Resource-Oriented Music Therapy as an Integrated Support for Adults with Severe OCD in an Interprofessional Intensive Treatment Setting: A Philosophical Inquiry

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ABSTRACT

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Jill Hedican

Obsessive-compulsive disorder (OCD) is a lifelong disorder impacting quality of life for approximately 1% of the population, with standard treatment offering clinically significant improvement for approximately 50% of those receiving care. On-going research indicates a need for additional approaches to caring for individuals with OCD. The purpose of this study was to consolidate evidence and knowledge from scholarly literature to formulate a clear rationale as to why a resource-oriented music therapy approach would be an ideal means of support for adults living with severe OCD when integrated within an interprofessional intensive treatment setting. A philosophical inquiry methodology was employed. Key psychosocial needs of adults living with OCD were identified and organized within three overarching categories: *affective, sense of self,* and *relational*. Standard and emerging treatments for OCD were reviewed, identifying affordances and gaps and/or drawbacks within each. Rationale for the integration of additional approaches into current OCD treatments was provided. Subsequently, ways in which the four characteristics of Rolvsjord's resource-oriented music therapy approach may be realized and integrated within an intensive *treatment* setting for adults living with severe OCD were described. These include: (a) nurturing strengths, resources and potentials; (b) collaboration rather than intervention; (c) viewing the individual within their context; and (d) viewing music as a health resource. Finally, limitations of the study are presented along with implications for practice and future research.

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Chapter 1. Introduction

Significance and Need

Obsessive-compulsive disorder (OCD) involves a cycle of experiences including intrusive and unwanted thoughts, urges, or images (obsessions) followed by rigid and repetitive engagement in neutralizing thoughts or behaviours (compulsions) in an attempt to relieve the anxiety or distress elicited by the obsessions (American Psychiatric Association, 2022). For adults experiencing this recurrent OCD cycle, quality of life is often impacted, including difficulty with relationships, activities of daily living (ADLs), and employment, as well as increased isolation, limited engagement in meaningful and leisure activities, and a reduced overall sense of happiness (American Psychiatric Association, 2022; Mulhall et al., 2019; Pampaloni et al., 2022; Żerdziński et al., 2022). Engaging in this obsessive-compulsive cycle can consume an hour or more each day (American Psychiatric Association, 2022). Nevertheless, many individuals describe ambivalence toward changing OCD related behaviours, citing both the associated challenges, yet also a wish to hold on to these familiar and reassuring behaviours (Murphy & Perera-Delcourt, 2014). Literature indicates that OCD occurs in approximately 0.93% of the Canadian population age 15 or older (Osland et al., 2018), and 1.3% of the population worldwide (Fawcett et al., 2020). The course of OCD varies considerably from person to person, ranging from remission or reduced symptoms, to fluctuating or lifelong symptoms (American Psychiatric Association, 2022; Kühne et al., 2020).

The symptoms of OCD are measured with the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989), and they differ from person to person. Symptoms include a range of obsession types such as contamination, symmetry/exactness, scrupulosity, harm related, or obsessions of a sexual nature (American Psychiatric Association, 2022; Goodman et al., 1989). These obsessions are typically experienced as intrusive and ego-dystonic thoughts that may be accompanied by feelings of doubt, overly imaginative or magical thinking or an overvalued sense of responsibility. Compulsions may be experienced internally, including checking, counting or mental rituals, such as engaging in neutralizing thoughts, or involve observable behaviours such as cleaning, ordering/arranging, repeating, hoarding/collecting, confessing, avoiding, or seeking reassurance (Goodman et al., 1989). Individuals may also experience difficulty making decisions, difficulty initiating or completing tasks, or experience periods of rumination and detachment from the present moment (Goodman et al., 1989; Kollárik et al., 2020). In addition, a high co-occurrence of anxiety, mood, or neurodevelopmental disorders means that many individuals with OCD may also be experiencing significant anxiety, depression, or navigating additional neurodivergent related needs (Sharma et al., 2021).

What is currently identified as best practice in the treatment of OCD involves cognitive behavioural therapy (CBT), including exposure and response prevention (ERP) in combination with selective serotonin reuptake inhibitors (SSRIs; Castle et al., 2023; Reid et al., 2021). While this combined approach to treatment is effective for many, a significant portion of individuals with OCD continue to experience OCD-related symptoms after a period of treatment (Pampaloni et al., 2022, 2024; Steketee et al., 2019). This may, in part, be due to feelings of distress elicited by ERP which involves gradual intentional exposure to unwanted thoughts, experiences or objects, leading many individuals to decline or prematurely withdraw from treatment (Ong et al., 2016; Steketee et al., 2019). In an effort to address the need for additional approaches to care, other therapies including acceptance and commitment therapy (ACT), mindfulness based cognitive therapy (MBCT), dialectical behavioural therapy (DBT), compassion focused therapy (CFT), and inference-based cognitive behavioural therapy (I-CBT) are being explored in both research and clinical practice contexts (Aardema et al., 2022; Castle et al., 2023; International OCD Foundation, n.d.). In a recent literature review that examined emerging psychological and supportive therapies, the authors pointed to early studies on the use of music for OCD, indicating a potential adjunctive treatment role for music therapy, and they highlighted an opportunity for additional research (Castle et al., 2023).

Music therapy is a professional discipline wherein certified music therapists use music experiences and the relationships that develop through them to facilitate meaningful and constructive change in various domains of functioning (Bruscia, 2014; Canadian Association of Music Therapists, 2020). In mental health treatment contexts, music therapy/psychotherapy[1] is used to support individuals with a wide range of mental health needs and is often informed by psychotherapeutic theoretical orientations including psychodynamic, humanistic, or cognitive-behavioural orientations. It may also involve an eclectic approach wherein various practices are utilized based on an individual's needs (McFerran et al., 2023; Wheeler, 2015). Some music therapists situate their work within a specific music therapy model, such as vocal psychotherapy (Austin, 2008), the Bonny method of guided imagery and music (GIM; Grocke, 2019), or resource-oriented music therapy (Rolvsjord, 2010).

[1] Though terminology varies globally and among provincial and territorial regions in Canada, the term music psychotherapy often used to identify music therapy practice with psychotherapeutic intent. In 2015, psychotherapy legislation was proclaimed in Ontario (the researcher's province of residence; College of Registered Psychotherapists of Ontario, 2024). As the researcher is both a certified music therapist and registered psychotherapist, the terms music therapy and music psychotherapy will be used as deemed most applicable throughout this paper.

Regardless of the specific model or orientation, an essential feature of music therapy is its inherent experiential nature. Whether music is experienced through listening, singing, moving, instrument playing or any number of other ways, Bruscia (2014) explains that it is not merely music, but rather the client's experience of engaging with music within a relational context that acts as the agent of change. In this context, the music therapist adopts a nonjudgmental and accepting stance toward a client's musical expression and engagement with music. Music experiences are viewed broadly, from engagement with elements of music such as vibration and sound, to more complex rhythms and melodies, or elicited experiences such as movement, emotion or discussion (Bruscia, 2014). Of primary importance is the "purpose, value and meaning of music within the therapy process" (Bruscia, 2014, p.xxiv).

While much of the music therapy literature speaks to its realizations within mental health contexts, there is very little literature that addresses applications of music therapy for individuals with OCD. In a systematic review of scientific studies of music and OCD, three clinical trials were identified that examined applications of music as a treatment for OCD (Truong et al., 2021). Two of these studies (Abdulah et al., 2019; Shirani Bidabadi & Mehryar, 2015) demonstrated a greater reduction in OCD symptoms when receptive music listening was provided in addition to standard treatment as compared to standard treatment alone. In the Abdulah et al. (2019) study, participants with OCD were instructed to engage in independent daily listening to one of seven pre-recorded 50 minute music tracks for a three month period. The Shirani Bidabadi and Mehryar (2015) study provided 12 individual sessions for adults with OCD, listening to pre-recorded Iranian classical music followed by discussion with a psychiatrist, over a span of four weeks. The third clinical trial (Ciambella et al., 2019) reviewed by Truong et al. (2021), involved 14 weekly sessions of receptive music listening and/or active jazz improvisation facilitated by a psychiatrist who was also a musician. The study took place in a psychiatric day hospital setting where only two of the participants had a diagnosis of OCD. Other positive observations noted in the study included increased interaction with others, sharing instruments, facial expression and reduced tension.

While these studies demonstrate promise for applications of music for individuals with OCD, they were limited in various ways. Even though these studies were referred to as music therapy studies, none of them seemed to involve a music therapist in the facilitation of the music experience, which is an inherent component of what defines music therapy as *therapy* (see definition above). Two of the studies (Abdulah et al., 2019; Shirani Bidabadi & Mehryar, 2015) focused on applications of recorded music without considering the use of live music which is typically more prominent in music therapy. While the

Ciambella et al. (2019) study involved participation in music improvisation in addition to music listening, the intervention was described as jazz improvisation facilitated by a psychiatrist and musician, thus limiting the applicability of the results to music therapy. All three of these studies could perhaps be more accurately described as music medicine studies wherein music (typically pre-recorded) was broadly applied or examined as a means of general wellness or symptom management without being tailored to support an individual's specific needs within the context of a therapeutic relationship (Dileo, 2013).

Only two studies were found that addressed the specific application of music therapy for OCD. One case study described an adapted GIM process with a 50 year old male diagnosed with OCD and depression (Summer, 2010). This study described the use of re-educative music therapy involving music and imagery, where after two months the client began to connect with inner resources, and experience periods of reprieve from his constant symptoms while engaged in music therapy sessions. Over the course of three years, he experienced significant personal gains that allowed him to shift from his previous negative narrative to one that included positive inner resources for coping with challenges of daily life. The second, a theoretical study and narrative literature review including one author with lived experience of OCD, proposed applications of music therapy in the treatment of OCD, grounded in theories of evaluative conditioning, incompleteness and not just right experiences, as well as transdiagnostic theory. Music therapy interventions and areas of potential impact in treatment were proposed as they might address cognitive-functional domains identified in the Cognitive Assessment Instrument of Obsessions and Compulsions (Bourdaghs & Silverman, 2024; CAOIC-13; Dittrich et al., 2011).

The lack of music therapy research in this area is surprising given that an international survey study conducted on the status of music therapy practice worldwide, found that 7.3% of the 2,331 music therapists who responded, were supporting individuals with obsessive-compulsive and related disorders within their practice (Kern & Tague, 2017). While this demonstrates potential for the application of music therapy to support individuals with OCD, there is an obvious gap in research to inform practice. The present study aims to take strides toward addressing this gap.

Researcher's Relationship to the Topic

For more than 20 years, I have worked as a certified music therapist within a large urban teaching hospital that provides a diverse array of programs and services. Within this context, I spent the majority of those years (up to December 2022), focused on adult palliative care where I supported individuals with life-limiting illnesses and prognoses spanning days to many months. I approached my

work through a humanistic lens, supporting meaningful moments at bedside and fostering a sense of community among those living their final months in a hospital. Though goals often addressed needs related to anxiety, depression, existential distress, relational challenges and more, the overall aim was to ease suffering and support quality living at end of life.

In 2022, I had the opportunity within the same hospital setting, to design and initiate music therapy programming for adults with severe OCD who were participating in a short term intensive live-in and day treatment program grounded in cognitive behavioural therapy (CBT), including exposure and response prevention (ERP). I reflected on whether the clinical approaches that had shaped my practice up to this point would be applicable in this context. As I began to work with clients it became evident that for some, music was already playing a significant role in their lives. Clients shared with me how they had been intuitively using music to improve mood, as a distraction, as a coping mechanism, as a motivator, or as a vocational or leisure pursuit. Within music therapy sessions, many individuals engaged easily in expressive music making, regardless of their musical background, demonstrating more comfort with this mode of expression when compared to expressing themselves verbally. Other responses to music that became apparent through discussion or observation in assessment sessions included avoidance of music, compulsive music related behaviour, experiences of dysphoria, or possible music elicited disassociation.

Upon beginning work in this setting, I initiated an anonymous client satisfaction survey to be completed after each client's final music therapy session, as a means of developing the music therapy program. I continued to administer the survey over a period of two years, obtaining responses from a total of 43 clients. All of these clients noted perceived benefits of music therapy including reduced anxiety, improved mood, enhanced self-expression, enjoyment, relaxation, enhanced present moment awareness, and increased social engagement. Twenty-nine clients indicated that they did not experience any challenges related to using music as part of their treatment program. Eighteen clients noted challenges, including negative emotional responses or associations, music related compulsions, and social anxiety. Anecdotal feedback within sessions revealed initial concern over lack of experience playing instruments, and initial skepticism about the potential benefits of music therapy as part of treatment for OCD. Cumulatively, all of this information highlighted not only the possibility for music therapy to meet a variety of client needs within this intensive treatment setting but also revealed an opportunity to explore circumstances under which music could cause unintended harm by maintaining or exacerbating symptoms of OCD.

