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Review Paper

Reframing Obsessive–Compulsive Disorder Through the Lens of Mentalization: A Narrative Review of Mentalization-Based Psychotherapy

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ABSTRACT

Historically, Obsessive-Compulsive Disorder (OCD) has been analyzed through behavioural and cognitive-behavioural paradigms. These frameworks focus on learning that doesn't work, beliefs that don't work, and compulsive avoidance. Even though Exposure and Response Prevention (ERP) is still the best treatment, many patients only respond partially, have lingering symptoms, or have a relapse. Recent studies suggest that people with OCD may have trouble understanding their own and other people's behaviour in terms of mental states. This may lead to obsessive doubt, intolerance of uncertainty, rigid moral reasoning, and inability to clearly distinguish one's own physical, emotional, and mental states from those of others. Mentalization-Based Psychotherapy (MBP), initially developed for borderline personality disorder, provides a relational and metacognitive framework that may address fundamental mechanisms of obsessive-compulsive pathology. Unlike ERP, MBP specifically aim to improve patients' ability to comprehend and reflect on their own and others' mental states, potentially diminishing obsessive doubt and fortifying healthy self-boundary setting. This narrative examination looks at both old and recent studies on how MBP principles might be used to treat OCD and how mentalisation works. We define the notion of mentalisation, outline relevant evaluation tools and emerging therapy protocols, and compare MBP with ERP. Finally, we discuss how this can be applied in medicine, its limitations, and the potential future research directions. Reconceptualising OCD within a mentalisation framework may enhance current therapy and foster psychological flexibility and interpersonal relationships.

Keywords: *Obsessive-Compulsive Disorder, Exposure and Response Prevention, Mentalization, Metacognitive framework, healthy self-boundary setting*

Mentalization-based psychotherapy (MBP) for obsessive–compulsive disorder (OCD) posits that obsessive thoughts, compulsive rituals, and the concomitant emotional distress arise, in part, from deficits in mentalizing, which is the ability to comprehend behaviour (one's own and others') through the lens of intentional mental

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states, including feelings, desires and convictions, and intentions (Fonagy, Gergely, Jurist, & Target, 2002; Bateman & Fonagy, 2016). Mentalisation encompasses cognitive and affective dimensions and operates at both implicit and explicit levels of processing. When things are going well, people can tell the difference between thoughts and facts, feelings and what's really going on, and temporary doubts and real danger. But when mentalizing breaks down because of stress, emotional arousal, or a threat to attachment, people may go back to more basic ways of understanding their own experiences (Fonagy et al., 2002). In this view, OCD symptoms are not just the result of faulty beliefs, but also of problems with controlling mental states. Traditional cognitive-behavioural therapy modules for OCD focus on cognitive distortions due to the misinterpretation of intrusive thoughts and the reinforcement of compulsive behaviours through anxiety reduction (Rachman, 1997; Salkovskis, 1985). Exposure and Response Prevention (ERP), the preeminent psychotherapeutic intervention, seeks to diminish the correlation between intrusive stimuli and ritualistic behaviours by fostering habituation and inhibitory learning (Abramowitz, 2006; Wells, 2009). This model is very helpful for many patients with OCD, but it primarily focuses on changing repetitive negative, anxiety-provoking thoughts and behaviours. A mentalization-based reframing, on the other hand, changes the goal of therapy from cognitive restructuring to helping the patient better understand and deal with their own negative mental states. In a mentalization-based framework, obsessive phenomena are not merely considered epiphenomenal intrusive cognitions but are interpreted as dysregulated metarepresentational processes. Obsessions reflect a breakdown in the capacity to recognize one's thoughts as temporary, subjective, and potentially mistaken mental events, rather than as accurate reflections of reality or indicators of moral worth (Fonagy et al., 2002; Bateman & Fonagy, 2016).

