

Short Report

Exploring Patient Experiences of Live Music in an Oncology Setting Through the Lens of Compassion Focused TherapyPeter Shannon ¹, Paul Gilbert ^{2, *}

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Abstract

Live music interventions are increasingly employed in healthcare settings through a range of models, including clinical music therapy and Arts-in-Health musician programs. This study examines patient responses to live music delivered by trained professional orchestral musicians within an outpatient chemotherapy infusion unit. Although a substantial body of research associates music with reductions in anxiety, pain, and distress, findings remain heterogeneous, and the mechanisms underlying these outcomes remain incompletely understood. This is particularly true in live music settings, where musical experience is inseparable from interpersonal encounter. The aim of this study was to explore whether Compassion Focused Therapy (CFT), the psychotherapeutic model developed by Paul Gilbert, offers a useful interpretive framework for understanding patient experiences of live music delivered by Arts-in-Health musicians. Drawing upon qualitative patient reflections collected through a service-evaluation questionnaire, the study examines how processes associated with emotional regulation, social safeness, connection, comfort, and self-soothing may emerge within live musical encounters. Viewed through a compassion science perspective, patient accounts frequently reflected experiences of meaningful autobiographical connection, reduced isolation, emotional comfort, and feelings of being cared for. These observations



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suggest that some benefits of music in healthcare may arise not solely from acoustic properties of the music itself, but also from relational processes embedded within the musical encounter. The purpose of this study is not to apply CFT as an intervention, but to use it as an interpretive framework for examining patient experiences of live music within an oncology setting. Through this lens, the findings contribute to emerging discussions concerning music, compassion, and human connection within healthcare.

Keywords

Music; compassion; healthcare

1. Background

In regard to the motivation to listen to music, considerable evidence indicates that people choose music specifically to have emotional impacts. Analysing large-scale survey data on the functions of everyday music listening, Schäfer et al. report that “people listen to music to regulate arousal and mood, to achieve self-awareness, and as an expression of social relatedness”, with the first two dimensions judged to be more important than the third [1].

While everyday choice is driven by clear emotional goals, evaluating these choices within standard clinical paradigms has yielded highly conflicting empirical data. Finn and Fancourt note that “it remains unclear whether similar effects of listening to music occur when it is used in clinical settings compared to in our everyday lives, how much of an effect individual choice has on biological response relative to the effect of musical features such as genre, and the length of listening period required for a biological response to occur” [2].

While some studies report robust reductions in anxiety, cortisol, pain, and medication use following music interventions, particularly in clinical and perioperative contexts [3, 4], others report null or opposite effects in laboratory stress paradigms. For example, Thoma et al. found that listening to music prior to stress did not reduce cortisol and was associated with higher cortisol levels compared to silence or nature sounds [5].

Direct contradictions are also evident in studies comparing music selection: self-selected music has been shown to produce greater anxiety reduction in some studies [6, 7], yet equivalent or no differences have been reported in others [8], and in at least one case, researcher-selected music was found to be more effective than self-selected music for cortisol regulation [9]. The Groarke & Hogan study suggested that the ‘regulatory effects of music may be enhanced when stimuli are self-selected due to increased feelings of control, dominance, and agency’ rather than any specific emotional, nostalgic, or autobiographical qualities of the music itself [8].

Crucially, these inconsistencies do not reflect a lack of academic rigor. Indeed, studies have exhaustively investigated physiological measures and experimental conditions; including placement of electrodes, midrange setting of CD players, ambient temperature, down to the exact wattage of a lamp in the room [6]. In other studies musical content such as key, tempo, duration, and time signature have undergone analysis [10], as well as accounts of ‘speechiness’, ‘acousticness’ and ‘instrumentalness’ [11]. Adiasto et al. indicated unresolved tension in their conclusion, observing that while music is often presented as a promising method for stress recovery, music listening is

also “a highly personal activity”, and that “new approaches are needed to better discern the effects of music listening on the recovery process” [11].

The issue, then, is not whether sufficient variables have been measured, but how such divergent findings are to be understood, and what conceptual lens might allow them to be meaningfully integrated.

1.1 Music in Healthcare through the Lens of Compassion Focused Therapy (CFT)

The present study proposes that Compassion Focused Therapy (CFT) may offer one such lens. The intention is not to explain music solely through compassion, nor to suggest that compassion is the only mechanism underlying musical benefit. Rather, CFT provides a framework through which relational, affective, and interpersonal dimensions of musical encounters may be examined. In this sense, CFT helps illuminate aspects of patient experience that have often remained difficult to account for when music is treated primarily as an acoustic stimulus.