In 2023, I decided to return to university and complete a master's degree in music therapy. This afforded me the opportunity to develop new clinical and research skills through advanced music therapy education, and to explore the use of music therapy for OCD through my thesis proposal development and research process. I was introduced to Rolvsjord's (2010) seminal book, *Resource-Oriented Music Therapy in Mental Health Care* which presented a model for music therapy in a mental health context that fostered client strengths and agency through a therapeutic relationship based in collaboration. This approach immediately resonated with the needs I was observing in my clinical work, where I was encountering clients whose lives had been overtaken by engagement in compulsions, avoidance of previously enjoyed meaningful activity, and a reduced sense of self. This model also appeared to align with the short-term intensive OCD treatment approach, that called for clients to engage in difficult ERPs, to trust in their ability to tolerate uncertainty and doubt, and to work toward re-engaging in daily life with new skills and a belief in their capacity to manage the ongoing challenge of living with OCD. Finally, resource-oriented music therapy seemed to hold potential for attending to a client's psychosocial needs, promoting change toward quality and meaningful living.

Purpose Statement

Given the prevalence of OCD, its impact on quality of life, the need for additional approaches to care, my personal relationship to the topic, and the unique possibilities inherent in a resource-oriented music therapy approach, the purpose of this study was to consolidate evidence and knowledge from scholarly literature, and formulate a clear rationale as to why a resource-oriented music therapy approach would be an ideal means of support for adults living with severe OCD when integrated within an interprofessional intensive treatment setting. In alignment with the strengths-based nature of a resource-oriented music therapy approach, and with intent to bring new perspectives to the dialogue of OCD research and treatment, care was taken whenever possible throughout this paper to avoid deficit-focused language that could be perceived as pathologizing. However, this was not always possible when citing information from studies that were conceptualized within traditional medical model frameworks. The word *treatment* for example will be italicized throughout Chapters 4 and 5 for clarity and context, but also to acknowledge that it is not reflective of terminology used within a resource-oriented music therapy approach.

Research Questions

The primary research question was: Why would a resource-oriented music therapy approach be an ideal means of support for adults living with severe obsessive-compulsive disorder (OCD) when integrated within an interprofessional intensive treatment setting? This question was broken down into

four subsidiary research questions: According to existing literature, what are the psychosocial needs of adults with OCD? What standard and emerging treatment approaches are being used to address these needs? What affordances, gaps and drawbacks exist within these approaches? How can a resource-oriented approach to music therapy be realized and integrated within an interprofessional intensive treatment setting for adults living with severe OCD?

Definitions of Key Terms

Key terms contained in the research questions (not already defined above) are presented below. Other notable terms will be defined in context as they occur throughout the thesis.

Resource-Oriented Music Therapy

Resource-oriented music therapy is a music therapy approach that seeks to work collaboratively with the client, and emphasizes their competence within the therapeutic process. Resource-oriented music therapy emphasizes the client's musical identity, strengths, resources and potentials within context, and views music as a health resource (Rolvsjord, 2015).

Severe Obsessive-Compulsive Disorder (OCD)

Severe obsessive-compulsive disorder (OCD) is defined as experiencing symptoms of OCD, typically measured with the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989) for approximately three to eight hours each day, significantly impacting an individual's functioning in domains such as occupational, social, or activities of daily living (Taube-Schiff, Rector, Larkin, et al., 2020). Severe OCD is also often described as treatment resistant in that symptoms persist despite several initial courses of standard treatment such as pharmacotherapy and CBT, in an outpatient setting (Taube-Schiff, Rector, Larkin, et al., 2020).

Interprofessional Intensive Treatment Setting

An interprofessional intensive treatment setting for OCD can be a live-in and/or day treatment setting where daily intensive treatment for severe OCD is provided by an interprofessional team for a period of approximately 10 to 12 weeks (Taube-Schiff, Rector, Larkin, et al., 2020). Treatment involves daily participation in primary treatment modalities under the guidance of a range of health professionals. These treatment modalities may include pharmacotherapy, CBT, coached exposure and response prevention (ERP), along with psychoeducation. Other supportive therapies that may be integrated into the intensive treatment program include CBT, ACT, DBT, MBCT, occupational therapy (OT), family education, art therapy, and music therapy (Taube-Schiff, Rector, Young, et al., 2020).

Psychosocial Needs

Psychosocial needs can be defined as determinants of mental health influenced by social, cultural and environmental factors (*APA Dictionary of Psychology*, 2018; Martikainen et al., 2002). Within the context of this study, psychosocial needs are considered in relation to the impact of OCD on one's sense of self, affective, and relational needs, that if attended to may lead to improved well-being and quality of life (World Health Organization, n.d.).

Chapters Summary

This introductory chapter outlined the significance and need for the present study, my relationship to the topic, the purpose for the study, as well as the research questions. Key terms contained in the research questions were also defined. Chapter 2 delineates how a philosophical inquiry methodology was realized within the context of this study. Chapter 3 provides context for the present study by reviewing and consolidating evidence and knowledge from relevant literature, grouped into three key areas: (a) psychosocial needs of adults with OCD; (b) standard treatment approaches; and (c) emerging treatment approaches for OCD, including affordances, gaps and drawbacks. Chapter 4 presents an approach to music therapy practice conceptualized within a resource-oriented framework suitable for an intensive OCD treatment setting, that centers the client's experience and active role within the therapeutic process and attends to identified psychosocial needs of adults with severe OCD. Chapter 5 outlines limitations of the present study, discusses implications for music therapy practice within OCD treatment contexts, and provides suggestions for future research.

Chapter 2. Methodology

Design

To answer the research questions outlined in Chapter 1, this study employed a philosophical inquiry methodology, realized within a pragmatic research paradigm "that prioritise[d] practical outcomes and real-world applications of research" (Pretorius, 2024, p.19). I engaged in a process of critically evaluating existing knowledge and assumptions—organizing ideas and making links among them within new systems of thought (Aigen, 2005; Jorgensen, 1992). From an epistemological perspective, this research design aimed to contribute to dialogue and understanding related directly to the research questions posed, which in turn would have direct implications for knowledge mobilization (Stige & Strand, 2016).

Delimitations

To focus the scope of this study, a number of delimitations were employed. There were no participants. The data was delimited to knowledge and evidence extracted from relevant scholarly literature published in English between 2007 and 2025. To align with the collaborative and strengths-based aspects of a resource-oriented approach, literature that focused on the psychosocial needs and lived experiences of adults with OCD was prioritized.

Materials

Materials included word-processing, spreadsheet and reference management software (Zotero). Data was stored on a password protected laptop and an external storage drive. Generative AI (OpenAI, 2026) was used for minor copy-editing including context-based synonym generation, and occasional clarification of language to improve readability of individual or partial phrases.

Data Collection and Analysis Procedures

Data collection involved identifying relevant literature through searching databases using Concordia's Sofia discovery tool and Google Scholar. A wide range of search terms were used in various combinations. These included: music, music therapy, resource-oriented, obsessive-compulsive disorder (OCD), lived experience, mood, anxiety, depression, emotion regulation, alexithymia, anhedonia, self-esteem, shame, self-efficacy, agency, neurodiversity, neurodivergence, Autistic, autism spectrum disorder (ASD), tic, Tourette, attention-deficit/hyperactivity disorder (ADHD), psychosocial, co-occurring, comorbid, symptoms, rumination, social, quality of life, enjoyment, pleasure, strength, treatment, harm, motivation, inhibitory, cognitive behavioural therapy (CBT), exposure and response prevention (ERP), acceptance and commitment therapy (ACT), mindfulness based cognitive therapy (MBCT), dialectical

behavioural therapy (DBT), compassion focused therapy (CFT), inference-based cognitive behavioural therapy (I-CBT), and positive affect treatment (PAT). This search resulted in hundreds of publications. All of these potential sources were assessed by reviewing titles and abstracts and pared down based on their relevance to the research questions, with priority given to the most recent articles, to ensure inclusion of the latest knowledge and to reduce redundancy. Reference lists of these publications were reviewed, and additional potentially relevant sources were identified, reviewed, and assessed. Generative AI (OpenAI, 2025) was used to generate initial summaries of many of the articles using the prompt "using only the PDF provided, please provide a detailed summary of the article," prior to the researcher reading and reviewing the content of the article directly from the original source. All literature used for this study was stored within Zotero and organized into topic folders. In total this included 85 journal articles, two books, two book chapters, one doctoral dissertation and two webpages.

To conduct the data analysis, I extracted relevant information from the identified sources and organized it within predetermined categories based on the subsidiary research questions. These included: (a) the identified psychosocial needs of adults living with OCD; (b) standard and emerging treatments for OCD including affordances, gaps and drawbacks that exist in addressing these identified additional needs; and (c) applications of resource-oriented music therapy relevant to an interprofessional intensive treatment setting for adults with severe OCD. Throughout this process I incorporated a reflexive component wherein I called upon my experiences and knowledge as a music therapist (in this treatment setting and at large). This helped to shape how the data was organized and interpreted, and facilitated practical links between theory, knowledge and real-world music therapy practice (Creswell & Creswell, 2023).

Chapter 3. Establishing the Foundation

Building upon the overview of OCD symptoms presented in Chapter 1, this chapter further establishes a foundation for the present study by describing some key psychosocial needs of adults living with OCD identified in the literature. These have been organized within three overarching categories: *affective, sense of self,* and *relational*. Standard and emerging treatments for OCD are then reviewed, with affordances, gaps and/or drawbacks being identified within each treatment approach. This chapter culminates by presenting a rationale for the integration of additional approaches into current/emerging OCD treatments, which could strengthen the affordances of these treatments and/or address identified gaps.

Psychosocial Needs of Adults Living with Severe OCD

Affective Psychosocial Needs

Affective needs are defined as needs pertaining to emotion. When affective needs are not met, it can result in reduced mental health and quality of life, which is particularly relevant for adults living with OCD where emotional difficulties and disorders often co-occur (Sharma et al., 2021). In a study that examined factors related to sense of happiness for 75 adults with OCD, results indicated that sense of happiness was significantly and negatively correlated with OCD severity (Żerdziński et al., 2022). In other words, participants who reported a higher severity of OCD symptoms as measured with the Y-BOCS, reported a lower level of happiness as measured with The Oxford Happiness Questionnaire; Polish version (OHQ-23; Kołodziej-Zaleska & Przybyła-Basista, 2018). In a study that examined lived experiences of OCD, adult participants (n = 20) described their experiences as being "disturbing, destructive, and debilitating, causing strong emotional reactions such as anxiety, irritation, anger, sadness, discomfort and disgust" (Kohler et al., 2018, p.8). Specific challenges that prevent the fulfillment of affective needs of adults living with OCD are described in more detail below. These include anxiety, depression, emotion regulation, alexithymia, and anhedonia.

Anxiety. Although OCD is no longer classified as an anxiety disorder in the most recent publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR; American Psychiatric Association, 2022), key definitions continue to reference anxiety. Obsessions are described as "recurrent and persistent thoughts, urges, or images that are experienced . . . as intrusive and unwanted, and that in most individuals cause marked anxiety or distress" (American Psychiatric Association, 2022, p.237). Furthermore, the presence of compulsions is described as "behaviors or mental acts [that] are aimed at preventing or reducing anxiety or distress" (American Psychiatric

Association, 2022, p.237). The literature also provides a significant amount of evidence of high co-occurrence between OCD and anxiety disorders such as generalized anxiety disorder (GAD), social anxiety disorder (SAD), panic disorder or post-traumatic stress disorder (PTSD; Pampaloni et al., 2022; Sharma et al., 2021). In a population register-based study that compared genetic and rearing sources of familial transmission of OCD and anxiety disorders (Kendler et al., 2023), results indicated evidence for a primarily genetic transmission of OCD from parent to child, a high genetic correlation between OCD and GAD, and moderate correlations with other anxiety disorders including panic disorder and social phobia.

As previously noted in Chapter 1, there is also anxiety associated with engagement in standard treatment for OCD itself, with exposure and response prevention (ERP) involving engagement with distressing thoughts, objects, situations or behaviours while refraining from compulsions. Participants sharing lived experiences of participating in ERP, explained the gradual process over time of engaging in exposures in a hierarchical order from least to most anxiety inducing, and described ERP as "having to confront anxiety-provoking situations as part of treatment" (Marsden et al., 2018, p.255).

Cumulatively, these studies point to an on-going level of anxiety related distress experienced by individuals with OCD, in particular when living with severe OCD, and engaged in intensive treatment.