In patients with OCD, Intrusive thoughts, images, and impulses are a natural part of their thinking system. Research has long shown that nearly everyone experiences these kinds of unwanted mental intrusions from time to time (Rachman & de Silva, 1978; Clark & Rhyno, 2005). From a cognitive neuroscience perspective, this spontaneous mental activity is associated with the brain's default mode network (DMN), particularly the medial prefrontal and posterior cingulate regions, which are involved in self-reflection (Raichle et al., 2001; Buckner et al., 2008). For most people who do not suffer from OCD, such distressing thoughts are quickly recognized as harmless mental events and dismissed through healthy metacognitive awareness and self-regulation, supported by the medial prefrontal and anterior cingulate cortices (Fleming & Dolan, 2012). In obsessive–compulsive disorder (OCD), intrusive cognitions experience distorted evaluation and intensification. Cognitive models assert that it is not the existence of intrusions but their erroneous interpretation, particularly regarding exaggerated responsibility, threat overestimation, and thought–action fusion, that leads to symptom persistence (Salkovskis, 1985; Rachman, 1997; OCCWG, 1997). From a mentalization standpoint, this amplification signifies a diminished reflective function, the ability to comprehend one's thoughts and emotions as representational states rather than objective realities (Fonagy et al., 2002).

When reflective capacity is unstable, individuals may default to what Peter Fonagy and colleagues conceptualized as the psychic equivalence mode (Fonagy et al., 2002). In this prementalizing mode, internal and external realities are conflated: what is imagined is experienced as real; what is thought is treated as morally or causally consequential. An intrusive image of harming a loved one is therefore not encoded as a hypothetical simulation but is experienced as evidence of latent violent intent. This phenomenology overlaps with the construct of thought–action fusion described in cognitive accounts of OCD (Rachman,

1993). Obsessive–compulsive disorder (OCD) has consistently been associated with dysfunction within cortico–striato–thalamo–cortical (CSTC) circuits, particularly involving the orbitofrontal cortex, anterior cingulate cortex, and striatal structures (Menzies et al., 2008; Pauls et al., 2014). These neural systems are centrally implicated in error detection, threat appraisal, and performance monitoring. Hyperactivity within these circuits may contribute to heightened sensitivity to perceived discrepancies, uncertainty, and potential harm. However, neurobiological dysregulation alone does not fully account for the subjective intensity and persistence of obsessive phenomena. From a mentalization framework, the critical difficulty lies in the individual's capacity to adopt a reflective stance toward internal experiences. Mentalization refers to the ability to understand thoughts and emotions as mental representations rather than direct reflections of external reality (Fonagy et al., 2002; Bateman & Fonagy, 2016). When this capacity is compromised, particularly under conditions of heightened affect, intrusive thoughts may lose their representational status and instead be experienced as concrete, reality-equivalent events.

So, this reduction in metarepresentational distance contributes to what may be conceptualized as over-signification, wherein ordinary cognitive events acquire disproportionate epistemic and moral weight. Emotional states such as doubt or anxiety are interpreted as indicators of objective threat rather than as transient affective signals. For example, the experience of uncertainty may be equated with actual danger, and intrusive imagery may be construed as evidence of intention. Such processes resemble the "psychic equivalence" mode described by Fonagy and colleagues (2002), in which internal experiences are treated as if they directly correspond to external reality. Within this framework, compulsive behaviours can be understood as attempts to restore epistemic certainty and regulate intolerable ambiguity. As proposed in cognitive models of OCD, rituals and reassurance seeking function to neutralize perceived threat and temporarily reduce distress (Salkovskis, 1985). From a mentalization-based perspective, these behaviours compensate for weakened internal reflective processes by providing external confirmation that uncertainty has been resolved (Bateman & Fonagy, 2016). The central disturbance, therefore, does not lie primarily in the occurrence of intrusive thoughts, which are common across the general population, but in the diminished capacity to maintain psychological distance from them. When mentalization fails, cognition becomes concretized, affect tolerance decreases, and internal experiences are processed in a symbolic mode less capable of sustaining ambiguity. This interaction between neurobiological vulnerability and impaired reflective functioning offers an integrative account of why intrusive thoughts in OCD are experienced as urgent, meaningful, and morally compelling rather than as transient mental events. Furthermore, mentalization encompasses the ability to tolerate ambiguity in internal states. OCD is strongly associated with intolerance of uncertainty and heightened need for cognitive closure (Tolin et al., 2003). From a mentalization framework, compulsive behaviours can be understood as concrete strategies to eliminate or regulate intolerable ambiguity in mental states. Checking, washing, counting, confessing, or reassurance-seeking may function as teleological solutions, actions aimed at producing certainty when symbolic reflection fails. In the teleological mode, internal distress is perceived as modifiable only through physical acts (Fonagy et al., 2002). Thus, compulsions are not simply anxiety-reducing behaviours but attempts to restore a sense of epistemic certainty regarding one's intentions, morality, or safety. This reconceptualization situates compulsions within a broader affect-regulation system. Mentalization is closely linked to the development of secure attachment and effective affect regulation (Bateman & Fonagy, 2016). When reflective functioning is compromised, due to developmental adversity, attachment

