ decision-making processes. Measurable outcome data were not incorporated because the aim of the study was not to evaluate the effectiveness of music therapy, but to explore therapists’ clinical reasoning, decision-making and experiences in oncology care. These nuanced professional perspectives were best captured through in-depth interviews, which allowed for a detailed understanding of practices and clinical considerations.

Implications for clinical practice

The findings of this study offer several implications for music therapists working with adult cancer patients, helping clinicians make more informed decisions while remaining flexible and responsive to each patient. First, this study highlights the importance of aligning music therapy practices to clinical goals. Short-term patients often require interventions targeting immediate physiological or emotional needs, whereas long-term patients may benefit from deeper psychotherapeutic work. Recognising these distinctions can guide therapists in structuring sessions, selecting appropriate practices and setting realistic goals, while still maintaining responsiveness to individual patient preferences and readiness.

Second, music therapists and students should reflect on their musical and communication strengths and limitations. For instance, therapists who find it challenging to maintain a large song repertoire or adapt songs spontaneously may face difficulties in short-term, often hospital-based work. Similarly, they should consider their skills and willingness to engage in improvisation or songwriting when these practices are clinically indicated in various settings. Developing specific musical and music therapy skills can expand the range of patients and settings a therapist can work effectively. Moreover, the results of this study suggest that strong communication skills are essential across all contexts, enabling therapists to build rapport, understand patient needs, and facilitate meaningful therapeutic interactions.

Third, the findings underscore the need for specific training programs in Medical Music Therapy and Music Psychotherapy for cancer care. Awareness of the distinct skills and competencies required for each potential specialisation can help therapists make informed decisions about their clinical work with cancer patients, ensuring they are best equipped to support them.

Finally, healthcare institutions and oncology departments can use this information to plan services more effectively, including integrating music therapists into multidisciplinary teams, scheduling session frequency, allocating staff and supporting both short- and long-term therapy models.

Suggestions for future research

Participants highlighted the need for research that captures the nuanced and diverse needs of patients and different types of clinical practices. Due to the complexity of music therapy, studies could examine how session frequency, duration and short- versus long-term music therapy influence outcomes and investigate the specific contributions of practices such as pre-composed songs, clinical improvisation, and music and imagery.

Moreover, the effectiveness of music therapy for cancer patients and survivors remains debated due to differences among studies, which make comparisons difficult (Gramaglia et al., 2019). Future research should prioritise achieving greater homogeneity in sample populations, practices, and settings to improve comparability and clarity in evaluating outcomes. Such evidence will enable clinicians to make informed decisions and adapt music therapy to the specific needs of individual patients. More precise research is essential to build a toolkit of evidence-based strategies that support both standardised protocols and individualised care.

Additionally, there is a need for both qualitative and quantitative research, in order to capture the complexity of music therapy. Studies should clearly define the music therapy practice(s) used and develop assessment tools that reflect the unique contributions of music therapy. At the same time, music therapy research should also incorporate mixed-method and flexible designs that capture long-term effects, ethical complexities and the full depth of clinical processes. Longitudinal research could further clarify the sustainability of benefits after the end of music therapy and the role of music therapy in processing trauma, supporting psychosocial adjustment and enhancing quality of life.

Finally, exploring how therapists' training, theoretical orientation and competencies shape clinical effectiveness can inform training programs and evidence-based guidelines to optimise both Medical Music Therapy and Music Psychotherapy in oncology care.

Conclusion

Music therapists' perspectives provided insights into the relationship between the duration and frequency of music therapy, clinical goals and practices. Short-term music therapy with cancer patients initially focuses on relieving physical symptoms, often addressed through receptive music therapy practices that typically involve musical entrainment. When the patient's physical health and available time allow, music therapists may then shift to psychosocial goals, frequently achieved also through receptive practices.

Long-term music therapy with cancer patients can address more complex psychosocial issues, as it allows time for profound exploration. Clinical improvisation is often used to encourage the emergence and processing of deeper feelings, conflicts and fears over time. Additionally, unscripted music and imagery practices are also regularly employed for these purposes.

The findings do not support a relationship between the duration and frequency of music therapy, clinical goals, and practices on one hand, and improved outcomes on the other – a result consistent with Köhler et al. (2020). An exception is outcomes involving trauma integration, which are evident in long-term patients.

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Vasiliki Tsakiridou: Conceptualisation, Methodology, Project Administration, Validation, Visualisation, Writing – original draft.
Esa Ala-Ruona: Conceptualisation, Methodology, Supervision, Validation, Writing – review & editing.

Artificial intelligence (AI) usage

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Ελληνική περίληψη | Greek abstract

Διερευνώντας τις απόψεις των μουσικοθεραπευτών σχετικά με τους κλινικούς στόχους, τις πρακτικές και τα αποτελέσματα σε διαφορετικά πλαίσια φροντίδας του καρκίνου

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Περίληψη

Αυτή η ποιοτική μελέτη διερευνά τη χρήση της μουσικοθεραπείας στη φροντίδα του καρκίνου, εξετάζοντας τις απόψεις έμπειρων μουσικοθεραπευτών. Διεξήχθησαν 16 ημι-δομημένες συνεντεύξεις με μουσικοθεραπευτές που εργάζονται ή που έχουν εργαστεί με ασθενείς με καρκίνο σε διάφορα κλινικά περιβάλλοντα και στάδια της ασθένειας. Οι συνεντεύξεις αναλύθηκαν χρησιμοποιώντας σχεσιακή ανάλυση περιεχομένου. Οι θεματικές ενότητες που αναδείχθηκαν στις συνεντεύξεις επικεντρώθηκαν στους κλινικούς στόχους που θέτουν οι θεραπευτές, στις πρακτικές μουσικοθεραπείας που χρησιμοποιούνται στις συνεδρίες, στα οφέλη που παρατήρησαν και στις προκλήσεις που αντιμετώπισαν. Η ανάλυση των συνεντεύξεων παρείχε μια εις βάθος κατανόηση των εμπειριών των συμμετεχόντων, τονίζοντας τη σημασία της προσαρμογής των πρακτικών μουσικοθεραπείας ώστε να ανταποκρίνονται στις μοναδικές ανάγκες των ασθενών με καρκίνο σε διαφορετικά στάδια της ασθένειας και σε ποικίλα περιβάλλοντα.

Λέξεις κλειδιά

φροντίδα για τον καρκίνο, πρακτικές μουσικοθεραπείας, κλινικοί στόχοι, συνεντεύξεις, ποιοτική ανάλυση περιεχομένου