Depression. For adults living with OCD, there is a high probability that they will experience co-occurring symptoms of depression or be diagnosed with a depressive disorder. The lifetime prevalence of this kind of co-occurrence ranges from 12.4% to 60.3% (Abramowitz, 2022; American Psychiatric Association, 2022; Tibi et al., 2017). While researchers continue to investigate the relationship between OCD and depression, there is some evidence indicating that depression may be a functional consequence of living with OCD, that those who experience insecure attachment may be more prone to depression, or that there are genetic factors that contribute to both OCD and depression (Abramowitz, 2022).

For those providing treatment for individuals with OCD, the assumed causal relationship between OCD and depression may lead them to focus primarily on treating OCD symptoms, with the view that as these improve, the symptoms of depression will also improve (Abramowitz, 2022). On the other hand, it could be the case that co-occurring symptoms of depression (such as avoidance of treatment or lack of engagement in exposures outside of treatment contexts) may have an impact on the success of standard treatments for OCD (Abramowitz, 2022). Furthermore, depression may impede inhibitory learning, which is currently viewed as a possible mechanism of change in ERP (Abramowitz, 2022). This involves "learning new safety information that inhibits existing obsessional fear," (Abramowitz, 2018, para. 4). Finally, in a study that examined a course of intensive treatment (primarily

CBT with ERP) for adults with OCD and depression (n = 137), results indicated a reciprocal relationship between OCD and depression, indicating that it is important that both be equally addressed in treatment (Simkin et al., 2022).

Emotion Regulation. Emotion regulation is "the process by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions," (Gross, 1998, p.275); and, several studies indicate that individuals with OCD experience difficulty in realizing this skill (Eichholz et al., 2020; See et al., 2022; Yap et al., 2018). In a two study paper that examined the role of emotion regulation difficulties in OCD (Yap et al., 2018), the first study surveyed a non-clinical sample of 306 participants from the community. A significant positive correlation was found between OCD severity as measured with the Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz et al., 2010) and emotion regulation difficulty as measured with the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004). In the second study, archival data from 59 adults who had attended an intensive OCD treatment program with a mean OCD score as measured with the Y-BOCS in the severe range, was compared with data from 59 adults from the first study who did not have OCD. Within the OCD group, no significant co-relation was found between OCD severity and difficulty with emotion regulation (as measured with the DERS). However, on measures of emotion regulation between groups, results demonstrated that participants with OCD had increased difficulty in accepting negative emotions, engaging in goal-directed behaviour while distressed, controlling impulses, and using emotion regulation strategies (Yap et al., 2018). In spite of this evidence, there is ongoing debate over which dimensions of emotion regulation are involved in OCD given the wide range of presenting symptom categories (See et al., 2022; Yap et al., 2018). Confounding symptoms of anxiety and depression are also noted as contributing factors to the complexity in understanding possible links between emotion regulation and OCD (See et al., 2022). Nevertheless, the potential benefits of addressing emotion regulation in the treatment of OCD is generally agreed upon in both theory and practice (Eichholz et al., 2020; See et al., 2022).

Alexithymia. Alexithymia is defined as "an inability to express, describe, or distinguish among one's emotions" (*APA Dictionary of Psychology*, 2018, definition of alexithymia). In research, it is often measured using the Toronto Alexithymia Scale (TAS-20) that identifies three potential areas of need: (a) difficulty identifying feelings, (b) difficulty describing feelings, and (c) externally-oriented thinking (Bagby et al., 1994). Several studies indicate a correlation between alexithymia and suicide risk in OCD, one that may be mediated by variables such as depressive symptoms or lack of insight (Abd-Elhamed et al., 2023; Albert et al., 2019; De Berardis et al., 2017). Studies conducted in Iran and Egypt demonstrated a

prevalence of alexithymia of 60.7% and 68.6% respectively, in adult participants with OCD (Abd-Elhamed et al., 2023; Khosravani et al., 2017), with culturally influenced suppression of forbidden thoughts noted as a possible reason for this high prevalence in the Iranian participants (Khosravani et al., 2017).

Of further relevance is the noted co-occurrence of alexithymia, OCD, and autism spectrum *disorder* (ASD)[2]. A structural equation modeling study that aimed to better understand the relationship among the three (Edwards, 2022), found evidence of a relationship whereby alexithymia and OCD partially cause ASD. This causal relationship was not direct but was found to include a complex interaction involving *psychological inflexibility* (difficulty engaging in goal-directed behaviour when difficult thoughts and feelings are present), *self as context* (ability to take an objective perspective on one's thoughts and feelings), and *interoception* (awareness of one's internal bodily state). This study underscored the complex relationship among alexithymia, OCD and ASD and went on to criticize the DSM-5-TR for its emphasis on following strict disorder specific treatment protocols rather than individualized treatment approaches (Edwards, 2022).

Anhedonia. Anhedonia can be described as the inability to experience pleasure or enjoyment in activities that typically elicit these feelings in others (*APA Dictionary of Psychology*, 2018). While anhedonia is often present with severe depression (Craske et al., 2016), studies that control for depressive symptoms have found that participants with OCD also experience anhedonia (Abramovitch et al., 2014; Li et al., 2019). A study involving 113 participants with a primary diagnosis of OCD investigating the relationship between OCD and anhedonia and controlling for depression (Abramovitch et al., 2014), found that those with anhedonia (n=32; as measured with the Snaith-Hamilton Pleasure Scale (SHAPS; Snaith et al., 1995), had significantly higher Y-BOCS scores (OCD symptom severity) than those participants without anhedonia (n=81).

A later study evaluating the specific differences in experiences of consummatory and anticipatory pleasure in participants with anhedonia and OCD (Li et al., 2019), compared results on the Temporal Experience of Pleasure Scale (CV-TEPS; Chan et al., 2012), between three groups: OCD (n=139), major depressive disorder (MDD; n=89), and healthy controls (HC; n=95). Participants in the OCD group demonstrated a significant difference in difficulty with consummatory pleasure (experiencing in the moment pleasure and feelings of gratification) compared to healthy controls. No significant

[2] In line with a resource-oriented approach, identity-first or neutral language will be used throughout the paper when referring to Autistic persons, or when discussing broader concepts of autism. Although autism spectrum *disorder* (ASD), is not in line with this approach it will be used for clarity when referencing the findings of a specific study that refers to autism as a *disorder* (Autism Alliance of Canada, 2025).

difference was found between the OCD and HC groups in anticipatory pleasure (described as a desire for or anticipation of future pleasure or reward). The MDD group demonstrated a significant difference in difficulty in both anticipatory and consummatory pleasure compared to the HC group. Authors proposed potential differences in neurobiological reward process and anhedonia in OCD and MDD, suggesting that anhedonia may be a symptom of OCD, and in need of further study.

Lu et al. (2023) suggested that social anhedonia may be a partial consequence of obsessive thoughts in conjunction with depression for individuals with OCD. As a means of addressing anhedonia in the treatment of OCD, Abramovitch et al. (2014) proposed the inclusion of behavioural activation protocols to foster engagement in activities that align with each individual's values.

Psychosocial Needs Related to Sense of Self

The APA defines sense of self as one's "feeling of identity, uniqueness, and self-direction" and also describes positive self-image as an essential component of overall well-being (*APA Dictionary of Psychology*, 2018, definition of sense of self). Studies that have sought to better understand experiences of OCD have indicated that for many, OCD has a negative impact on their sense of self, and that this may be involved in maintaining or worsening symptoms of OCD (Aminaee et al., 2024; Jaeger et al., 2021).

Results from a qualitative interview study that examined four young adult outpatients' experiences of OCD (ages 18-25), revealed a theme of disconnection from one's sense of authentic self (Bhattacharya & Singh, 2015). This result is supported by a subsequent literature review that investigated concepts of identity in the use of CBT treatment for OCD and other mental health disorders. This review revealed that individuals with OCD commonly experience a negative self-view, a "lack of identity," or a "disturbed identity," leading to beliefs in a "feared self" (Brewin, 2023, p.3). In an historical overview that explored understandings of the "feared possible self", the authors explained that this idea was particularly salient for individuals with OCD who experience ego-dystonic intrusive thoughts (i.e., thoughts that conflict with their values), fearing these may be indicative of their true selves (Aardema & Wong, 2020, p.2). Specific challenges that prevent the fulfillment of sense of self of adults living with OCD are described in more detail below. These challenges include those related to self-esteem, shame, self-efficacy, and neurodiversity.

Self-esteem. Given the negative self-appraisals often experienced by individuals with OCD, it follows that one's self-esteem or sense of self-worth may be compromised. Self-esteem can be defined as "the degree to which the qualities and characteristics contained in one's self-concept are perceived to be positive," and it may also be relational in nature, looking to others to reflect one's sense of worth (*APA Dictionary of Psychology*, 2023, definition of self-esteem). In an interview study that examined the

lived experience of OCD of nine adults self-identifying as having OCD, participants reported strong feelings of personal failure (e.g., missed milestones in education/careers, difficulty in relationships) and experiences of stigma related to OCD as contributing factors to low self-esteem (Murphy & Perera-Delcourt, 2014).

Schwartz et al. (2017) conducted a naturalistic study of 155 adults in hospital-based OCD treatment programs with a primary diagnosis of OCD. Following *CBT with ERP* based interventions, participants were asked to complete the Bern Post-Session Report (Flückiger et al., 2010) including a measure of self-esteem experiences. Results indicated a correlation between increased self-esteem and decreased OCD related symptoms over the course of therapy as reported on the Y-BOCS. Though efforts were made to isolate client perceptions of their self-esteem following the core components of the intensive treatment program focusing on *CBT with ERP*, authors noted the limitation that other interventions offered in conjunction, including music therapy and sports therapy, could have impacted the outcomes. Authors discussed implications for treatment, encouraging therapists to promote opportunities to develop feelings of self-esteem.

A later naturalistic study conducted by Toledano et al. (2020) involved 38 adults with a diagnosis of OCD, of which 39.5% had a co-occurring depressive disorder, who participated in *CBT with ERP* treatment in an OCD treatment clinic that did not involve other adjunctive therapies. Though results indicated no significant effect for self-esteem as a predictor of treatment outcomes, they noted a significant correlation between improved self-esteem and improved treatment outcomes as measured on the Y-BOCS (Goodman et al., 1989). Their study also provided significant evidence for the impact of self-esteem on depressive symptoms. Increases in self-esteem over the course of treatment as well as decreases in symptoms of depression were greater for those participants with lower self-esteem and higher symptoms of depression at the start of treatment.

Shame. Shame can be defined as a self-evaluative emotion, where one experiences a low sense of self-worth due to perceived improper behaviour or personal circumstances, believing that others view them as unworthy (*APA Dictionary of Psychology*, 2018). For individuals living with OCD, particularly those who experience what they believe to be unacceptable intrusive thoughts, there may be associated feelings of shame. A recent systematic review and meta-analysis investigated possible correlations between OCD and feelings of shame, and included 20 papers published prior to February 2022 (Laving et al., 2023). Findings demonstrated that higher severity of OCD was moderately related with higher measures of shame. A statistically significant but weak positive relationship, was also found between experiences of unacceptable intrusive thoughts or harm related obsessions, and experiences of

shame. As shame appeared to be an emotion impacting treatment motivation and quality of life, the authors recommended that it be given due consideration in the understanding and treatment of OCD (Laving et al., 2023). Furthermore, in an article presenting two studies that examined excessive reassurance-seeking behaviour in individuals with OCD, findings suggested that those experiencing shame or fear of self, related to intrusive thoughts perceived as unacceptable, may turn to online sources of reassurance and avoid seeking out interpersonal reassurance (Parsons & Alden, 2022). This could have implications for the ways in which certain aspects of current and emerging treatment approaches are realized.

Self-efficacy. Self-efficacy can be defined as an individual's belief in their own ability to handle difficulties they encounter in life, or to perform a desired change (*APA Dictionary of Psychology*, 2023; Bandura, 1997; Xu et al., 2024). Studies indicate that those with lower perceived self-efficacy or those holding maladaptive core beliefs related to dependency and incompetence, experienced higher severity of OCD symptoms (Wilhelm et al., 2015; Xu et al., 2024).