It is well noted across various fields of music literature that the psychological relationship between a performer and an audience holds therapeutic value, with several studies highlighting that the intentional, physical presence of a live musician can function as a powerful psychological mechanism of safety and comfort [12, 13].

Beyond having benefits for patients, live music in oncology settings has also proven beneficial to staff and carers [14]. However, the psychological and relational processes underpinning these outcomes remain incompletely understood.

Psychobiological research confirms that experiencing compassionate intent and feeling cared for by another human being triggers robust physiological regulation, directly modulating the autonomic nervous system, the hypothalamic-pituitary-adrenal (HPA) axis, and immune responses [15].

Compassion is defined in this context as a sensitivity to stress or suffering in the self and others, paired with a commitment to alleviate and prevent it [16]. Within the framework of compassion science, interactions oriented toward addressing states of suffering or distress with a helpful intention are classified as compassionate interactions [16].

The aim of the present study is not to evaluate the clinical efficacy of live music interventions, but to explore whether Compassion Focused Therapy (CFT) offers a useful interpretive framework for understanding patient experiences reported during a music-based intervention delivered by Arts-in-Health musicians within an outpatient oncology setting [17].

1.2 Program Description

The musicians involved in this study were professional orchestral musicians functioning as Arts-in-Health practitioners rather than music therapists. They played live, patient-selected music within an outpatient oncology setting as a complementary component of patient care.

Musicians completed the American Institute of Music and Healing (AIMH) ‘*Awakening the Inner Gift*’ training program, which prepares professional musicians to work appropriately within healthcare environments [18]. The curriculum addresses patient communication, professional boundaries, ethical considerations, repertoire selection, compassion science, and self-care. Musicians typically performed in pairs, most commonly violin and viola, or violin and a woodwind instrument such as flute or clarinet. Performances took place within the infusion areas of an

outpatient cancer centre. Patients were invited to select music from a curated repertoire, and the resulting musical interaction formed the basis of the patient reflections examined in this study.

2. Methodology

2.1 Program Context and Data Collection

The observations presented here were collected as part of the ongoing quality-of-care tracking for the AIMH 'Awakening the Inner Gift' program. All patients verbally consented to share their reflections following their personalized musical interactions.

The questionnaire was not designed as a psychometric instrument, but rather as a mechanism for capturing patient reflections on their experience of live music within the infusion unit.

The primary dataset comprises semi-structured interviews from a qualitative sample of 18 oncology patients ($n = 18$) collected over two distinct, randomly selected tracking dates. A descriptive thematic reading of the responses identified recurring references to autobiographical memory, family relationships, spirituality, gratitude, comfort, encouragement, nostalgia, and social connection. These recurring patterns were subsequently considered through the interpretive lens of Compassion Focused Therapy.

All patients present were offered the opportunity to select one or more pieces of music from a curated repertoire list divided into various genres, including Film Music, Religious Music (hymns), TV themes, Folk Songs, Pop Songs, Classical Music, and Irish music, and given 5-10 minutes time to browse the list. While a small cohort chose not to choose a piece (patients were either asleep, uninterested, or responded with 'anything is fine'), most were interested in choosing a specific piece of music. Following the musical interaction, participants who consented were invited to take part in a brief semi-structured interview. All completed interviews across both visits were included in the analysis ($n = 18$); no responses were excluded.

Data were collated by a third party to reduce potential researcher bias. The interview comprised three open-ended questions: 1. What piece would you like to hear today? 2. Can you tell us why you chose this particular song/piece? 3. Do you have anything else you would like to share about the experience?

2.2 Ethical Considerations

The patient feedback in this study was gathered as part of regular quality-tracking for the AIMH "Awakening the Inner Gift" program. Because live music was already a routine, non-invasive comfort for our cancer patients, this project was classified as a Healthcare Service Evaluation rather than an experimental clinical trial. For this reason, formal IRB approval was not required.

At all times, patient rights were strictly protected. We used an opportunistic approach to find participants during their regular treatment. A clinical coordinator first made sure each patient felt well enough to chat. We then used a two-stage verbal consent process: patients first agreed to pick a song and listen, and later agreed to answer our three brief questions. Everything was completely anonymous, and patients knew they could say no at any time without it affecting their medical care.

2.3 Participant Demographics and Lifespan Dynamics

We analysed responses from 18 patients (9 women and 9 men; see Table 1 below). They spanned a wide age range across the adult lifespan: two in their 30s, four in their 40s, three in their 50s, one in their 60s, four in their 70s, and three in their 80s (with one age unrecorded).

Table 1 Patient Questionnaire Responses.

