Clinical Article

Mentalizing the Clinical High-Risk for Psychosis Model: A Staged Intervention Framework

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Abstract

This article seeks to further specify how the mentalization-based approach may inform clinical intervention before the onset of psychosis, that is, during the stage of clinical high-risk for psychosis (CHR-P). We first review the concept of CHR-P, as well as the research evidence of the impact of early intervention. Next, we present evidence for the centrality of mentalizing as a process that may mitigate the risk for psychosis. We then review some of the key contributions in the psychoanalytical and phenomenological traditions concerning the centrality of core self disturbances in psychosis, and relate this to the *alien self* concept put forward in the mentalization framework. This leads us to expand on the structure of MBT for CHR-P, and to present a clinical vignette illustrating the process of epistemic trust at beginning of an intervention with a young person suffering from CHR-P. We summarize the links between core self disturbances, epistemic trust, and therapeutic communication in the context of CHR-P.

Keywords: mentalization, prodrome, schizophrenia, psychotherapy, schizotypy

More than a century after Swiss psychiatrist Eugen Bleuler introduced the term *schizophrenia* during his 1908 clinical lecture in Berlin (Bleuler, 1908; Fusar-Poli & Politi, 2008), the enduring clinical challenge persists in intervening with both psychological and psychiatric treatments to alleviate the suffering of schizophrenia spectrum and other psychotic disorders (SSPDs). While most treatment protocols focus on reducing symptoms, such as the use of neuroleptic medication that yields moderate effect sizes on positive symptoms (Leucht et al., 2017), individuals with SSPDs engaging in pharmacotherapy report only short-term benefits to their quality of life. Notably, the correlation between recovering from clinical symptoms of psychosis and achieving personal recovery is marginal (Van Eck et al., 2018). Regarding psychosocial treatments,

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including various forms of psychotherapy, such as cognitive-remediation training, family therapy, and group therapy, effect sizes remain small but significant; importantly, the most substantial gains in functional outcomes are associated with multicomponent interventions (Frawley et al., 2023). The characteristic treatment challenges in the field of SSPDs can be captured through the concept of the "symptom–disability gap" (Birchwood et al., 2013). This concept reflects the difficulty encountered by both psychotherapeutic and psychopharmacological treatments in significantly impacting the domains of interpersonal, role, and social functioning, even as significant therapeutic effects may be achieved by reducing the symptomatic expression of psychosis. It can be argued that in the face of such challenges, the field has turned to early intervention in the early stages of psychosis onset and even in its preceding stages to gain further thrust in closing the symptom–disability gap (Debbané & Toffel, 2019; Weijers, Ten Kate, Viechtbauer et al., 2020; Weijers, Ten Kate, Debbané et al., 2020). In this article, we first discuss why and how clinical practitioners and scientists have turned to early intervention in the preclinical stages of SSPDs to address the challenge of the symptom–disability gap. Then, we outline the rationale for focusing on mentalizing as a set of key processes that may mitigate not only the risk on conversion to SSPDs but also the clinical impact of comorbidities that commonly accompany the preceding stages to clinical onset, as captured by the CHR-P construct.

The Need for Early Intervention

The notion of a symptom–disability gap motivates clinical and research efforts to target the earliest stages of SSPDs. Indeed the developmental perspective on SSPDs is ingrained not only in the notion of neurodevelopment, as the basis of these disorders (Rapoport et al., 2005), but also in terms of age of onset, as the vast majority of SSPD cases emerge only in late adolescence or early adulthood (Solmi et al., 2022). In this context, many clinicians and scientists over the past three decades have focused on the earliest signs of vulnerability to SSPDs during adolescence by charting clinical signs and symptoms that may forecast their onset. Clinical research has explored two distinct approaches to CHR-P: the ultra high-risk approach (UHR) and the basic symptoms approach (BS). The UHR perspective, as conceptualized by McGlashan et al. (2001), introduced the structured interview for prodromal syndromes (SIPS), a criterion-based tool designed to assess subclinical symptoms indicative of an elevated risk for developing psychosis. These symptoms encompass unusual thought content, delusional ideas, suspicion,