Two studies hoping to better understand the mechanisms of change when individuals with OCD engage in *CBT with ERP*, highlighted the role of self-efficacy. Schwartz et al. (2017) found a significant causal relationship between increased feelings of mastery and resource activation, and a reduction in symptoms of OCD as measured by the Y-BOCS. In this context, mastery was viewed as being aligned with perceived self-efficacy, and a client's ability to exert influence over their own situation. Resource activation was described as a client's perception of their own resources and strengths. Authors concluded that efforts to increase feelings of mastery/self-efficacy and resource activation in therapy would improve overall outcomes in treatment (Schwartz et al., 2017). Wilhelm et al. (2015) suggested that efforts to decrease dependence and boost self-efficacy through increased autonomy, confidence, and self-reliance were potential ways to mitigate compulsive urges and reassurance seeking behaviour. Authors also proposed that potential increases in self-efficacy could lead to improvements in independent engagement in activities of daily living, improved coping with anxiety inducing situations, reduced need for accommodations from others, and a general reduction in the overall severity of OCD (Wilhelm et al., 2015).

Neurodiversity. An individual's sense of self may be further explored through a neurodiversity lens. The neurodiversity paradigm, originating within the Autistic community, conceptualizes human neurocognition as encompassing a spectrum of sensory, motor, social, and cognitive functioning. This framework prioritizes the recognition of these variations as natural differences rather than pathological deficits (Kapp, 2020; "Neurodiversity," 2024). Studies indicate that OCD often co-occurs with autism, tic

disorders such as Tourette syndrome, attention-deficit/hyperactivity disorder (ADHD) and more, which can lead to challenges in diagnosis and approaches to treatment that best meet individuals' specific needs (American Psychiatric Association, 2022; Pampaloni et al., 2022; Sharma et al., 2021). In a meta-analysis of studies that each had samples of 100 individuals (or more) with OCD (Sharma et al., 2021), the pooled lifetime prevalence of co-occurring disorders was reported as 16% for ADHD, 14% for tic disorders, and 6% for autism spectrum *disorder* (ASD). Notably, the ASD prevalence estimate was derived primarily from pediatric studies, with only a single study including adult participants (Sharma et al., 2021). A literature review examining the prevalence of anxiety in ASD found a range of occurrence between 7% and 24% of OCD in adults with ASD, based on four studies involving adult participants (Kent & Simonoff, 2017). Hirschtritt et al. (2015) noted a 50% lifetime co-occurrence of OCD in a study of 1374 participants with Tourette syndrome.

In a study that examined the lived experience of adults with co-occurring autism and OCD (n = 15), themes emerged that distinguished repetitive behaviours, activities and interests experienced as inherent to autism, with those associated with the compulsive nature of OCD. Participants described the former as being anxiety reducing and associated with a sense of self, with the later experienced as ego-dystonic and anxiety inducing. Participants further described desires for certainty, structure, and control as an experience common to both autism and OCD. They described OCD often taking over previously enjoyed or anxiety reducing routines leading to feelings of anxiety and negative self-appraisals. They further discussed challenges related to social contexts, where attempts to avoid stigma or causing difficulty to others, required the use of masking to hide overt behaviours associated with both autism and OCD (Long et al., 2024).

In a narrative review that integrated quantitative research of Tourette syndrome, with qualitative neurodiversity literature, findings emphasized the impact of context on tics as well as the experiencing of tics as an urge to act, likening them to compulsions and the "just right" experiences described by some living with OCD (Bervoets et al., 2023, p.1424). The authors suggested that Tourette syndrome and OCD may function on a spectrum. The study also highlighted that stigma and felt pressure to supress tics in social contexts contributed to a negative sense of self, and they emphasized the difficulty of functioning in environments designed for neurotypical individuals where individualized sensorimotor needs were not considered. They also made a case for the need to integrate lived experience into the understanding, research, and treatment of Tourette syndrome, re-shaping the primarily biomedical view with a focus on tic-reduction to one that considers an individual's psychosocial needs more broadly (Bervoets et al., 2023).

Though co-occurring ADHD has been linked to greater OCD symptom severity, lower quality of life, and earlier age of onset of OCD (Mersin Kilic et al., 2020; Miyauchi et al., 2023), a study examining the lived experience of adults with OCD who were not diagnosed with ADHD until later in life (Tal & Goodman, 2025), points to the development of personal strengths. Participants noted that the need to develop their own coping skills at an early age increased independence, creativity, and multitasking and gave them an opportunity to find ways of making sense of and meeting their own needs (Tal & Goodman, 2025).

Relational Psychosocial Needs

OCD has long been recognized as having a significant impact on individuals' social engagement and relationships (American Psychiatric Association, 2022; Pampaloni et al., 2022). This is reflected in findings that 73.6% of adult participants with OCD reported elevated levels of loneliness upon initial assessment (n=363; Friedman-Ezra et al., 2024), while co-occurring social phobia was identified in 20% of adult participants with OCD (n=382) in a study that examined interpersonal processes in individuals with both social phobia and OCD (Tibi et al., 2021).

For some individuals living with OCD, experiences outside the home or in social settings trigger obsessive thoughts and compulsions leading to avoidance of these triggers and thus increased isolation (American Psychiatric Association, 2022). Other evidence has pointed to reduced ability to experience pleasure in relationships and social interactions, in particular for individuals with higher severity of obsessive thoughts or when symptoms of depression are also present (Lu et al., 2023). In a study that examined symptom subtypes of OCD and domains of social functioning, individuals with the contamination subtype of OCD were found to have increased difficulty with marital, extended family, and family domains (Fan et al., 2023). Extensive and time-consuming cleaning rituals, and family involvement in accommodating rituals in the home were identified as factors contributing to strain in family relationships. Those who experienced combined contamination and symmetry related symptoms were found to avoid social and leisure pursuits, likely due to increased anxiety and lower levels of enjoyment in social or leisure settings (Fan et al., 2023).

A recent study by Da Silva et al. (2024) examined social skills of persons living with OCD prior to treatment as compared to a control group across five domains including: a) assertive conversation; b) affective sexual expression; c) expression of positive feelings; d) self-control and confronting; and e) social resourcefulness. Participants with OCD were found to have significantly lower overall social skill scores, with the lowest scores attributed to those with earlier onset of OCD. They also had significantly

lower scores than the control group in the domains of assertive conversation and social resourcefulness (da Silva et al., 2024).

In an effort to learn more about social cognition and empathy in adults with OCD, Bora (2022) conducted a meta-analysis of 25 studies, finding evidence for reduced social cognition, specifically a significantly lower ability to predict the behaviour of others according to perceived mental states such as feelings, beliefs, intentions, and desires. Evidence was also found for reduced cognitive empathy (taking the perspective of others) and increased affective empathy (experienced as increased personal distress rather than increased empathic concern for others).

Standard Treatment Approaches for OCD

Standard treatments for OCD focus primarily on symptom reduction, while also addressing, to greater or lesser extents, the psychosocial needs and challenges described above. Contexts wherein treatment takes place include community or outpatient settings for those with mild to moderate OCD, while more intensive treatment approaches may occur in live-in or intensive day treatment settings for those with severe OCD where symptoms have persisted despite initial community based approaches to care (Taube-Schiff, Rector, Young, et al., 2020). Two standard treatment approaches, pharmacotherapy and psychotherapy (specifically *CBT with ERP*), are summarized below and followed by an overview of identified challenges that exist within these approaches.

Pharmacotherapy

Pharmacotherapy for adults with OCD is often the first approach in OCD treatment, typically involving the use of selective serotonin reuptake inhibitors (SSRIs) for reducing symptoms associated with OCD (American Psychiatric Association, 2007). Specific SSRIs for the treatment of OCD include fluoxetine, fluvoxamine, sertraline, paroxetine, citalopram and escitalopram, which are also prescribed as antidepressants and therefore, can have the added benefit of reducing co-occurring symptoms of depression or anxiety. Several second line psychopharmaceuticals are also considered for those who do not show adequate response to SSRIs (American Psychiatric Association, 2013; de Oliveira et al., 2023; Richter & Selchen, 2019).

Exposure and Response Prevention (ERP)

Along with pharmacotherapy, the specific cognitive behaviour therapy (CBT) approach used as a primary treatment for OCD emphasizes the behavioural intervention component, exposure and response prevention (ERP; Castle et al., 2023; Reid et al., 2021; Taube-Schiff, Rector, Larkin, et al., 2020). ERP involves on-going experiential work with the support of a therapist, where an individual intentionally engages with thoughts, experiences, or objects that provoke obsessions and elicit feelings

of distress. This might include for example, writing about a feared outcome, or touching an object perceived as contaminated. These intentional exposures begin at a low level and progress over time to more challenging levels, which is referred to as an ERP hierarchy (American Psychiatric Association, 2007). The essential factor in ERP, however, is to accompany these exposures with response prevention, meaning that the individual is to refrain from engaging in their typical obsessive response such as washing their hands immediately. The aim of ERP is to reduce feelings of threat typically induced by triggers, and to increase tolerance for feelings of distress that may be encountered in everyday life, leading to reduced need for compulsive behaviours (American Psychiatric Association, 2007). Following coached exposures with a therapist, individuals learn to practice and incorporate ERP skills independently (Taube-Schiff, Rector, Larkin, et al., 2020).

Identified Challenges related to Standard Treatment Approaches

While pharmacotherapy continues to be standard of care for OCD, it also has its limitations in addressing the symptoms of OCD. Though SSRI's are considered standard treatment, guidelines point to a possible 50%-60% lack of response or partial response to initial attempts with first-line SSRI's, often requiring multiple SSRI trials (Conti et al., 2024; Pittenger, 2021). Further resistance to SSRI's is often treated with the addition of second generation antipsychotics, though current evidence is limited by number of studies and small sample sizes (Conti et al., 2024).

ERP, is also considered standard of care for OCD, however, as described above, the discomfort or distress associated with participating, may lead some clients to decline or prematurely discontinue treatment (Steketee et al., 2019). In a meta-analysis of randomized controlled trials that employed cognitive behavioural treatment of OCD between 1993 and 2014, researchers found an average 15% refusal rate for participation in ERP and a further 19% of patients dropping out of treatment. Participants receiving *CBT with ERP* and antidepressants had the highest dropout rate at 32% (Öst et al., 2015). Furthermore, research also indicates that even when individuals engage in this evidence-based treatment, a significant percentage is unlikely to experience significant improvement in OCD-related symptoms. In a multi-site study conducted across eight OCD treatment centres, Steketee et al. (2019) collected pre and post-treatment scores as measured by the Y-BOCS. Results included clinically significant improvement in OCD symptoms following treatment (with Y-BOCS scores in the nonclinical range) for only 36% of participants receiving ERP, for only 56% of those receiving cognitive therapy (CT) involving cognitive restructuring, and for only 48% of those receiving CBT (combined CT and ERP). Factors that appear to limit *CBT with ERP* treatment approaches include poor insight on the part of some individuals with OCD (American Psychiatric Association, 2022; Goodman et al., 1989), a high prevalence

of co-occurring disorders (Pampaloni et al., 2022), and possible limitations in addressing cognitive-functional needs of OCD as measured with the Cognitive Assessment Instrument of Obsessions and Compulsions (CAIOC-13; Dittrich et al., 2011; Varinelli et al., 2022).

When considering *CBT with ERP*, and pharmacotherapy as a whole, Gershkovich et al. (2017) highlighted that limitations in availability, duration, dosage, and adherence to treatment may be contributing factors to individuals' lack of response or low response to front-line treatment for OCD.

Emerging Treatment Approaches

Given the identified challenges to standard treatment outlined above, additional approaches to treating OCD including neuromodulation and additional psychotherapeutic approaches beyond *CBT with ERP*, are being researched and developed for practice. These are summarized below.

Neuromodulation

Neuromodulation in the treatment of OCD involves three approaches (Harquail Centre for Neuromodulation, n.d.; International OCD Foundation, n.d.). *Repetitive transcranial magnetic stimulation* (rTMS; Steuber & McGuire, 2023) is the least invasive and involves the external application of a magnetic pulse to stimulate electrical activity in the brain (Harquail Centre for Neuromodulation, n.d.). *Deep brain stimulation* (DBS; Acevedo et al., 2023; Gadot et al., 2022) is a form of reversable neurosurgery that involves insertion of an electrode into the brain. *Focused ultrasound* (FUS; Germann et al., 2021; Henn et al., 2024) is a scalpel free neurosurgery used to create a targeted lesion in the brain (Harquail Centre for Neuromodulation, n.d.). Emerging evidence for these treatments is promising, and while these offer additional hope for those who continue to experience severe symptoms, access to these treatments is limited. Furthermore, both DBS and FUS are more invasive treatments that are generally considered only after other more standard treatments have failed to provide significant relief (International OCD Foundation, n.d.).

Psychotherapeutic Approaches

To address the limitations of standard treatments for OCD, many studies point to the need for the integration of psychotherapeutic approaches in addition to *CBT with ERP* as part of OCD treatment (Abramowitz et al., 2018; Castle et al., 2023; Fineberg et al., 2020). These approaches are typically rooted in CBT principles and integrated as supportive therapies, alongside *CBT with ERP* situated as the primary psychotherapeutic treatment, particularly in intensive treatment settings (Taube-Schiff, Rector, Larkin, et al., 2020; Taube-Schiff, Rector, Young, et al., 2020). Upon reviewing the literature, I identified six psychotherapeutic approaches that have been applied or studied as part of OCD treatment. These are summarized below.