Participant Demographics	Q1: Requested Selection	Q2: Reason for Selection (Exact Quote)	Q3: Patient Comments/ Feedback (Exact Quote)
VISIT 1			
Female 30s	Ave Maria	"Speaks to my Soul."	"Thank you for making my day."
Female 40s	My Heart will go on.	"Titanic is one of my husband's favourite movies."	"You guys have really lifted my spirits."
Male (age NA)	Summertime.	"Love Porgy and Bess."	"I went to see the opera in NY and those were good times."
Female 50s	Morning has Broken, Great is they Faithfulness.	"Church Music has always helped me through tough times."	"Thank you for playing today."
Male 80s	Seventy-Six Trombones.	"I used to play trombone back in high school."	"Good memories."
Female 50s	Edelweiss.	"I love 'Sound of Music'."	"I really think that I feel better after hearing this music! Thanks!"
Male 70s	The Entertainer.	"I like ragtime, used to play the piano: the maple leaf rag."	"Not really."
Female 50s	Amazing Grace.	"I love hymns, they give me encouragement and hope."	"It's so nice to have the symphony bringing musicians to the cancer centre."
Male 30s	O Danny Boy.	"I like the old songs."	"Not today."
Female 40s	Can't help falling in love.	"It was played at my wedding and brings back happy memories."	"No."
VISIT 2			
Male 70s	Tennessee Waltz.	"My wife and I danced to this at our wedding."	"Good memories"
Female 40s	Mama Mia.	"Love this movie! The music is great."	"Thanks for spreading joy."

Male 80s	Ode to Joy.	"I love Beethoven, I used to play piano."	"No."
Male 70s	Red River Valley.	"I love old fiddle music."	"I used to play guitar, and I always wanted to be able to play the fiddle—it seems hard!"
Female 60s	Memory.	"I love cats! The song reminds me of good memories with my late husband."	"Yes, I just love music so much, it is so amazing that you came here!"
Female 30s	A Whole New World (Disney).	"I just saw Aladdin with my kids."	"So fun!"
Male 40s	O Danny Boy.	"My father used to sing this to me."	"Not today."
Male 60s	Amazing Grace.	"Brings so much comfort at this time in our life."	"I appreciate you coming out today!"

Although exploratory and based on a small sample, younger participants often selected music associated with contemporary family experiences, whereas older participants more frequently selected repertoire connected to longstanding autobiographical memories.

2.4 Data Analysis

Patient responses were reviewed descriptively to identify recurring patterns of meaning relating to memory, comfort, emotional regulation, social connection, spirituality, nostalgia, and personal significance. These recurring patterns were subsequently considered through the interpretive framework of Compassion Focused Therapy (CFT), particularly Gilbert's three flows of compassion.

3. Findings

3.1 Theme 1: Autobiographical Memory and Identity

Patients frequently selected music associated with significant life events and personal identity. Examples included wedding memories ("My wife and I danced to this at our wedding"), childhood and family memories ("My father used to sing this to me"), and past musical participation ("I used to play trombone back in high school").

3.2 Theme 2: Comfort, Hope and Emotional Support

Several participants described music as comforting during treatment, particularly through religious repertoire and familiar songs. Patients thanked musicians and referred to encouragement, hope, feeling better, and having their spirits lifted.

3.3 Theme 3: Gratitude and Human Connection

Many responses expressed appreciation for the musicians' presence, including comments such as "Thank you for making my day" and "Thanks for spreading joy".

4. A CFT Reading

Within Compassion Focused Therapy, emotional regulation, social safeness, and self-compassion are not separate constructs but interrelated processes arising from the activation of affiliative and soothing systems. Consequently, patient experiences of comfort, connection, and meaningful engagement may be understood as different manifestations of the same underlying regulatory processes. Compassion science literature suggests that experiences of social safeness, connection, and affiliative warmth are associated with physiological regulatory processes involving the autonomic nervous system and HPA axis, and immune responses [10, 19].

CFT identifies three directions for compassion—compassion directed to others, compassion received from others, and compassion directed toward oneself [16, 17]. All three flows of compassion appeared to be reflected in the patient accounts and observations collected during the program, and are described as follows:

4.1 Compassion Directed to Others (Musician to Patient)

For the most part the experience gave rise to 1. feeling socially connecting rather than disconnecting or isolating; 2. as calming rather than threatening; and 3. as personally meaningful rather than arbitrary. One observed dimension was that the process of creating and experiencing music in this context functioned as a form of compassionate communication, closely aligning with core CFT processes such as affiliative warmth, compassion for others, and self-compassion [17].