persecutory ideas, grandiosity, perceptual abnormalities/hallucinations, and disorganized communication. The subclinical nature of these symptoms implies that individuals can recognize their experiences while still acknowledging emotional and functional disturbances resulting from them. Notably, the UHR approach primarily focuses on the positive dimensions of psychotic symptomatology, making it potentially more sensitive to the identification of imminent risk of psychosis. In this sense, a recent meta-analysis (de Pablo et al., 2021) conducted on a total of 130 studies and 9,222 individuals at CHR-P, showed a transition rate of 0.19 (95%CI, 0.17–0.22) at 2 years, which increased at 0.25 (95%CI, 0.22–0.29; $k = 29$; $n = 4029$) at 3 years. In essence, a quarter of all individuals diagnosed with CHR-P transition to a clinical diagnosis on the schizophrenia spectrum within 3 years.

In contrast, the BS approach centers on subjectively reported disturbances in affective, cognitive, and perceptual processes (Schultze-Lutter et al., 2010). The diagnosis relies entirely on the patient's subjective report, considering the frequency and novel, ego-dystonic nature of the experienced disturbance. Basic symptoms are cognitive and perceptual in nature, including thought interference, unstable ideas of reference, derealization, and visual or auditory echoes. To qualify as true basic symptoms, these experiences must have occurred at least weekly over the past 3 months. While occasional experiences of such symptoms are common, it is the emergent, weekly occurrence that signals a potential CHR-P state for psychosis.

A clinically valuable strategy involves combining both assessments (UHR + BS) when evaluating CHR-P for psychosis. Schultze-Lutter, Klosterkötter, and Ruhrmann (2014) conducted a study examining the cumulative conversion rates of participants diagnosed with CHR-P, using both UHR and BS criteria over a 48-month follow-up period. Individuals exclusively meeting either UHR or BS criteria showed a conversion rate of around 30%. However, those diagnosed with both subclinical attenuated positive symptoms and cognitive basic symptoms exhibited a much higher conversion rate, with 70% progressing to psychotic disorders. This suggests that a combined approach utilizing these clinical tools can significantly assist clinicians in assessing the risk for psychosis.

Within such a framework of early identification of risk for SSPDs, there has been a prevailing notion in the field that intervening during the CHR-P phase could potentially mitigate, delay, or even forestall the onset of a full-fledged psychotic disorder. Over recent years, clinicians have increasingly recognized the necessity of initiating treatment promptly after the onset of sustained positive psychotic symptoms (Fusar-Poli et al., 2013). Extended delays in treatment are commonplace and are linked to numerous detrimental psychosocial consequences, as

well as an elevated risk of self-harm and aggression (Schultze-Lutter et al., 2015). Conversely, current evidence indicates that early intervention in psychosis may correlate with improved outcomes (Schultze-Lutter et al., 2016).

Considering that only a relatively small proportion of individuals diagnosed with CHR-P identified as prodromal develop a psychotic disorder within a 1-year period (de Pablo et al., 2021), treatment methods under investigation in the prepsychotic phase usually prioritize safety, avoid clinically relevant adverse effects, and offer excellent tolerability, public acceptance, and relatively low costs. The European Psychiatric Association guidelines (Schmidt et al., 2015) align with these specific needs, suggesting that psychotherapeutic interventions should be the primary choice for CHR-P conditions. Yet despite advances in early identification of risk states for developing psychosis, psychotherapeutic developments targeting the "psychosis prodrome" have been infrequent and insufficiently explored. Presently, emerging evidence supports the beneficial effects of cognitive-behavioral therapy (CBT) for psychosis (Mei et al., 2021) on the severity of attenuated symptoms. CBT may also reduce the transition rate to psychosis at 12 months, although sustained protective effects at 18 months remain less clear (McGorry et al., 2021). Family-focused treatment also appears to yield positive effects, although the research is still in the early stages (Miklowitz et al., 2014). Confirming the need to test the effectiveness of different therapeutic interventions based on various theoretical models, recent network meta-analyses (Fusar-Poli et al., 2020; Mei et al., 2021) have confirmed that, to date, there is no evidence that any specific intervention is notably more effective than others in preventing the transition to psychosis.