Acceptance and commitment therapy (ACT). Acceptance and commitment therapy (ACT) is an experiential psychotherapeutic approach that focuses on psychological flexibility as a mechanism of change for OCD. It involves a focus on values, present moment awareness, acceptance and committed action, as well as distancing techniques such as cognitive diffusion and self as context. It is typically recommended as an integrated support to standard treatment (Abramowitz et al., 2018; Castle et al., 2023). "ACT helps individuals move toward acceptance of symptoms, coupled with commitments to living consistent with their values, creating a different relationship with the OCD symptoms" (Castle et al., 2023, p.2). While preliminary evidence indicates that ACT may be beneficial in reducing OCD symptoms, anxiety, and co-occurring depression, and increasing psychological flexibility for individuals with OCD, research remains in the early stages, limited in part by small sample sizes. More rigorous research is needed to establish efficacy of the approach for OCD (Veloso & Pereira, 2025).

Mindfulness-based cognitive therapy (MBCT). Mindfulness-based cognitive therapy (MBCT) initially developed for clients with severe depression, is now being adapted for the treatment of OCD (Hanna, 2023; Selchen et al., 2018). Though studies are small in number, two recent literature reviews describe a range of experiences included in the adapted MBCT. Clients are guided in developing meditation and mindfulness practice that can be integrated into activities of daily living. The practices foster distance and objectivity related to one's thoughts and emotions, engage body awareness and the senses, and prioritize acceptance over avoidance (Hanna, 2023; Reis et al., 2024). Evidence suggests client satisfaction following participation in MBCT adapted for OCD, and improvements to anxiety, depression, quality of life, self-compassion, and mindfulness as well as reductions in obsessive beliefs (Hanna, 2023; Key et al., 2017).

Dialectical behavioural therapy (DBT). Dialectical behavioural therapy (DBT) assists individuals in building skills in the areas of emotion regulation, distress tolerance, mindfulness, and interpersonal interaction. With roots in behaviour therapy, CBT and mindfulness, it encourages tolerance of difficult emotions while promoting capacity for change (*APA Dictionary of Psychology*, 2018; Castle et al., 2023; Taube-Schiff, Rector, Larkin, et al., 2020). Despite the paucity of evidence for the specific use of DBT in the treatment of OCD, arguments have been made for its application in efforts to increase distress tolerance and address factors related to co-occurring conditions such as borderline personality disorder, thereby reducing treatment-interfering behaviours (TIBs) such as missed sessions, or lack of engagement in treatment (Castle et al., 2023; Davis et al., 2020; Taube-Schiff, Rector, Larkin, et al., 2020). Taube-Schiff, Rector, Young, et al., (2020) highlight the inclusion of DBT in the context of an intensive OCD treatment program, aimed at increasing skills for successful ERP, and in support of co-

occurring conditions, though Castle et al. (2023) note caution should be taken in the use of DBT with clients who may engage in distress tolerance skills as a distraction during ERP, thus reducing its effectiveness.

Compassion Focused Therapy (CFT). With roots in CBT and influences including Buddhist psychology and neuroscience, compassion-focused therapy (CFT) focuses on under-accessed affect regulation/attachment systems that might typically produce feelings of well-being, safety and "being cared for" (Gilbert, 2009, p.199). CFT supports individuals experiencing prevailing feelings of shame, self-criticism and threat, by increasing their ability to cultivate feelings of "warmth, safeness and soothing" (Gilbert, 2009, p.199).

Adults with treatment-resistant OCD often experience self-criticism, feelings of shame, abnormality, or unworthiness that according to Petrocchi et al. (2021) may benefit from CFT. In this clinical trial involving 8 adults with significant residual OCD symptoms following 6 months of CBT, the provision of 8 weekly group CFT sessions demonstrated further reduction in OCD symptoms, and improvements to self-criticism and fear of guilt. Participants indicated high satisfaction with the intervention, and authors noted potential benefits of the group setting for fostering compassion toward others while reducing feelings of isolation and shame. Though evidence for the specific use of CFT with OCD remains scarce, authors of this pilot study note their preliminary findings indicate potential feasibility for CFT as a stand-alone or integrated support for OCD (Petrocchi et al., 2021).

Inference-based cognitive behavioural therapy (I-CBT). Inference-based cognitive behavioural therapy (I-CBT), presented as an alternative treatment approach to ERP, is an approach born out of the view that individuals with OCD experience *inferential confusion*, placing increased emphasis on imagined negative possibilities over trust in themselves and their senses to determine more likely outcomes (Myers et al., 2024). This untrusting or vulnerable sense of self along with imagining worst possible outcomes, leads to belief in a *feared self* (Aardema & Wong, 2020; Llorens-Aguilar et al., 2022). I-CBT targets this distrust in one's self and one's senses. It teaches clients to recognize that their feelings of doubt are rooted in imagination and encourages a shift to focusing on evidence in the here and now (Aardema et al., 2022).

Results from the Myers et al. (2024) study measuring the efficacy I-CBT and ERP, indicate that both inferential confusion (the focus of I-CBT) and cognitive appraisals (the basis for ERP) are important mechanisms to address in the treatment of OCD. The study highlights different symptom domains addressed through each approach, suggesting that future research consider an integrated approach that attempts to further understand the nuances and individual presentations of the symptom domains.

Aardema et al. (2022) cited evidence of comparable results in the efficacy of treatment between I-CBT and ERP, with some potential increased acceptability for I-CBT in that it does not require exposures. Of note is that while I-CBT highlights the role of self-doubt and a feared self in the maintenance of OCD, it does not appear to involve an experiential component that might engage clients in developing new positive experiences of self. Rather, it aims to correct faulty reasoning (Aardema et al., 2022).

Positive Affect Treatment (PAT). A recently developed behavioural and cognitive treatment approach, positive affect treatment (PAT), is aimed at increasing reward sensitivity for individuals with anhedonia, who have difficulty experiencing enjoyment or pleasure as a result of depression or anxiety disorders, including OCD (Meuret et al., 2022). In a study comparing the effectiveness of PAT, aimed at increasing positive affect, with CBT aimed at decreasing negative affect and termed negative affect treatment by the authors (Craske et al., 2023), participants in the PAT group showed greater reductions in symptoms of anxiety, depression, and anhedonia. They also demonstrated increased positive affect, along with changes in reward anticipation and motivation. While studies involving PAT have included participants with OCD, the use of PAT in the context of an intensive OCD treatment setting has not been evaluated. Nonetheless, findings from researching PAT (Craske et al., 2019, 2023) and the role of reward processes in exposure therapy (Rosenberg et al., 2024), highlight the potential benefits of imaginal or active engagement in pleasurable activities, and attending to or "savoring" (Craske et al., 2019, p.467) elicited positive emotions as stand alone or in conjunction with other forms of treatment such as ERP. PAT presents a strong rationale for a shift away from a sole focus on reducing negative affect (the primary aim of standard approaches) as well as promoting the nurturing of positive affect. While PAT includes in-session activities followed by the recounting and savouring of pleasurable moments (Craske et al., 2019), it appears to differ from experiential therapies that may more directly foster and engage clients in direct, in-the-moment experiences of positive affect within the therapeutic encounter.

Summary Rationale for the Integration of Additional Approaches

This chapter has identified psychosocial needs of adults with OCD presented in the literature, including *affective*, *sense of self*, and *relational* needs. The reviewed literature presented evidence for considering these needs in the treatment of OCD. While standard treatment primarily addresses these needs through first addressing the primary symptoms of OCD as measured with the Y-BOCS, emerging psychotherapeutic approaches reviewed in this chapter address some of the psychosocial needs more directly. These psychotherapeutic approaches, though lacking in rigorous/comprehensive evidence, suggest potential for supporting the identified needs when provided as integrated supports with standard care within an intensive OCD treatment setting. There does appear to be a gap, however, in

psychotherapies that facilitate emotional engagement and expression, which is important to note given the range of affective needs outlined above. Emerging approaches also seem to predominantly be based in CBT, involving protocols that may not be as readily adaptable to clients' individual needs, in particular those who would benefit from non-verbal or experiential ways of engaging in therapy. For all of these reasons outlined above, it is my position that a resource-oriented music therapy approach could be integrated into an interprofessional intensive OCD treatment setting for adults with severe OCD, in ways that could considerably complement and/or strengthen current treatment approaches. The following chapter describes the parameters of how a resource-oriented approach to music therapy could be realized and integrated within an interprofessional intensive treatment setting for adults living with severe OCD.

Chapter 4. Integration of a Resource-Oriented Approach as Psychosocial Support

Chapter 3 highlighted psychosocial needs for adults living with OCD and summarized standard as well as emerging treatments. The current chapter presents the four characteristics of Rolvsjord's resource-oriented music therapy approach (Rolvsjord, 2010) and describes how each one may be realized and integrated within an intensive *treatment* setting for adults living with severe OCD. These include: (a) nurturing strengths, resources and potentials; (b) collaboration rather than intervention; (c) viewing the individual within their context; and (d) viewing music as a health resource (Rolvsjord, 2010, 2015). In line with the resource-oriented approach, the client's experience and their active role in therapy is centered within each characteristic discussed below. Particular attention is also paid to how resource-oriented music therapy might attend to the identified psychosocial needs, complementing and addressing gaps in the treatments previously described. References to music therapy literature that is not specific to resource-oriented music therapy, are used to help clarify discipline specific terminology and practices.

Characteristic One: Nurturing Strengths, Resources, and Potentials

The first characteristic of resource-oriented music therapy described by Rolvsjord (2010) is the nurturing of client strengths, resources and potentials. With roots in positive psychology, resource-oriented music therapy seeks to shift away from illness ideology, not by ignoring challenges or pathology, but by emphasizing an individual's strengths and capacity for change. Drawing on earlier concepts of resource-orientation from Schwabe (2005) which emphasizes the potential of the client's own healing forces and the need for "direct, active and constructive" engagement in one's "surrounding reality," resource-oriented music therapy emphasizes potentials over deficits, and supports the client in accessing both their internal and external resources (Rolvsjord, 2015, pp.49-50).

Centering The Client's Experience and Active Role

For adults with OCD, engagement in resource-oriented music therapy invites exploration of their lived experience of OCD, as well as their lived experience of music. It allows both client and therapist to explore opportunities to mobilize the strengths, resources and potentials the client brings to therapy. Past and current experiences of music may range from receptive experiences such as listening, to more active experiences such as dancing, singing, instrument playing or composing. They may range from recreational use of music to engaging with music professionally (e.g. performing, teaching, etc.). Music experiences could also include independent use such as listening with headphones, to social uses such as listening to music selected by friends and family, or experiencing music in social, religious or cultural settings. Exploring these lived experiences in the beginning stages of music therapy may highlight areas

of need to be approached in sessions, but also sheds light on clients' strengths, and the existing musical resources available to them as the therapeutic process begins. For example, a client may share that they listen to music to improve their mood, demonstrating both emotional awareness and the ability to access musical resources for emotion regulation.

In an intensive OCD *treatment* setting it is not uncommon for clients to arrive to music therapy at a time in their lives when they are avoiding music. Song lyrics can act as triggers, instrument cases may be considered as contaminated, and once loved music associated with happier or better times may elicit feelings of grief or depression. Exploring a client's avoidance of music can also offer insight into their strengths, resources and potentials. In what ways did music highlight a strength before avoidance began? In what ways does the client wish music was once again part of their life? What personal strengths have been quieted by the absence of music? For example, a client may share that they previously enjoyed listening and dancing to music during family or cultural gatherings. However, they now avoid gatherings where music is being played for fear of hearing lyrics that may trigger thoughts of harming others. They might express a wish to be able to once again enjoy movement, expression and connection through music, something that currently feels absent from their life. From this example, both client and therapist learn about values, social strengths, previous means of self-expression, cultural identity and more.

Attending to Psychosocial Needs

Resource-oriented music therapy fosters strengths by inviting emotional engagement through experiences with music. For those living with severe OCD, who may be experiencing anxiety, low mood, anhedonia or alexithymia, engagement with music can facilitate connections with emotion and elicit new affective experiences. Bruscia (2014) highlights music's emotive qualities, and describes music listening as an experience that elicits memories, associations and emotions, with the more active use of music, through clinical improvisation, as an opportunity to "externalize impulses, release physical and emotional energy, and express feelings and emotions" (p.144). He further describes the non-verbal benefits in the therapeutic use of music which allows for "sensorimotor expression that expresses the physical self and the emotions contained therein, or… a highly representational or abstract expression of feelings that cannot be expressed in words (Bruscia, 2014, p.144).