4.2 Compassion Received from Others (Patient to Musician)

Elements consistent with compassion received from others were suggested by the gratitude expressed in patient feedback. Comments such as "Thanks for spreading joy" and "I appreciate you coming out today" may be interpreted as instances in which patients directed warmth and appreciation toward the musicians.

4.3 Compassion to Self (Self-Compassion)

The third and possibly clinically most consequential flow is the observation of compassion directed toward oneself. Patient accounts frequently suggested that when given the opportunity to select their preferred repertoire, patients often reported emotionally a sense of meaningful connectedness with memories, and reflections evoked by the musical experience. Patients appeared to use the musical encounter in ways consistent with self-soothing, selecting repertoire associated with comfort, supportive relationships, spirituality, or positive autobiographical memories.

Additionally, informal staff comments, not included in the formal dataset, suggested improvements in mood and atmosphere during musician visits. From a CFT perspective, it is unsurprising that healthcare staff also reported improved mood and atmosphere during the

musicians' presence, as cues of safeness and affiliation tend to diffuse through social environments, supporting co-regulation and collective emotional tone [20].

4.4 Limitations of the Study

This study was designed as a small-scale, practice-based qualitative inquiry rather than an evaluation of clinical efficacy or outcome durability. Its purpose was to explore how patients experienced live, patient-selected music, using Compassion Focused Therapy as an interpretive framework. Accordingly, the findings should not be interpreted as evidence of universal benefit, comparative effectiveness, or sustained therapeutic impact.

Participation in both the music sessions and the interviews was voluntary, introducing the possibility of self-selection bias, whereby individuals with a more positive orientation toward music may have been more likely to engage and respond. Participation in both the subsequent interviews was voluntary, reflecting the study's focus on individuals who elected to engage with music within a clinical environment. Patients who declined music, were asleep, or expressed disinterest were not interviewed, and their perspectives are therefore beyond the scope of the present analysis. This does not constitute a methodological deficit but rather delineates the boundaries of the phenomenon under investigation: the subjective experience of music when it is actively chosen and received. The study prioritised participants' own accounts of meaning, memory, and emotional response, without attempting to standardise demographic or clinical variables that were not central to the research question. As such, the material should be understood as illustrative rather than representative, offering insight into how music may function as a vehicle for self-compassion and self-regulation for some patients within real-world healthcare settings. Responses were gathered at a single time point, precluding examination of longer-term effects or changes over repeated exposures. Finally, the findings are context-specific and may not be generalisable to other healthcare settings, patient populations, or forms of musical delivery. It should also be noted that the musicians delivering the intervention had received elementary training in compassion science, mind-body medicine and principles of Compassion Focused Therapy—including attention to relational presence, emotional safety, and the psychophysiological dynamics of soothing. This contextual feature may have shaped the nature of the musical encounter and should be considered when interpreting the findings or comparing them with studies involving musicians without comparable training.

5. Conclusion

Existing music-in-healthcare research has produced heterogeneous findings. The present study suggests that one reason may be that music is often conceptualised primarily as an acoustic stimulus, whereas relational processes occurring within live musical encounters may also contribute to patient experience. This paper suggests that some benefits may be better understood as emerging from relational and compassion-related processes occurring within the musical encounter itself. This study suggests that professional musicians in healthcare settings may provide more than an aesthetic experience, with patient accounts indicating relational, emotional, and self-soothing processes that can be understood through the lens of Compassion Focused Therapy.

Questionnaire findings suggest that when patients are offered agency over repertoire, they often select music that is autobiographical, meaningful, and comforting, engaging self-compassion,

emotional regulation, and affiliative connection. CFT would predict that such experiences engage psychological processes associated with safeness and soothing, processes which previous compassion science research has linked to autonomic and HPA-axis regulation.

The contribution of this study is therefore not to reduce the effects of music to compassion, but to suggest that compassion science may offer a useful framework for understanding dimensions of patient experience that music research has often struggled to explain. By directing attention toward processes of connection, care, social safeness, and self-soothing, CFT provides a conceptual bridge between the observable benefits of music in healthcare and the lived experiences reported by patients themselves.

Author Contributions

Peter Shannon conceived the study, designed and conducted the project, and collected the data. Paul Gilbert contributed to the conceptual development of the study through Compassion Focused Therapy and to the interpretation of the findings. Both authors contributed equally to the writing and revision of the manuscript and approved the final version.

Competing Interests

The authors have declared that no competing interests exist.

AI-Assisted Technologies Statement

ChatGPT (OpenAI) was used to assist with the editing and structure of the manuscript. All research, analysis, interpretation, and final content are the work of the authors, who take full responsibility for the manuscript.

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