It is crucial to note that (1) only a limited number of randomized-controlled trials for CHR-P preventive treatment have been conducted, with modest effect sizes of available treatments; (2) there is a lack of evidence regarding the active agent, as no specific intervention appears more effective than others in preventing the transition to psychosis; (3) the current psychotherapeutic models offer a symptom-focused perspective, and do not address the global clinical picture of adolescents and their families facing the challenges of CHR-P. Consequently, there is a need to conceptualize alternative forms of psychotherapeutic intervention for CHR-P, particularly focusing on processes that may directly impact both psychotic symptoms and other comorbidities, which represent the two primary clinical challenges to address the emerging symptom–disability gap. Importantly, a recent meta-analysis has emphasized that in people who do not undergo transition, the clinical and functional outcomes often remain unfavorable, with less than half

experiencing remission from the risk status over time (de Pablo et al., 2022). In this context, the rationale for a therapeutic method that could be adapted to address psychotic symptoms, while also providing the clinicians with tools known to diminish comorbidities, appears worthwhile to explore. In other words, the current state of early intervention in CHR-P underscores the necessity to explore new therapeutic models aimed at reducing the transition to psychosis and, more broadly, improving the clinical/functional outcome.

A Focus on Mentalizing in Youths Diagnosed with CHR-P

Research on outcomes across the clinical continuum of psychotic disorders indicates that social cognition plays a crucial role in maintaining positive and adaptive functioning (Debbané, Salaminios, et al., 2016). Social cognition is fundamentally tied to the processing of one's own and others' mental states, enabling adaptive engagement in social interactions (de Pablo et al., 2022). This is important because impairments in social functioning persist as formidable obstacles to achieving complete recovery in schizophrenia spectrum disorders, despite symptomatic improvement following psychological or pharmacological treatment (Armando et al., 2019). While early research on psychotic disorders typically concentrated on symptomatology, particularly reducing symptoms like hallucinations or delusions, the past decade has witnessed a shift toward emphasizing functionality and social integration in everyday life for patients with psychosis (Green et al., 2015). Dysfunctions in social integration stand out as key factors hindering full recovery and represent a common factor sustaining the symptom–disability gap, irrespective of the diverse range of symptoms exhibited by people suffering with psychotic disorders. Shifting from a symptom-based perspective to a psychological process perspective, we underline that the skills related to building social cognition hinge on mental state processing or *mentalizing*, involving the understanding of one's and others' intentions, emotions, beliefs, desires, and similar aspects. Mentalizing constitutes a multifaceted construct that encompasses psychological functions leading to the comprehension of one's own and others' behavior in terms of intentional mental states (Fonagy et al., 2002). In essence, mentalizing sustains the ability to form representational models of human behavior in order to adaptively navigate the complexity of social interactions, as well as regulate one's own thinking and feeling states. As such, a psychological-process-based approach to the treatment of CHR-P can be usefully conceptualized from a mentalization-based perspective.