insecurity, or acute stress, individuals may struggle to process intense emotions symbolically. In OCD, emotions such as shame, disgust, fear, and moral anxiety often accompany intrusive thoughts. If these affective states cannot be adequately identified, labelled, and integrated into a coherent narrative, behavioural regulation may substitute for reflective processing. Rituals temporarily reduce emotional intensity, reinforcing their use as regulatory strategies. Empirical findings provide preliminary support for this model. Research on social cognition in OCD has identified impairments in certain aspects of theory of mind and reflective functioning, particularly under conditions of heightened emotional arousal (Bora, 2014). Reduced insight into the irrationality of obsessions has also been linked to poorer mental state differentiation (APA, 2022). Although findings are heterogeneous, these results suggest that at least a subset of individuals with OCD may exhibit vulnerabilities in higher-order mentalizing processes. Such vulnerabilities could contribute to rigid interpretations of intrusive thoughts and diminished capacity to tolerate uncertainty. Within this framework, mentalization-based psychotherapy for OCD can be defined as a structured, process-focused intervention aimed at enhancing reflective functioning in order to reduce reliance on compulsive behaviours as maladaptive affect-regulation strategies. Specifically, MBP seeks to: (1) improve the individual's ability to identify and articulate internal mental states; (2) strengthen differentiation between thoughts, feelings, and external events; (3) increase tolerance for uncertainty and emotional ambiguity; and (4) foster flexible meaning-making regarding intrusive experiences.

Clinically, MBP adopts a "not-knowing" therapeutic stance characterized by curiosity and collaborative exploration (Bateman & Fonagy, 2016). Rather than immediately challenging the accuracy of obsessive beliefs, the therapist encourages the patient to examine their internal experience in the moment. For instance, when a patient reports an urge to wash after a contamination thought, the therapist may explore: "What are you feeling right now?" "What does the doubt mean to you?" "Can we stay with this uncertainty for a few moments?" Such interventions aim to reestablish reflective functioning during affective arousal. The therapeutic process emphasizes linking affect to cognition, identifying shifts in mental states, and maintaining symbolic distance from intrusive content. Importantly, MBP does not replace ERP; rather, it can complement it. Exposure exercises inherently activate distress and uncertainty, precisely the conditions under which mentalization may collapse. By strengthening reflective capacity, MBP may enhance the patient's ability to engage with exposure tasks without resorting to ritualization. Post-exposure reflection further consolidates learning by helping patients observe fluctuations in anxiety and doubt over time, thereby reinforcing the distinction between transient mental states and objective danger. The ultimate therapeutic aim of MBP in OCD is to reduce anxiety-driven certainty-seeking strategies and increase flexible, exploratory meaning-making. As reflective functioning improves, intrusive thoughts can be experienced as mental events rather than threats requiring action. Doubt becomes tolerable rather than catastrophic. Compulsions gradually lose their regulatory function as patients develop alternative ways to process ambiguity. In this sense, MBP addresses the underlying architecture of mental state regulation, thereby promoting psychological flexibility beyond symptom reduction.