Through emotional engagement with music, individuals with OCD, such as those with co-occurring alexithymia who have difficulty identifying or verbally expressing emotion, may experience increased emotional response (Liu & Fukushima, 2023; Lyvers et al., 2020). This may allow for increased understanding and expression of their internal experiences. Through my work with clients, I have found

many are able to put words to their experiences after first identifying and listening to a piece of music with which they resonate. In some cases, individuals who struggled to verbally express how they were feeling at the start of a music therapy session, demonstrated strength in selecting a piece of recorded music that reflected their current state. This could then be followed up by inviting the client to select music reflecting an internal state they wish to experience, which in turn offers opportunities for regulation, helps to identify goals and may foster feelings of hope or motivation for overall participation in the intensive *treatment* program.

Resource-oriented music therapy allows client strengths to emerge so that affective change can occur. Rolvsjord (2010) describes the flexible nature of music experiences in the therapeutic context where one might focus on life difficulties such as expressing them through songwriting or engaging in joyful and strength affirming moments such as singing a favourite song. This flexibility allows for a flow within or between sessions that can be client led, allowing for recognition of personal strengths and needs, and building capacity for emotion regulation (Rolvsjord, 2010). A recent study examined the use of music therapy involving group instrumental improvisation and discussion, for medical students experiencing high test anxiety and difficulty with emotion regulation (Song et al., 2024). Findings highlighted the benefits of experiential music therapy in improving emotion regulation, allowing personal strengths such as self-confidence, self-esteem, optimism, emotional awareness, assertiveness in sharing emotional experiences, and insight and acceptance of negative feelings to emerge.

Though many of the novel experiences in music therapy sessions may initially challenge a client's level of personal comfort, experiences of enjoyment and pleasure also have the potential to occur. Rolvsjord (2010) indicates that "experiences of joy and interest are important, as they build up resources that can be used to create a richer life and that can act as a buffer against negative experiences" (p.125). This may also allow individuals to re-experience parts of themselves that they have not experienced in quite some time. Individuals who have been experiencing depression or anhedonia may encounter new emotional experiences, and those with difficulty identifying or expressing emotion may begin to find a new way of exploring this aspect of themselves (Craske et al., 2023).

Resource-oriented music therapy also fosters strengths and potentials by inviting connection with, and expressions of self, for individuals with OCD. This is illustrated through a study involving eight adults with substance use disorder (SUD) and co-occurring ADHD receiving resource-oriented and recovery-oriented music therapy (Ghetti et al., 2024), where participants shared their perspectives on engagement with music and music therapy within their recovery. They reported experiences of self-exploration and self-development, in particular through the use of clinical improvisation. The

opportunity for individuals with OCD to connect with the self and explore psychosocial strengths and needs beyond the presenting OCD symptoms that brought them to this *treatment* setting, may be essential not only in supporting success in *treatment* overall, but in continuing to thrive following *treatment*. A theoretical paper and case review, arguing that internal experiences such as hopelessness, loss of identity and shame often persist for individuals with chronic mental illness (Jackson, 2015), cited music therapy facilitated songwriting, instrument playing and singing as beneficial in fostering a strengthened sense of self.

In a literature review on music therapy and self-esteem, authors noted that music experiences realized in the context of music therapy allowed for exploration of one's identity and sense of agency, tapping into the "healthful" aspects of the client (Lawendowski & Bieleninik, 2016, p.97). These experiences increased self-esteem and feelings of strength, often shifting one's self-view to one of ability from one previously focused on inability or illness. Authors highlighted factors that challenged one's self-expression, including the emotional impacts of illness, overall mental health, difficulty with verbal communication or difficulty accessing internal experiences and expressing them verbally, suggesting that engaging in creative experiences in music therapy may allow for a greater sense of "one's own strength and self-efficacy" (Lawendowski & Bieleninik, 2016, p.96).

Experiences in music therapy may also foster strengths, resources and potentials, by reframing beliefs concerning successes and failure. With OCD driving desires for correctness and certainty as well as fueling beliefs in an inadequate or feared self, engaging in experiences that include spontaneity, creativity and self-expression offers new challenges and new possibilities. Instrumental improvisation, for example, where music is created in the moment, involves taking the risk that unpleasant or unwanted sounds might occur (Bruscia, 2014). At the same time, it allows for the experiencing of pleasant sounds, or unexpected experiences of skill or success. When considering singing in the context of music therapy, one may be able to challenge the belief that they cannot or should not sing. Sharing one's voice with others, an experience that can feel quite personal or vulnerable, also invites experiences of being heard by others. This can challenge long held self-limiting beliefs, and can begin to shift one's sense of their own abilities, and the worthiness of their contributions. According to Ghetti et al. (2024), facilitating resource-oriented music therapy in an addiction recovery setting, "learning to sing, including just daring to try it, [was] perceived [by the participant] as a satisfying example of personal development" (p.11).

Characteristic Two: Collaboration Rather than Intervention

Rolvsjord (2010) emphasizes that a fundamental perspective of the resource-oriented approach is that the recognition and nurturing of client strengths be carried throughout the whole of the therapeutic process, with therapy being viewed as a collaboration rather than as an intervention. This includes affirming the client's "competence and knowledge about [themself], about ways of working, about how to use music, [and] about problems and solutions" (Rolvsjord, 2010, p.77). In emphasizing this collaborative and relational approach, Rolvsjord (2015) writes:

> A good relationship in therapy is not an intervention (something that the therapist does) but is something evolving and unfolding between two human beings, both two [*sic*] persons with strengths and weaknesses. The active involvement of both the client and the therapist is emphasized and described in terms of interactions, mutuality, authenticity, and democratic negotiations. (p.562)

Rolvsjord (2010) points out the flawed assumptions made when using language such as *intervention,* which positions the therapist as sole expert, and other words such as *response, resistance or noncompliance* that devalue a client's contributions within the therapy process. She emphasizes that everything the client brings to the process is essential to "make [music] therapy work" (Rolvsjord, 2010, p.77). The client's active engagement, ideas, and efforts are as central to the work of therapy as are the engagement and contributions of the therapist. Power is shifted away from the therapist as sole expert, toward equal yet differing roles for client and therapist, where the two collaborate in determining the direction and goals in music therapy sessions. This equal and authentic collaboration can be achieved through dialogue, yet also through collaborative experiences of music making, involving the active participation of both client and music therapist, that are authentic, "meaningful, aesthetic and expressive" (Rolvsjord, 2010, p.79). Bruscia, (2014) elaborates on ways in which the experiential and "unique nonverbal advantages" (p.233) of music can be combined in varying degrees with verbal interaction, within music psychotherapy. This allows therapeutic needs to be accessed, explored and integrated: (a) primarily through music; (b) through music, with verbal interaction used to enhance the use of music; (c) with equal emphasis on music and verbal exchange to increase insight; or (d) primarily through dialogue with music used to stimulate or enhance discussion.

Centering The Client's Experience and Active Role

As therapy begins, the client's experience is valued and self-efficacy fostered by approaching assessment as a collaborative exploration. This is a time for client strengths and needs to surface, drawing from the client's intimate knowledge of their lived experience and what has brought them to this *treatment* setting. Initial music experiences such as listening to a client's chosen recording together,

attending to thoughts, imagery, emotions or physical responses elicited through presented sounds or music, or engaging with instruments, can offer helpful information to both the client and the music therapist. Some clients, for example, after a shared experience of listening to recorded music, will express to me the ways in which they resonate with the music or lyrics, such as no longer feeling like the person they were before OCD worsened. Through these experiences with music, the themes that emerge highlight for both of us, potential areas for further exploration in music therapy sessions.

As strengths and needs emerge and goals begin to present themselves, the music therapist has an opportunity to offer information about ways that music experiences may support these goals. Most importantly, "the therapist is considered to be, and acting as, an authentic person in the collaborations with the client, not primarily as an intervening expert" (Rolvsjord, 2015, p.562). The client's contribution and recognition of their competence in this beginning phase of therapy is essential. As client autonomy, strengths, and feelings of self-efficacy are promoted, a therapeutic relationship fostered in collaboration and mutual respect can begin to be established (Rolvsjord, 2015). Collaboration though does not mean passively following the client's lead. With OCD often fueling avoidance or a wish for correctness for example, there are often moments when clients initially decline experiences with music. I have found these moments to be an opportunity for discussions or negotiations about why a music experience might in fact be helpful despite initial feelings of discomfort or fears of failure. I invite clients to consider challenging themselves to engage musically, and more often than not they experience self-affirming outcomes, such as a positive component of their own musicality.

Stressing the importance of what the client brings to therapy and a collaborative beginning to the therapeutic process also invites strengths and interests that might not otherwise come to light in an intensive *treatment* setting. Clients have often arrived to music therapy, not only sharing with me that music plays a significant role in their life, but also expressing their enjoyment of creative writing, a love for dance or movement, a shared connection with a loved one through music, a love of singing, a vivid imagination, creativity and curiosity, or a strong connection to religious or cultural identity. What the client brings to music therapy expands their use of self, ability to be authentic, and the breadth and depth of potential to engage in collaborative processes. For example, I've encountered many clients for whom writing poetry or lyrics offered them an emotional outlet prior to arrival in the *treatment* program. Finding themselves now in a therapeutic context where creative means of expression are invited and valued, clients often eagerly share their writing with me. The opportunity as a music therapist to frame these creative expressions as personal strengths, through further supporting the

client in expressive songwriting for example, then opens the door for more creative and emotional expression to lead the direction of the therapeutic collaboration as music therapy moves forward.

Attending to Psychosocial Needs

Using a collaborative approach in music therapy sessions allows for relational psychosocial needs to be attended to through shared experiences of music. Bruscia (2014) describes the fundamental relational nature of music involving listeners, composers and/or performers. Music is described as eliciting shared experiences of connection, emotion, and meaning making where it can invite opportunities for non-verbal collaboration and communication, and engage our capacity for empathy or inferring the intent of others (Bruscia, 2014; Koelsch, 2013). In illustrating the relational and experiential aspects involved in music psychotherapy, Bruscia explains:

> When the goal is psychotherapeutic, the client is engaged in music experiences that evoke the feelings and interpersonal dynamics that are of concern, while also experiencing their resolution or transformation through the music. Thus, what makes music therapy unique is not merely its reliance upon the music, but its reliance upon music experience as the primary aim, process, and outcome of therapy. (Bruscia, 2014, pp.119–120)

Rolvsjord (2010) describes the relational aspect of the resource-oriented approach as involving both the active role of the client and the therapist in the therapeutic process, and the necessity of interaction or "musical interplay" (p.207). While inviting the client's emotional engagement and expression through music experiences, the therapist also brings emotional and authentic engagement to the music making, "supplying energy and vitality" to the experience (Rolvsjord, 2010, p.207). This relational exchange invites clients to connect with their sense of self through experiences unique in the intensive OCD *treatment* setting. Instrumental or vocal improvisation, for example, may invite new ways of engaging with the self and others. Insights may emerge that need not be expressed verbally, but may be felt or sensed through the novel musical and relational experience itself. Rolvsjord (2010) highlights the "ambiguity of music as expression and symbol," allowing for self-expression to occur within the therapeutic relationship of what can perhaps not be put into words (p.184).

Collaborating non-verbally or musically with others invites relational experiences that may feel more authentic to some. In a study by Low et al. (2023), the lived experience of four Autistic young adult men involved in music therapy was explored. They were longstanding participants in Nordoff-Robbins Music Therapy, a music-centered approach that involves clinical improvisation within the context of a therapeutic relationship (Wheeler, 2015). Participants highlighted that having opportunities for personal and musical development was important to them. Additionally, they emphasized the value of

relationship development, and having a forum wherein they could explore interests and cultural concerns with a trusted therapist. This study highlighted how music therapy with Autistic individuals could provide opportunities for personal, social, and musical exploration and growth as determined by the individual (Low et al., 2023). In a publication that examined the use of music therapy to support the *invisible symptoms* of mental illness, Jackson (2015) presented a clinical vignette where the use of instrumental improvisation allowed for meaningful interaction including "curiosity, humor, sharing, empathy and trust" to occur between two individuals with chronic mental illness (p.93).