Of further significance are the shared developmental aspects of both mentalizing and CHR-P. During adolescence and early adulthood, targeting mentalizing can be particularly fruitful because numerous systems interact to achieve fully mature social behavior (Badoud et al., 2016; Rossouw & Fonagy, 2012). Within the interpersonal context, young people's decreasing dependence on the family, along with the increasing importance of novel interpersonal relationships with peers and romantic partners contribute to the elaboration of mentalizing as a means to confront a social world of renewed complexity. Importantly, however, the developmental challenges brought about by developmental psychopathology during this period may interfere with the elaboration of critical mentalizing skills (Salaminios et al., 2021). Psychological development during adolescence and early adulthood involves interactive and transactional dynamics among cerebral maturation, high-order cognitive functions, and emotion regulation capacities, all essential for sharpening understanding and integrating increasingly complex social information (Blakemore, 2012). The development of skills enabling the perception, analysis, interpretation, and selection of adaptive behaviors in interpersonal and social contexts (Gibson et al., 2010) is thus in crucial gestation during adolescence and early adulthood. Because the ability to imaginatively envision intentions, emotions, or beliefs in others and in oneself is crucial for understanding, anticipating, and adapting to one's surroundings (Fonagy et al., 1994), the development of mentalizing may require increased external support for adolescents and young adults who are simultaneously confronted with emerging developmental psychopathology such as CHR-P.

In this vein, research all along the continuum of psychosis, from the premorbid stages to the clinical expression of the disorder, indicates significant links between mentalizing capacities and the expression of symptoms. At the behavioral level, even children as young as 11–12 years old demonstrate positive correlations between the presence of positive schizotypal symptoms (such as auditory verbal hallucinations) and faulty inferences about others' mental states, marked by a "hyper-mentalizing" tendency to overattribute intentions in the absence of observable evidence (Clemmensen et al., 2016; Clemmensen et al., 2014). Interestingly, young people at risk for developing psychosis, but with intact mentalizing capacities, are less likely to see their symptoms exacerbate during adolescence (Bartels-Velthuis et al., 2011; Salaminios et al., 2023). Conversely, sociocognitive impairments appear to serve as predictive factors for conversion to psychosis (Addington et al., 2008; Jang et al., 2011). Indeed, longitudinal research establishes a direct link between impaired mentalizing function and the development of first episode psychosis (FEP) among CHR-P

samples. For instance, Boldrini et al. (2020) found that mentalizing impairments, assessed using a narrative interviewer-rated measure, significantly predicted conversion to FEP among a sample of young adults diagnosed with CHR-P.

In light of this evidence, there is a focus on sustaining and fostering the capacity to mentalize oneself and others through mentalization-based therapy (MBT), which has already shown promising results in various disorders (such as borderline personality disorder and anti-social personality disorder) in both adult and adolescent populations (Rossouw & Fonagy, 2012). This intervention has also been tested with adult patients with schizophrenia (Horan & Green, 2019), but, as of now, only preliminary evidence suggests that MBT could usefully target young patients diagnosed with CHR-P (Debbané, Benmiloud, et al., 2016). Through these early reports, the clinical legitimacy of mentalizing as a focal point of treatment for CHR-P has gained greater emphasis, particularly in recent years, supported by empirical research (Brent, 2009; Brent et al., 2019; Debbané, 2019; Debbané & Bateman, 2019; Debbané, Benmiloud, et al., 2016; Weijers et al., 2018; Weijers, Ten Kate, Viechtbauer et al., 2020; Weijers, Ten Kate, Debbané et al., 2020). To synthesize, research indicates that mentalizing mitigates the impact of psychotic expression in various ways. Developmentally, robust mentalizing capacities seem to lessen the functional impact of symptoms such as auditory verbal hallucinations (Gore et al., 2011), reinforcing mentalizing as a viable treatment target for adolescents at high risk for psychosis. Additionally, in contexts where emotional factors sustain the exacerbation of psychotic symptoms in high schizotypy and high-risk-for-psychosis cohorts (Salaminios et al., 2021), focusing on mentalizing as a factor strengthening emotion regulation provides further rationale for MBT. A recent study demonstrated that sustaining mentalizing emotions in oneself and others reduces delusional belief formation and withdrawal behaviors, which contribute to the progression of functional impairments associated with psychosis in youths displaying clinical psychotic features and psychosocial withdrawal (Dangerfield & Brotnow Decker, 2023). Furthermore, given that emotion expression in family settings is known to sustain or exacerbate the expression of psychotic symptoms, intervening at the family level to regulate emotional expression is both empirically motivated and clinically warranted. Family interventions are increasingly integrated into various therapeutic models for UHR (Landa et al., 2016), offering an additional framework to alleviate stress, emotional arousal, and uncertainty associated with the transition to clinical psychosis (Haidl et al., 2018). Data suggest that strengthening mentalizing helps mitigate the negative effects of expressed emotion on psychosis liability (Pazar et al., 2022).