Conceptually, this reframing integrates cognitive, affective, and relational dimensions of OCD. It situates compulsive behaviour within the broader context of attachment, epistemic trust, and developmental trajectories of mentalizing capacity. Future research should examine whether improvements in reflective functioning mediate symptom change in combined ERP–MBP protocols. Such work would clarify whether mentalization represents a

transdiagnostic process underlying compulsive certainty-seeking and whether targeting this process enhances long-term treatment outcomes.

SEARCH METHODOLOGY

A structured narrative review was conducted using PubMed, PsycINFO, Scopus, and Google Scholar databases. Search terms included: "Obsessive–Compulsive Disorder," "mentalization," "reflective functioning," "metacognition," "mentalization-based therapy," and "attachment." Literature from 1990 to 2025 was prioritized. Both foundational theoretical texts (Fonagy et al., 2002; Bateman & Fonagy, 2016) and empirical studies examining reflective functioning in OCD were included. Given the limited direct trials of MBP for OCD, related literature on metacognitive dysfunction and MBP in other disorders was incorporated. (Lind, Basedow, & Lewandowska, 2013).

Theoretical Foundation of Mentalization-Based Psychotherapy

Mentalization is the ability to understand your own and others' actions by thinking about what people might feel, want, or intend (Fonagy et al., 2002). This ability mostly grows in safe, caring relationships and helps people manage feelings, see different points of view, and stay open-minded (Fonagy & Luyten, 2009). When mentalizing is intact, individuals can differentiate between thoughts and facts, emotions and external reality, and subjective interpretations and objective events. (Bateman & Fonagy, 2016). Under conditions of heightened stress or emotional arousal, however, reflective functioning may deteriorate. When this occurs, individuals may shift into pre-mentalizing modes of processing. In the psychic equivalence mode, internal experiences are treated as concrete realities; thoughts feel true simply because they are experienced (Fonagy & Luyten, 2009). In the pretend mode, thoughts become detached from emotional grounding, resulting in intellectualization without affective integration. In the teleological mode, psychological distress is perceived as resolvable only through observable actions rather than symbolic reflection (Fonagy et al., 2002; Bateman & Fonagy, 2016). These modes have clear parallels with obsessive–compulsive processes. For example, thought–action fusion (Shafran et al., 1996) resembles psychic equivalence, as intrusive thoughts are experienced as morally or causally significant. Similarly, compulsive rituals reflect teleological reasoning, in which action becomes the primary means of restoring certainty or safety. Mentalization-Based Psychotherapy (MBP) seeks to interrupt these rigid processing patterns by restoring reflective capacity, particularly during moments of emotional activation (Bateman & Fonagy, 2016). The therapeutic mechanism does not rely on directly challenging the content of obsessive beliefs. Instead, MBP strengthens the patient's ability to observe thoughts as mental events, to tolerate uncertainty, and to link affect with cognition. Through a structured yet exploratory "not-knowing" stance, the therapist models curiosity about internal experience and helps the patient re-establish psychological distance from intrusive material (Fonagy et al., 2002).

In this way, the central mechanism of MBP lies in stabilizing reflective functioning under stress, thereby reducing the tendency to concretize thoughts and act compulsively in response to them.

Aim of Mentalization-Based Psychotherapy

To restore and stabilize the patient's capacity to maintain reflective distance from intrusive thoughts and affective states, thereby reducing their over-signification and weakening the compulsive drive to achieve certainty.