A resource-oriented music therapy approach also invites connection to one's self within a collaborative relational context that creates room for personal growth, which can be further enhanced within a group setting. Within the range of musical experiences that may take place in music therapy groups, previously avoided or novel ways of engaging with others can occur, leading to increased tolerance for social discomforts, and increased meaningful interaction. Even the simple act of sharing a music recording for group listening can be experienced as challenging, yet may also yield the powerful result of reducing feelings of isolation and shame as the group resonates with themes of lived experience of OCD that may be reflected in the music. A study that investigated the lived experiences of six adults who participated in group music therapy within a mental health setting in Ireland McCaffrey (2018), identified the theme "group music therapy fosters reciprocity"(p.28). Participants described benefitting from listening to and supporting others, and reported experiencing feelings of shared identities, bringing out positive responses in others, meaning making, feeling good about oneself, and feeling worthwhile.

As music therapy progresses, not only may clients *experience* their personal strengths within the context of the therapeutic relationship and group setting, but they may begin to *contribute* to these relationships through the use of their strengths (Rolvsjord, 2010). A collaborative approach with the music therapist invites interactions where client strengths are valued and self-esteem and self-efficacy are fostered. Clients may begin to experience feelings of competence and contribution, and reframe previously held beliefs in the feared-self, dependency and need for accommodation. Within the group setting a range of experiences allow for strengths to emerge. For example, engaging in group instrumental improvisation may help clients experience an increased awareness of the creative or emotional expression of others. They may explore expressive, collaborative, supportive or assertive ways of playing their own instrument within this group context. Collaborative group songwriting may invite taking social risks, negotiating ideas, exploring leader and follower roles, and invite collaborative exploration of meaningful or playful themes. In contrast to previous experiences of avoidance, isolation

and loneliness, clients may begin to experience meaningful social interaction and explore their relational sense of self, developing insight, intention and social resources with the potential to be carried forward into daily life post *treatment*.

Characteristic Three: Viewing the Individual Within their Context

The third characteristic of resource-oriented music therapy involves viewing the individual within their context (Rolvsjord, 2010). Three levels of contextual awareness can be considered in music therapy practice: *music therapy in context*, referring for example to healthcare, community, cultural or political environments that surround music therapy; *music therapy as context*, emphasizing the unique musical and relational context experienced within music therapy; and *music therapy as interacting contexts*, which highlights connections between the therapeutic process and broader systems, such as clients' communities, interdisciplinary contexts, or healthcare politics (Rolvsjord & Stige, 2015). Authors underscore the value of *interacting contexts*, reframing the view of music therapy from the therapist's *treatment* of the individual, toward a broader conceptualization of therapy that encompasses relational, structural and community dimensions. Emphasizing this context shapes "how we perceive the people we work with, how we understand health and illness, [and] how we conceptualize therapy and change" (Rolvsjord & Stige, 2015, p.59).

Centering The Client's Experience and Active Role

Music therapy *in context* is realized by first considering the contexts in which the client is situated in daily life as well as within the intensive *treatment* setting. When someone has been living with severe OCD for some time, the context in which they find themselves may be one of isolation and strained relationships. Their perceived context by the time they find themselves in an intensive *treatment* setting, may be one of failure, loss of identity, or loss of previously enjoyed life experiences. Their personal values, challenged by OCD, may feel difficult to uphold and connections to community, spirituality and culture may be strained. The lifelong nature of OCD, may have led to "silent symptoms" frequently encountered by individuals with chronic illness, such as loneliness, grief, stigma or reduced quality of life that often persist throughout and beyond *treatment* even when active symptoms have been resolved (Jackson, 2015, p.92). Despite these challenges, the collaborative work of client and music therapist can be to identify both the needs related to the context of living with OCD, as well as uncovering the client's strengths, values and contextual resources that hold potential to bring change.

Through resource-oriented music therapy, there is space for the client's context to emerge. By selecting and listening to familiar music with which they resonate for example, clients may begin to share their context with the therapist or other clients within a group setting. Music that clients select

often conveys so much more about their experience than can be put into words, yet can also lead to rich and meaningful discussion. For example, in a group session a client shared a song recording with the following lyric: “they keep saying just live in the moment… what they don’t say is the moment is a wild place” (Downie & Rock, 2023). Many of the group members resonated with the shared experience of living in that *wild place* in their minds so much of the time. In this case, the group setting provided a space where the clients began to understand that they were not alone in their experiences of OCD, and that theirs is a shared context in many ways.

Resource-oriented music therapy also allows individuals to inhabit their cultural identity. The music therapist’s role in creating space for this to occur is a complex endeavor given the unique variables their own cultural identity may bring to the therapeutic relationship (Hadley & Norris, 2016). Nonetheless, the music therapy setting recognizes that “cultural differences impact an individual’s lived experience,” (Hadley & Norris, 2016, p.129) and in resource-oriented music therapy these are considered as integral to the client’s context before, during and after involvement in music therapy (Rolvsjord, 2015). In the resource-oriented setting, the client’s cultural identity is valued, can be essential to the client’s exploration of self, and can be integrated into relational experiences with others in the therapy setting (Rolvsjord, 2010; Samaritter, 2018). For example, a client describing their background experiences with music, may share that learning to play an instrument was viewed as indulgent within the cultural context of their family of origin, where hard work and academic achievement were prioritized. This context informs considerations for the way instrument playing might then be used thoughtfully and intentionally in music therapy sessions. It highlights the complexity in which a seemingly simple experience of instrument playing may in fact be highly interconnected with cultural identity, the client’s emotions, sense of themselves or relationships.

Likewise, a client’s spiritual identity and values are integral parts of their lived experience that can be fostered within a resource-oriented music therapy setting. For example, a client who struggles with scrupulosity type obsessions and compulsive praying, may be supported by a therapist or coach in challenging this fear driven compulsive behaviour through ERP. In the context of music therapy sessions, the music therapist can support the client in reconnecting with the more authentic and values based aspects of their faith through music, such as singing hymns and engaging in discussions of the deeper meaning elicited by the music and/or lyrics.

Attending to Psychosocial Needs

Music therapy *as context* allows for attending to clients’ psychosocial needs in ways that are unique to the intensive *treatment* setting. The artistic, aesthetic and creative side of music therapy

renders it inherently adaptable to the individual strengths and needs of each client in a way that does not depend on protocols, but rather emphasizes intentional flexibility, creativity and spontaneity (Rolvsjord, 2010). The therapeutic process unfolds in an organic yet purposeful way that complements the client's overall goals in their personal life and in the broader interdisciplinary *treatment* program. For example, the resource-oriented approach allows for different ways of being and engaging in therapy to shape the therapeutic process. Each client I encounter resonates with different expressive and musical experiences offered. A client may feel most at ease when engaged in movement to music, which in turn helps them to connect with their emotions or sense of self. Another may find that singing is more effective in this regard. Goals and themes in therapy can then be explored through whichever experience allows the client to connect to the psychosocial needs being attended to in the music therapy sessions. Inviting the therapeutic work to take place through individualized and often non-verbal means of expression, offers the potential to tap into the healthful part of the person, mobilizing the client's strengths, and initiating movement toward positive change.

Another way in which music therapy *as context* may be of benefit in the intensive *treatment* setting, involves the strong connection that exists between music and the human experience. This allows for a therapeutic context where both negative and positive affect, sense of self, and relational experiences can be explored. For some, when lack of pleasure and enjoyment in life are further compounded by OCD, experiences with music offer the potential for previously enjoyed and new experiences of pleasure or joy to occur. Rolvsjord (2010) emphasizes that fostering strengths through music experiences, eliciting a sense of accomplishment and a positive sense of self, can also lead to feelings of enjoyment or happiness. Many individuals I have supported have expressed motivation and hope through songwriting, or shared experiences of playfulness and joy through musical interactions with peers in a group setting. Rolvsjord (2010) describes that experiencing these moments of positive emotions, even for a short time, can offer a reprieve from life's problems and allow for a period of focus on strengths and enjoyment. This can inspire feelings of hope or the perspective that life is indeed worth living, which is of particular importance for clients at risk of suicidal ideation.

The music therapy context also allows individuals to approach difficult emotions that may have been avoided due to OCD. It has been my experience that some adults with severe OCD who have experienced the death of a loved one, or other losses related to living with OCD, may not have allowed themselves to grieve for fear of not being able to cope with elicited emotions. In music therapy sessions, experiencing grief or emotions such as sadness, anger or guilt can take place in a contained and supported way, such as through instrument playing or songwriting. A client, for example, may request

that the music therapist play the violin while improvising with them. The client notes the sadness of the instrument, but wants to explore the feelings it elicits in them within this non-verbal musical interaction. Engaging in this symbolic musical expression offers the client safe distance from the feared emotion, allowing it to be approached gently. Experiencing difficult emotion in a relational context, and having the experience of being able to cope, can begin to foster feelings of self-compassion and self-efficacy, building strengths that can be carried forward throughout and beyond the *treatment* setting (Jackson, 2015).

Music therapy *as interacting contexts* considers the client's context within and beyond the *treatment* setting. Within a resource-oriented music therapy approach, there is opportunity for advocacy within the *treatment* setting by highlighting the client's strengths when there is a predominant focus on pathology, or behaviours that interfere with *treatment*. Clients, for example, who struggle with standard or structured approaches to therapy, may demonstrate strength in understanding a concept such as emotion regulation when experienced through non-verbal means, such as instrumental improvisation. Highlighting these strengths with members of the *treatment* team can help to shift their understanding of what they might be observing in other contexts.

Engagement in resource-oriented music therapy also invites new possible life contexts to be imagined by clients. Having experienced personal strengths in the music therapy setting, one might be more open to conceiving of interests or life aims not previously considered. One might imagine the possibility of success, or the ability to cope with or reframe thoughts of failure, or may have a more embodied sense of confidence or take initiative in pursuing something new. Music therapist supported music and imagery experiences may allow clients, to envision feeling good, experience self-compassion, or imagine living life in more meaningful or purposeful ways. These, along with experiences of enjoyment and success from within music therapy sessions, may lead to increased feelings of hope, and a sense of agency in life. The client who has learned the basics of playing guitar can imagine enjoying the challenge of a new hobby or playing in social contexts. The client who has found movement to music to be grounding and calming can imagine attending a weekly yoga or dance class. The client who has written a song about their personal strengths can imagine a life where they have the upper hand over OCD.

Having taken on the challenge of new interpersonal experiences in music therapy and having engaged in positive or balanced relational experiences that may not have been previously encountered, one's relational repertoire may have expanded allowing for re-imagined contexts at home, work, school, social settings or within romantic relationships. Clients may also begin to experience personal strengths

in roles with new peers who have joined group music therapy, where they can model and foster feelings of hope for others, or they may begin to explore advocacy in their own care, even at systemic levels of care beyond music therapy.

Characteristic Four: Viewing Music as a Health Resource

Rolvsjord (2010) acknowledged that engaging with music is not something unique to the music therapy setting, but is an innate human activity and as such, resource-oriented music therapy considers music as a health resource beyond music therapy. Rolvsjord (2015) citing Ruud (1997), identified *awareness of feelings*, *agency*, *belonging*, and *meaning* as areas in which music has been demonstrated to impact wellbeing and quality of life when considered as a health resource (Rolvsjord, 2015; Ruud, 1997). Music therapy invites the opportunity for clients to deepen their relationship with music and their musical selves, discovering new ways of engaging with music to positively impact their health and wellbeing both during and following involvement in the intensive program.

Centering The Client's Experience and Active Role

It has been my experience that clients arrive to the music therapy setting with external influences that have shaped their view of the role(s) music plays in their lives. This view may be closely linked with the role of music in within their own cultural contexts, or beliefs they hold about success and failure. Often this includes the idea that active music making experiences such as singing or instrument playing are something reserved for those who have studied music, or who have *natural* musical talent. There is also often a belief in the need to create *good music*, that which adheres to a standard of musical proficiency and aesthetic quality that many believe they are unable to produce (Rolvsjord, 2010). When inviting engagement and considering music as a health resource, the first aim of the music therapist should be to invite a reimagining of what constitutes *good music*, introducing the concept that everyone has an inherent right as a human being to experience active music making, and to express themselves musically (Rolvsjord, 2010).

Cultivation of musical strengths and resources also involves promoting ways a client has already been effectively accessing music as a health resource, prior to their involvement in the intensive *treatment* setting such as listening to music during walks, or for relaxation. Supporting clients to reconnect with past music-based strengths that have been put on hold due to OCD may also be of benefit. Often this means reimagining previous personal experiences of music. For example, it would not be uncommon for an individual with severe OCD to have abandoned instrument playing due to feelings of incompetence or experiences of getting stuck in repetitive attempts to achieve perfection in playing. Music therapy can help to reframe this experience by shifting the focus away from skill development or

performance outcomes, toward meaningful, enjoyable musical engagement for its own sake as it occurs in the present moment. Exploring creativity, expression and engaging in novel music making through improvisation or songwriting, for example, can allow clients to foster new relationships with music, more aligned with feelings of enjoyment or wellbeing.