As highlighted above, three main reasons support the relevance of such a model for psychosis across its various stages of clinical evolution. First, recent studies on MBT adapted for patients with nonaffective schizophrenia spectrum disorders have demonstrated feasibility and promising results. Second, MBT has proven effective in adolescents who typically present with personality pathology, including subclinical psychotic symptoms. Third, the same therapy model is applicable to the range of clinical manifestations along the continuum of psychosis expression, making it adaptable to the progression of the illness. Randomized controlled trials conducted with patients with borderline personality disorder have shown MBT's therapeutic effect on interpersonal relationships and emotion regulation processes (Bateman et al., 2016; Bateman & Fonagy, 1999, 2009; Pazar et al., 2022). More recently, MBT has been successfully adapted to a range of disorders (Bateman & Fonagy, 2019), and several preliminary reports describe successful attempts to adapt MBT for CHR-P (Debbané, Benmiloud, et al., 2016; Debbané, Salaminios, et al., 2016) and schizophrenia-spectrum disorders (Brent & Fonagy, 2014; Brent, 2015; Brent et al., 2014).

Collectively, this body of research leads to the working hypothesis that mentalization processes may not necessarily represent causal agents responsible for the onset of psychosis, but rather represent resilience factors protecting against clinical illness among those who are at increased risk. Such research aligns with the hypothesis that MBT, aimed at strengthening mentalization abilities, could assist individuals in restructuring (rerouting) the functional organization of thinking toward less rigid, delusional, and perseverative patterns of reality testing. Therefore, MBT can potentially serve as a valuable psychotherapeutic intervention aimed at reducing transition rates to psychosis and improving both prognosis and functioning in young patients with a CHR-P condition.

Conceptualizing Psychosis

Over the past decade we have progressively conceptualized the MBT approach along the continuum of psychosis expression (Bateman et al., 2023; Debbané & Bateman, 2019) inspired by the initial case description and theorizing provided by Benjamin Brent (Brent, 2009; Brent & Fonagy, 2014). In addition to the empirical evidence presented above, which describes a variety of developmental associations between mentalizing and risk for psychosis (both distal and proximal), theoretical integration from key psychoanalytic authors working with patients with psychotic disorders may be bridged to the work of phenomenological

psychiatrists and philosophers exploring the question of the nature of schizophrenia.

Freud primarily developed psychoanalysis as a form of treatment he believed would uncover unconscious conflicts and repressed thoughts along the therapeutic journey leading to psychological relief. When it came to psychosis, Freud acknowledged the limitations of traditional psychoanalysis. He recognized that individuals with disorders such as schizophrenia exhibited a more profound detachment from reality, making it difficult to establish the trust and insight necessary for traditional psychoanalytic exploration.