MBP seeks to:

1. Enhance reflective functioning
2. Differentiate thoughts from actions
3. Increase tolerance of uncertainty
4. Improve affect regulation
5. Reduce rigid self-evaluative processes

Useful Psychological Assessment Tools in Therapeutic Formulation

OCD Symptom Severity

- Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989)
- Obsessive Compulsive Inventory-Revised (OCI-R; Foa et al., 2002)

Mentalization / Reflective Functioning

- Reflective Functioning Scale (Fonagy et al., 1998)
- Reflective Functioning Questionnaire (Fonagy et al., 2016)
- Mentalization Questionnaire (Hausberg et al., 2012)

Obsessive Beliefs

- Obsessive Beliefs Questionnaire (OCCWG, 2005)

Formulation integrates attachment stressors, mentalization breakdown patterns, and compulsive behaviours.

Probable Integrated MBP–ERP Protocol for OCD

(Based on review of literature and studies of Foa, Yadin, & Lichner, 2012; Rossouw, & Fonagy, 2012; & Bateman, & Fonagy, 2016).

This integrative therapy module not only structures the progression of subsequent intervention phases but also establishes a coherent and theoretically grounded explanatory model that links symptoms, affective processes, cognitive appraisals, and relational dynamics. By offering patients a clear understanding of how intrusive thoughts, emotional arousal, and compulsive behaviours are interconnected, the formulation reduces confusion and self-blame while increasing epistemic clarity. Such transparency strengthens the therapeutic alliance and promotes collaborative goal setting. Moreover, when patients recognize the functional role of rituals within a comprehensible maintenance cycle, they are more likely to tolerate exposure-based tasks and uncertainty. The integration of mentalization principles further fosters reflective engagement, enabling patients to approach distressing experiences with curiosity rather than avoidance. Collectively, this structured and meaning-oriented framework enhances motivation, adherence to treatment procedures, and long-term self-regulatory capacity.

Phase 1: Assessment and Case Formulation (Sessions 1–4)

The initial phase is devoted to developing a comprehensive, collaborative, and theoretically integrated case formulation grounded in both Exposure and Response Prevention (ERP) and mentalization-based principles. A detailed clinical history is obtained, including onset, duration, course, and fluctuations of obsessive–compulsive symptoms. Symptom dimensions, such as contamination, checking, harm, sexual, religious, or symmetry concerns, are systematically explored, along with the form and frequency of compulsions (overt rituals, covert mental acts, reassurance seeking, avoidance behaviours). Insight level,

functional impairment, and family accommodation are carefully assessed, as these factors influence both prognosis and treatment planning. Standardized assessment tools are administered to ensure diagnostic precision and to establish measurable baselines. The Yale–Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989) is used because it remains the gold-standard clinician-rated measure of OCD severity and provides dimensional ratings of obsessions and compulsions independent of symptom content. The Obsessive Compulsive Inventory–Revised (OCI-R; Foa et al., 2002) complements the Y-BOCS by offering a self-report measure that captures symptom subtypes and allows monitoring of change over time. Dysfunctional cognitive appraisals are assessed using the Obsessive Beliefs Questionnaire (OCCWG, 2005), which is useful for identifying maladaptive belief domains, such as inflated responsibility, threat overestimation, perfectionism, and importance/control of thoughts, that maintain compulsive behaviour and may be specifically targeted during treatment. Given the integrative framework, mentalization capacity is also evaluated. The Reflective Functioning Scale (Fonagy et al., 1998) is valuable when detailed narrative material is available, as it provides an in-depth assessment of the individual's capacity to interpret behaviour in terms of mental states. The Reflective Functioning Questionnaire (Fonagy et al., 2016) offers a more time-efficient self-report alternative that captures certainty and uncertainty about mental states, which may be particularly relevant in OCD presentations characterized by rigid or over-concrete interpretations of internal experience. The Mentalization Questionnaire (Hausberg et al., 2012) can further clarify deficits in emotional awareness, self-reflection, and affect regulation. Assessing mentalization is clinically important in this model because it helps identify patterns of stress-related collapse in reflective functioning that may contribute to the over-signification of intrusive thoughts. In addition to symptom measurement, developmental and attachment histories are explored to identify relational experiences that may predispose the patient to shame proneness, moral rigidity, heightened responsibility beliefs, or chronic self-doubt. Trauma exposure, emotional invalidation, and early attachment disruptions are examined because such factors can increase vulnerability to affect dysregulation and impair the capacity to maintain psychological distance from distressing internal states. Particular attention is given to situations in which emotional arousal appears to reduce reflective functioning and precipitate compulsive behaviour.