Attending to Psychosocial Needs

When exploring personal responses to music within music therapy sessions, clients often develop increased insight and competence about how they can use music independently to benefit their own health and wellbeing. For example, they may develop new ways of engaging with music listening, such as building intentional or goal directed playlists (Buchanan, 2022), or they may feel motivated to explore new or previously avoided music. In a mixed-methods feasibility study with youth who were accessing mental health care, McFerran et al. (2018) used the Healthy-Unhealthy Uses of Music Scale (HUMS; Saarikallio et al., 2015) tool, to promote participants' insight about their own music listening practices. Findings suggested that without support, youth often listened to music in ways that promoted rumination with the potential to exacerbate low mood and difficult emotions. With music therapist support in using music listening in more intentional ways, participants experienced shifts in mood through increased awareness of their emotional responses to music, and developed agency in selecting music to meet their mental health needs (McFerran et al., 2018).

In music therapy, clients can encounter new ways of experiencing the self through music. They may feel more comfortable with previously avoided experiences such as spontaneous music making, expressing emotion or moving with music. They may begin to engage in musical self-expression in ways that feel authentic to them. An individual for example who speaks softly, is overly agreeable or has difficulty asserting their thoughts or wishes may benefit from use of voice in music therapy. Gently increasing comfort with the use of voice through humming, vocalizing or singing within a relational context can support a shift over time. Strengths that emerge through this process such as increased comfort with using their voice and being *heard* by others, may transfer into daily life. This could include singing alone for enjoyment, singing in social contexts, or feeling more comfortable or confident when speaking.

Following a client's involvement in resource-oriented music therapy and specifically group music therapy, they may experience increased comfort with shared musical experiences. They may also discover new ways of relating with others that feel enjoyable or more genuine than what they have encountered in other social settings. Clients may begin to recognize new sources of enjoyment or social leisure they wish to pursue, or develop a new sense of meaning in relationships, reframing interpersonal

interactions that were previously experienced as predominantly stressful or anxiety inducing. Individuals may be more open to communal music experiences such as attending concerts or joining a choir. They may consider participating in a karaoke night, or engage in collaborative songwriting or instrument playing. Social media may also offer ways of connecting with others through music. Sharing favourite songs or preferred playlists with friends and family through online means can offer a new way to stay in touch and to share something of oneself. Those who have avoided sharing their own original music may also feel ready to share this in a public forum or with others in their life.

The unfortunate reality, though, is that constraints may exist that can limit a client's ability to access music in a variety of ways (Rolvsjord, 2010). Personal constraints such as discomfort in social musical settings may hinder participation in community experiences of music. Psychosocial needs such as those reviewed in Chapter 3 (e.g. low self-worth or depression) may also directly impact one's ability to access music experiences. Additionally, there may be financial limitations such as access to musical instruments, or social, cultural or spiritual factors that can limit ways in which music is accessed (Rolvsjord, 2010). This calls for the music therapist to consider contextual factors both within and beyond the music therapy setting when collaborating with clients to increase their access to music.

Music Therapy as an Integrated Support in the Intensive *Treatment* Setting

Integrating resource-oriented music therapy into the intensive OCD *treatment* setting involves some challenges. However, as described above, doing so offers the potential to attend to psychosocial needs which, in turn, contributes to positive change and improved quality of life for clients with severe OCD. My program development experience has highlighted many important considerations when working to foster client success. The first involves the provision of music therapy by a certified music therapist, and where applicable, one who is registered with a relevant regulatory body in order to permit the inclusion of psychotherapy techniques within their scope of practice. This ensures that the music therapist is appropriately certified and adheres with the standards of practice outlined in Chapter 1 and allows for the intentional integration of psychotherapy. Training and experience in mental health as well as an understanding of the needs of individuals with OCD is also essential. As research in both music therapy and OCD continues to develop, knowledge of current literature and an intent to maintain currency with emerging research findings would promote ongoing effective integration of music therapy in the intensive setting and the ability to adapt to new developments in the *treatment* of OCD.

My experience in supporting individuals in this setting has revealed initial client skepticism and anxiety when they first attend music therapy within the intensive program. Equally evident was the fact that clients often quickly overcame these initial feelings, and they expressed experiences of enjoyment

and offered their appreciation for the opportunity to receive this service. Two specific practices were supportive of this observed change in perspective. First, it was beneficial to offer both individual and group music therapy sessions, beginning when possible with an individual session, conceptualized to provide an introduction to music therapy. This introduction also provided an opportunity to begin to establish a therapeutic relationship based in collaboration. Second, it has been beneficial to present music therapy as a core component of the intensive *treatment* program. Importantly, this means that music therapy is integrated into the standard weekly schedule alongside other regular groups and therapy sessions.

Consideration of the music therapy space is also essential. Sensory needs of clients should be considered, with options for natural light, reduced environmental noise, and adequate space for movement and group sessions. A selection of quality instruments appropriate for adult use should be placed around the room in ways that are accessible and invite exploration. These include both familiar instruments that may require some specific techniques such as guitar and piano, but also accessible instruments that do not require previous knowledge/experience such as hand drums, other percussion instruments and melodic instruments that can be tuned to a specific scale or mode. Access to music streaming, a good quality speaker for music listening, and a device for basic live recording are also needed.

Effective collaboration with the interprofessional team is also essential for successful integration of music therapy into the intensive *treatment* setting. On-going communication with team members is necessary so that clients can be consistently supported in ways that align with their overall program goals. Collaboration also allows team members to benefit from each other's scope of practice. For example, knowledge obtained from the occupational therapist's sensory assessment can be integrated within music therapy, and information regarding clients' unique strengths gleaned from music therapy sessions can be shared with the team. Finally, perspectives of the resource-oriented music therapist can add a new voice to the interprofessional team and can introduce different ways of engaging clients in therapy, such as non-verbal and experiential approaches to care. In my experience, meeting the needs of individuals with severe OCD also involves creativity and flexibility of the whole team as they adapt to clients' shifting daily needs. The ability to bring that flexibility into the way that music therapy is offered within the program is key to best supporting clients, and working effectively as a team. Although introducing a resource-oriented approach into an intensive *treatment* program primarily based in *CBT with ERP* poses challenges that require the music therapist to navigate theoretical differences and differences in the language used to describe aspects of the therapeutic processes, my experience has

been that the two can complement one another in ways that benefit the client. ERP, for example, may help a client overcome avoidance of touching their guitar, and music therapist support in creative and expressive guitar playing may foster feelings of self-efficacy that carry over into other areas of *treatment*. It is also essential, however, for the music therapist collaborating in this way to be aware of how to align with the *CBT with ERP* approach. For instance, it would hinder a client's progress to offer reassurance or accommodation in music therapy sessions that counters the client's efforts to increase their tolerance for uncertainty while refraining from compulsions. Instead, I often find myself inviting clients to challenge themselves, despite discomfort, and to engage rather than avoid.

Finally, a successful integration of resource-oriented music therapy into the intensive OCD *treatment* setting involves on-going evaluation of the service, including consideration of clients' perspectives on the perceived benefits or drawbacks. The effort to engage in on-going quality improvement of the program, continuing education for the music therapist, and opportunities for research that will enhance or address gaps in knowledge, all aid in maintaining and advancing the potentials this service offers to individuals with OCD.

Chapter Summary

This chapter has conceptualized the integration of resource-oriented music therapy within an intensive OCD *treatment* program for adults with severe OCD. It provided descriptions of possible client experiences and their active role in the music therapy process. It described ways in which psychosocial needs can be attended to, and general ways in which music therapy can be integrated within the interprofessional intensive *treatment* setting. Resource-oriented music therapy as an integrated support not only aligns with standard approaches to *treatment*, but also could directly address previously identified gaps/challenges and psychosocial needs in ways that could promote agency and success for individuals with severe OCD in the intensive *treatment* setting.

Chapter 5. Discussion

Cumulatively, Chapters 3 and 4 served to answer the research question originally presented in Chapter 1: Why would a resource-oriented music therapy approach be an ideal means of support for adults living with severe obsessive-compulsive disorder (OCD) when integrated within an interprofessional intensive *treatment* setting? This question was broken down into four subsidiary research questions: According to existing literature, what are the psychosocial needs of adults with OCD? What standard and emerging *treatment* approaches are being used to address these needs? What affordances, gaps and drawbacks exist within these approaches? How can a resource-oriented approach to music therapy be realized and integrated within an interprofessional intensive *treatment* setting for adults living with severe OCD? The purpose of the present chapter is to discuss limitations of the study along with implications for practice and future research. I conclude with some final reflections.

Limitations

While I was able to draw upon my own clinical experience in this study, individuals with severe OCD were not included as participants, and as such, client perspectives were not reflected in the content of this paper. The time and length of a master's thesis limited the scope of this study. As this was my first experience of conducting research, the results may have been limited by my learning curve, specifically with regard to the philosophical inquiry methodology. Finally, the lack of existing research directly investigating the use of music therapy for OCD was also a significant limitation of the study. This required that the conceptualization of the resource-oriented approach be derived from OCD literature, music therapy in mental health publications, and my own understanding of practice in this area based on my clinical experience thus far.

Implications for Practice

The process and results of the present study offer implications for music therapy practice and beyond. Music therapists supporting individuals with OCD are provided with a rationale and framework from which they might further their own practice in intensive *treatment* settings or similar mental health care settings. They are also provided with information about integrating music therapy within the interprofessional team context, along with ways in which supporting psychosocial needs through music therapy can enhance client experiences and positively impact overall outcomes within the *treatment* program. Music therapists working in other settings or in private practice, supporting individuals with varying severity of OCD, may also draw from this framework in considering how they might best support their clients. This includes not only specific ways that music therapy can be of benefit, but also an

understanding of how music might serve to maintain or exacerbate OCD if used without consideration and intent, in particular if clients are simultaneously engaged in standard *treatment* for OCD.

This paper also provides a rationale and information for intensive OCD *treatment* programs that do not currently offer music therapy, as to the potential benefits of adding music therapy to the program. It describes the unique contribution that music therapy can make within an interprofessional setting based primarily in *CBT with ERP*, noting specific ways that supporting psychosocial needs can align with overall aims of intensive *treatment*. The study also exemplifies the depth of reflection and intention involved in the therapeutic use of music in this setting, expanding the understanding of what music therapy provided by a certified music therapist (and registered psychotherapist) involves. It offers clarity in how the presented approach differs from music medicine (described in Chapter 1), recreational or activity-based music offerings (such as karaoke night), or the integration of music in ERPs (such as playing the guitar in a public space) that, while also beneficial, serve a very different function in a mental health setting. This increased understanding of music therapy may broaden opportunities for music therapy practice and the integration of music therapy services into interprofessional team settings.

Finally, this study may also serve to offer new information to individuals with OCD seeking therapy that integrates experiential and expressive elements, or that allows for other ways of being to be integrated into the therapy experience. This may have implications for increased demand for services, increased willingness to engage in *treatment*, and the possibility of better *treatment* outcomes.

Implications for Future Research

The process and results also revealed areas for future research. In order to evaluate the effectiveness of the proposed integration of resource-oriented music therapy in an intensive OCD *treatment* setting, there is a need for research investigating the application of the findings within a clinical setting. There is also a need to investigate client perspectives on their experiences of music therapy in this context, in particular when considering the collaborative nature of the resource-oriented approach. Currently, I am conducting a study investigating client perspectives on their participation in music therapy as part of their involvement in intensive *treatment* for OCD, that will contribute to filling this gap in knowledge.

This study also emphasized the identified challenge of client engagement in standard *treatment*, including non-participation or early withdrawal. In my experience, there is often a lack of readiness for intensive *treatment* when a client is admitted to the program, despite a lengthy waitlist. This points to a potential area of investigation in the application of resource-oriented music therapy prior to intensive

treatment, with the aim of supporting psychosocial needs such as self-efficacy and social engagement to promote *treatment* readiness.

As the present study was delimited to applications of music therapy for adults with severe OCD, similar research involving children, adolescents, and/or adults with milder symptoms of OCD is also warranted.

Concluding Reflections

Through engaging in this philosophical inquiry I've had the opportunity to reflect on the work of integrating music therapy within the intensive OCD *treatment* setting, including the nuances of why and how a resource-oriented approach might best meet the needs of the clients I support. While my work informed the approach proposed in this paper, the research and reflection processes have also informed my practice, offering opportunities to further integrate the resource-oriented approach into my work and to observe its benefits in practice. Responses from my music therapy clients continue to reinforce my own conviction about the benefits of this approach and the value of integrating resource-oriented music therapy in this setting. My hope is that this paper will initiate dialogues on the use of music therapy in support of individuals with OCD, increase practice offerings in this area, and prompt future research that could further identify potential benefits it may afford.

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