Notwithstanding his reservations, Freud's analysis of the Daniel Paul Schreber case in his "Psycho-Analytic Notes on an Autobiographical Account of a Case of Paranoia" (1911/2014) led him to explore the life and mental struggles of a German judge who experienced severe psychosis. Notably, Freud employed his concept of narcissism to scaffold his analysis of the Schreber case. It is significant that this primary relationship to oneself (narcissism) constitutes an instrumental vantage point from which the founder of psychoanalysis analyzed psychosis. It is of further note that in Greek mythology, Narcissus develops a delusional relationship to himself "as another." Caravaggio's painting (circa 1598–1599) illustrating Narcissus falling in love with his specular image as reflected in the calm water surface evokes a kind of dissociative phenomena of an individual relating to oneself as a separate object of perception. This image captures the schism between the self and the ideal self, and the narcissistic withdrawal that characteristically orients the mind of the individual to oneself at the expense of relating emotionally with others (i.e., other objects of libidinal investment) and the external world. It is also noteworthy to underline that Freud conceptualized the stage of primary narcissism as foundational of the self-structure, preceding the ability to develop emotional relationships to others. Although psychoanalysts from the object relations' tradition did not retain the concept of primary narcissism, their perspective on psychosis has remained centered around the notion of vulnerable self-structure.

We would argue that over time, the work furthered by psychoanalysts on conceptualizations of psychosis and clinical work with patients with psychotic disorders significantly deepened the understanding of the underlying self-structure at the core of psychotic phenomena. Authors in the object relation's tradition of psychoanalysis, such as Melanie Klein, Wilfred R. Bion, and Donald Winnicott, centered on the unbearable affect nested in the subjective experience of a split self, with major motivational dysfunctions linked to the thwarted relationship to oneself in terms of agency, affect regulation, and continuity of thought processes. More recently, authors working on the development

of personality, such as Daniel Stern and Sydney Blatt, extended the idea of how the early self-structure is essential to experiencing the self as unified, and establishing a sense of being able to ground one's thinking in reality (Table 1).

The works of psychoanalytic authors can be put in parallel to the works of psychiatrists and philosophers interested in capturing the phenomenology of the first-person schizophrenic experience of the self. Bleuler himself wrote on the significant alterations in the very structure of the self experienced by individuals with schizophrenia, and described both the splitting of the self and the loss of being able to feel or experience oneself. The role of affect is important to both the psychoanalytic and the phenomenological approaches yet is used differently in relation to psychosis. Psychoanalytic authors usually emphasize how the capacity to mentally contain affective states, which usually sustains one's sense of being, is severely impaired in schizophrenia, while phenomenological authors describe the very affect that lies at the core of being, what it is to feel being an "I," or the loss thereof, and how the basic sense of being can be thwarted or lost in the schizophrenic experience.

Peter Fonagy and colleagues' concept of "alien self" (Bateman et al., 2023; Fonagy et al., 2002) serves to integrate the psychoanalytical and phenomenological perspectives on the central issue of "core self experience" along the continuum of psychosis. The main idea put forward in this concept is that intolerable internal self-experiences can be regulated only through a process of *externalizing into* alienating self-representations. For instance, unbearable experiences such as acute loss of agency, intense shame, intolerable dread, or other triggers typically disrupt the usual linking of sensory, affective, and cognitive levels of experience of oneself sustaining the sense of self-continuity. In such instances, the mind often turns to alienating self-representations as an attempt to rescue a minimal sense of self. In particular, self-threatening losses of agency can be externalized into representations of one's mind being under the influence of alien control; experiencing intense shame can be externalized into parts of oneself experienced as "weak," "bad," or "worthless," then externalized through self or other-directed aggressive behavior; intolerable dread can be externalized through a perceptual splitting of self-experience, such as out-of-body experiences, perceptual basic symptoms, and the like. For the individual, idiosyncratic psychotic experiences will usually take the form of a unique set of such alienating self-representations, for which more or less adaptative externalization strategies will be employed. Importantly, the process of mentalizing (linking sensory, affective, and cognitive experience of oneself) is absent during the process of externalizing into alienating self-representations

TABLE 1. Parallel citations of key authors in the fields of psychoanalysis and phenomenology