A functional analysis is then collaboratively constructed. Using the standard ERP framework, the maintenance cycle is mapped as Trigger → Intrusive Thought → Misinterpretation → Anxiety → Compulsion → Temporary Relief → Reinforcement. This model clarifies how avoidance and ritualizing are negatively reinforced. The formulation is subsequently expanded through a mentalization lens: Trigger → Affective Arousal → Collapse of Reflective Distance → Psychic Equivalence → Ritual. This addition highlights how intrusive thoughts may be experienced as concrete realities rather than mental events when reflective functioning deteriorates under stress.

Phase 2: Psychoeducation and Mentalization Stabilization (Sessions 5–8)

This phase provides psychoeducation that integrates neurobiological, cognitive, and mentalization perspectives. Patients are introduced to a simplified neurobiological explanation of CSTC circuit overactivation, emphasizing that the brain's error-detection system is hypersensitive and prone to generating false alarms. Intrusive thoughts are normalized as universal experiences. The cognitive-behavioural model of OCD is then explained, highlighting that thoughts are not equivalent to danger, anxiety naturally decreases without ritualizing, and compulsions maintain the disorder through negative

reinforcement. Concepts such as habituation and inhibitory learning are introduced to prepare for exposure work. Mentalization education follows, teaching that thoughts are mental events rather than facts, emotions are signals rather than evidence, and stress reduces reflective functioning The concept of psychic equivalence is explained, illustrating how anxiety can make thoughts feel real and urgent. Patients are encouraged to adopt a reflective stance toward their internal experiences ("This is my mind generating content"). Basic affect regulation skills, including emotion labelling, grounding techniques, and distinguishing thoughts from intentions, are introduced to stabilize arousal before intensive exposure begins.

Phase 3: ERP with Mentalizing Integration (Sessions 9–18)

In this core therapeutic phase, standard ERP procedures are implemented while explicitly integrating mentalization techniques. A SUDS-based exposure hierarchy is collaboratively constructed, ranking triggers from least to most distressing and identifying specific rituals to be prevented. Both situational and internal (imaginal) triggers are included. During in-session exposure, gradual confrontation with feared stimuli is paired with response prevention and elimination of reassurance. Patients remain in exposure long enough to allow anxiety reduction or inhibitory learning to occur. Throughout exposure, the therapist monitors affective arousal and, when necessary, supports regulation, while avoiding excessive cognitive analysis that might undermine learning. Mentalizing prompts are used to foster reflective distance, such as asking whether the experience is a thought or a fact, or exploring whether a feeling of certainty equates to objective truth. Moments of psychic equivalence and over-signification are identified and gently examined. Shame and guilt linked to intrusive content are processed explicitly, separating moral identity from mental events. Behavioural experiments are embedded within reflective dialogue, encouraging patients to compare predicted outcomes with actual outcomes and to reconsider the meaning of intrusive thoughts. This integration aims to combine inhibitory learning with strengthened metacognitive decentring.

Phase 4: Interpersonal and Relational Work (Sessions 19–22)

Given that OCD frequently involves reassurance seeking, family accommodation, and fear of moral judgment, this phase addresses interpersonal dynamics through a mentalizing lens. Relational triggers are explored to identify how anxiety and doubt influence interactions. Responsibility beliefs, shame, and guilt are processed within the therapeutic relationship. The therapist may address rupture moments in therapy to model reflective repair and highlight episodes of mentalization breakdown as they occur. Efforts are made to reduce reliance on reassurance and promote epistemic flexibility, encouraging patients to tolerate uncertainty within relationships without seeking compulsive validation.