Psychoanalytical authors	Citation	Phenomenological authors	Citation
M. Klein (1946) (Klein, 1946)	*"I hold that anxiety arises from the operation of the Death instinct within the organism is felt as* ***fear*** *of* ***annihilation*** *(death) and takes the form of fear of persecution."* (p. 100)	K. Jaspers (1913) (Jaspers, 1913/1963)	"*The individual suffering with schizophrenia "is* ***no longer able to feel he exists****. Descartes' 'cogito ergo sum' (I think therefore I am) may still be superficially cogitated but it is no longer a valid experience.*" (p. 122)
W. R. Bion (1957) (Bion, 1957)	*"[T]he characteristics I listed as intrinsic to schizophrenic personality . . . lead(s) to minute* ***fragmentation*** *of the personality, particularly of the apparatus of* ***awareness of reality****"* (p. 267)	L. Binswanger (1958) (Binswanger, 1958)	*"All these are expression-forms of existential emptiness in the sense of the schizophrenic process. Added to this is the 'feeling' that all inner life has stopped, that everything is* ***unreal****, everything* ***senseless****."* (p. 359)
D. Winnicott (1974) (Winnicott, 1974)	*"In the more psychotic phenomena that we are examining it is a* ***breakdown*** *of the establishment of the* ***unit self*** *that is indicated."* (p. 103)	K. Schneider (1959) (Schneider, 1959)	*"****[D]isturbances of self-experience*** *show the greatest degree of schizophrenic specificity. Here we refer to those disturbances of first personal givenness (Ich-heit) or 'mineness' (Meinhaftigkeit)."* (p. 58) "[First rank symptoms can be] . . . *regarded as a group which represent the 'lowering' of the 'barrier' between the self and the surrounding world, the* ***loss of the very contours of the self****."* (p. 134)
D. N. Stern (1985) (Stern, 1985)	*"These four self-experiences, taken together, constitute a* ***sense of a core self****. . . . It is only in major psychosis that we see a significant* ***absence*** *of any of these four self-experiences."* (p. 71)	W. Blankenburg & A. L. Mishara (2001) (Blankenburg & Mishara, 2001)	*"In schizophrenia, however, there seems to be a true abdication of common sense involving a* ***loss of 'natural self-evidence'*** *. . . There is also a characteristic sense of perplexity, a sense of amazement before that which would normally seem self-evident and a frequent tendency to reflect upon the conditions of possibility of existence that otherwise remain concealed."* (p. 303)
J. S. Auerbach and S. J. Blatt (1996) (Auerbach & Blatt, 1996)	*"Schizophrenic hyper-reflexivity may follow from* ***failure*** *to establish or find a* ***bodily sense of self****."* (p. 306)	L. A. Saas & J. Parnas (2003) (Sass & Parnas, 2003)	*"Schizophrenia, we argue, is fundamentally a self-disorder or ipseity disturbance . . . that is characterized by complementary distortions of the act of awareness:* ***hyperreflexivity*** *and* ***diminished self-affection****."* (p. 427)

Note. Bold text highlights references to core self-disturbances.

(Debbané, Salaminios, et al., 2016). As Ricoeur notes, the psychological experience of alienation oscillates between experiencing part of selfhood as de-possessed from oneself, and the experience of becoming another, alienated from one's original selfhood (Ricoeur, 2021).

Contemporary psychodynamic approaches for psychotic disorders often integrate insights from psychoanalysis but are clinically adapted to the unique challenges and characteristics of psychotic conditions. Rather than relying on traditional psychoanalytic techniques, such as interpretations of deep unconscious conflicts, or linking early experiences to current behaviors, these approaches may focus on building a therapeutic alliance, providing support, and helping patients foster the capacity to mentally represent and reflect on their emerging thoughts and feelings, including the distress associated with psychotic experiences (Fonagy & Allison, 2023). Critically, the unfolding of the therapeutic alliance encounters significant obstacles in the form of vigilance, suspiciousness, and even paranoia (Weijers, Ten Kate, Viechtbauer, et al., 2020), which often inhibit the confidence or trust that may be otherwise invested in the information communicated by the therapist to the patient at risk for psychosis. The expression "epistemic trust" translates the relational process whereby the patient not only rationally thinks but also deeply feels that the information coming from carers and significant others is valuable and worth integrating into one's life (Fonagy & Allison, 2014). Therefore, trust is central to establishing a relationship that includes emotional learning about oneself, one's emotional dynamics, and how these relate to interpersonal and social functioning. Mistrust and suspiciousness about oneself as a reliable unit, and others as reliable source of information, lie at the heart of the challenge for psychotherapy along the clinical continuum of psychosis.