Phase 5: Consolidation and Relapse Prevention (Sessions 23–24)

The final phase focuses on consolidating gains and preparing for long-term maintenance. Patients identify early warning signs of relapse, high-stress triggers, and situations in which reflective capacity may collapse. A personalized mentalization-based coping plan is developed, outlining sequential steps for managing rising anxiety: labelling the emotion, identifying intrusive thoughts as mental events, resisting ritual engagement, tolerating uncertainty, and reflecting on alternative interpretations. Termination processing includes reviewing changes in the patient's relationship to intrusive thoughts, increased tolerance of uncertainty, and reductions in compulsive urgency. Emphasis is placed not only on symptom

reduction but also on strengthened reflective functioning as a durable protective factor against relapse.

Comparison Between Mentalization-Based Psychotherapy and Exposure and Response Prevention

Mentalization-Based Psychotherapy (MBP) and Exposure and Response Prevention (ERP) represent two distinct but potentially complementary approaches to the treatment of disorders characterized by anxiety, obsessions, and interpersonal difficulties (Bateman & Fonagy, 2013; Foa et al., 2022). MBP is rooted in attachment theory and focuses on enhancing the individual's capacity to understand their own and others' mental states as subjective, fallible, and context-dependent (Bateman & Fonagy, 2013; Fonagy et al., 2016). It places strong emphasis on the therapeutic relationship, using it as a live arena in which breakdowns in mentalizing can be observed, explored, and repaired (Bateman & Fonagy, 2013). In contrast, ERP emerges from the behavioural and cognitive-behavioural traditions and targets symptom reduction more directly by systematically exposing individuals to feared stimuli while blocking their usual avoidance or compulsive responses (Foa et al., 1984; Rosa-Alcázar et al., 2021). Whereas MBP primarily aims to improve reflective functioning, affect regulation, and interpersonal understanding, ERP is designed to modify maladaptive learned associations between intrusive thoughts, anxiety, and compulsive behaviours, often conceptualized through habituation and inhibitory learning models (Bateman & Fonagy, 2013; Craske et al., 2022). MBP sessions typically involve exploratory dialogue, attention to shifts in emotional arousal, and a stance of curiosity toward inner experience, while ERP requires collaboratively planned exposure exercises and careful monitoring of anxiety reduction or inhibitory learning over time (Craske et al., 2014; Bateman & Fonagy, 2013; Craske et al., 2022). Clinically, MBP may be especially relevant for patients with complex presentations, emotional instability, and relational trauma, where difficulties in mentalizing under stress contribute to symptom persistence (Bateman & Fonagy, 2013; Bateman & Fonagy, 2008). ERP, by contrast, has a particularly strong evidence base for obsessive-compulsive and related disorders, where clearly identifiable triggers and rituals allow for structured exposure protocols (Foa et al., 1984; Rosa-Alcázar et al., 2021; Foa et al., 2022). Despite these differences, both approaches recognize the importance of helping patients develop a new relationship to their thoughts and emotions, either by understanding them as mental events (MBP) or by learning that they can be tolerated without compulsive action (ERP) (Bateman & Fonagy, 2013; Craske et al., 2022).

Application of Mentalization-Based Psychotherapy in OCD

1. Moral Scrupulosity

In scrupulosity, intrusive doubts about morality reflect difficulty mentalizing intention and responsibility rather than mere cognitive distortion. Patients often operate in a state of psychic equivalence, in which thoughts are experienced as morally equivalent to actions (Fonagy et al., 2002). MBP enhances differentiation between intention, affect, and action, reducing compulsive reassurance and moral checking (Bateman & Fonagy, 2016).

2. Relationship OCD (ROCD)

ROCD is conceptualized as attachment-related mentalizing failure under relational stress. Doubts about love or compatibility may represent projections of internal insecurity onto the partner (Mikulincer & Shaver, 2007). MBP strengthens reflective functioning regarding self–other representations, thereby stabilizing relational meaning and reducing compulsive checking.

3. Pure Obsessional Presentations

In "Pure Obsessive," intrusive thoughts gain pathogenic significance when patients cannot differentiate thoughts from identity or intent. This reflects impaired metacognitive awareness and heightened cognitive fusion (Wells, 2009). MBP promotes affect labelling and reflective distance, weakening the perceived necessity of mental neutralization.

4. Comorbid Personality Pathology

When OCD co-occurs with personality pathology, obsessive symptoms may function as affect-regulatory strategies amid attachment instability. Impaired reflective functioning is common in personality disorders (Bateman & Fonagy, 2016). MBP addresses underlying self-structure and relational dysregulation, improving tolerance of uncertainty and reducing compulsive control.

5. Adolescents

Adolescence involves ongoing maturation of reflective capacity and identity formation. Mentalizing abilities are still consolidating during this developmental period (Fonagy & Target, 1997). MBP provides a developmentally attuned framework that strengthens perspective-taking, affect recognition, and epistemic trust.

Future Directions

1. Randomized Controlled Trials

Rigorous randomized controlled trials (RCTs) comparing Mentalization-Based Psychotherapy (MBP) with Exposure and Response Prevention (ERP) and integrative models are essential. While ERP remains the gold-standard intervention (e.g., Foa, Yadin, & Lichner, 2012), no large-scale trials have directly evaluated MBP in OCD. Comparative efficacy and non-inferiority designs would clarify clinical indications and mechanisms of change.

2. Neuroimaging Studies

Neuroimaging research should examine whether MBP modifies neural circuits implicated in social cognition and self-referential processing. OCD is associated with cortico-striatal dysfunction, whereas mentalizing engages medial prefrontal and temporoparietal networks (Frith & Frith, 2006). Functional MRI studies could investigate whether treatment enhances integration between cognitive control and social–reflective systems.

3. Longitudinal Relapse Prevention

Long-term follow-up studies are needed to determine whether strengthening reflective functioning improves relapse prevention. Although ERP demonstrates durable outcomes, relapse remains clinically significant (Simpson et al., 2004). MBP may enhance resilience by targeting metacognitive flexibility and epistemic trust over time.

4. Reflective Functioning as Mediator

Future research should examine reflective functioning as a potential mediator of treatment outcome. Validated measures such as the Reflective Functioning Scale (Fonagy et al., 1998) could clarify whether improvements in mentalizing precede symptom reduction. Mediation analyses would strengthen the theoretical claim that metacognitive repair drives clinical change.

5. Development of OCD-Specific MBP Manuals

The creation of OCD-specific MBP treatment manuals is necessary to standardize intervention protocols. While MBT manuals exist for borderline pathology (Bateman & Fonagy, 2016), adaptation for obsessive–compulsive presentations would improve treatment fidelity and research reproducibility.

6. Integration with Third-Wave Approaches

Integration with third-wave therapies such as Acceptance and Commitment Therapy (ACT) and Metacognitive Therapy (MCT) warrants systematic investigation. Given the increasing recognition of transdiagnostic metacognitive dysfunction (Wells, 2009), hybrid models may extend beyond fear-conditioning frameworks and address broader deficits in cognitive flexibility and self-reflection.

CONCLUSION

Reframing OCD through the lens of mentalization offers a theoretically coherent and clinically promising expansion of current models. While ERP remains a cornerstone treatment, it may not address all underlying mechanisms, particularly those related to reflective instability and attachment-based uncertainty. Mentalization-Based Psychotherapy provides a relational and metacognitive framework that targets the capacity to understand mental states under stress—an ability that appears compromised in many individuals with OCD. Although empirical support specific to OCD remains preliminary, theoretical integration and related evidence suggest that enhancing mentalization may reduce compulsive certainty-seeking and foster durable psychological flexibility. Future controlled studies are required to determine efficacy and optimal integration strategies. Conceptually, MBP invites clinicians to move beyond symptom eradication toward restoration of reflective agency and epistemic resilience.

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Conflict of Interest

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