The Structure of MBT for CHR-P

Over the past decade we have applied the MBT approach along the continuum of psychosis (Debbané, Salaminios, et al., 2016; Debbané & Toffel, 2019; Salaminios & Debbané, 2021). In this section, we specifically outline mentalization-based therapeutic rationale, treatment structure, and outcome objectives for CHR-P. The rationale behind MBT for CHR-P is centered on fortifying the ability to mentalize oneself and others within significant relationships, which is critically dependent upon managing the epistemic trust vector in therapeutic communication. MBT aims to alleviate the impact of distressing symptoms typically linked or triggered by criticism (from others or oneself), heightened affective experiences (both negative and positive), and

cognitive complexity (disorganized thoughts in the face of cognitively complex expectations) (Bateman et al., 2023; Debbané, Salaminios, et al., 2016). Facilitating the experience of epistemic trust in individual and group settings contributes to strengthening the understanding of mental states in relation to idiosyncratic triggers for each patient. In turn, thinking about mental states assists in navigating experiences such as perceptual abnormalities, awkward self-experiences (feeling disconnected from or overwhelmed by others), and acute but unusual beliefs (e.g., distressing certainty of being the object of hostile intentions, i.e., paranoid phenomena), as previously highlighted in case studies using MBT along the psychosis continuum (Brent, 2009; Debbané, Benmiloud, et al., 2016). We cannot emphasize enough how aberrant perceptual and emotional experiences along the psychotic continuum disturb one's well-being, often to the extent of triggering social withdrawal, discontinuation of goal-oriented behaviors, and potential isolation from sources of emotional and psychological support as protection or coping mechanisms to alleviate their impact. Unfortunately, these strategies hinder the very process of relating meaningfully to oneself and others, both of which are critical in sustaining mental health in the context of risk for psychosis. Mentalizing becomes a valuable tool to support the individual in reducing or refraining from relying solely on such maladaptive mechanisms, thereby sustaining a better overall balance between mental health and illness.

As we have previously outlined (Armando et al., 2019), the treatment structure aligns with a "staging" approach that tailors interventions based on the level of impact symptoms exert on the individual (Table 2). Our staged MBT approach enables us to target different goals depending on the stage of symptom expression a young person diagnosed with CHR-P presents, as well as personalizing the domains of intervention within the individual psychotherapy. We believe it is important to present a dynamic, flexible, and coherent intervention framework that can be adapted to the patient's needs. Accordingly, we propose a revised model focusing on the progressive social cognition impairments exhibited in CHR-P. Early psychotic symptomatology is characterized by five stages ranging from subtle, subjective, nonclinical psychotic-like experiences (stage 0) to chronic psychosis (stage III; see Table 2). At the start, patients typically wish to address interpersonal, academic, and social complaints, which can exacerbate and lead to interruptions in the development of higher order mentalizing abilities with an impact on the psychotic trajectory (see Table 3).

In the CHR stage, individual psychotherapy sessions are oriented toward enhancing mentalizing skills. Additionally, this training is extended to the group settings (family and/or patient groups) to

TABLE 2. Clinical staging model of psychosis with focus on progressive social dysfunctions (impairments of social understanding)

Stage	Clinical pattern	Duration and impact on reality testing	Comorbidities	Impact on social functioning
Stage 0	Psychotic-like experiences, basic symptoms, anomalous self experiences, soft neurological signs, cognitive and negative symptoms	Transient with little impact on reality testing	Nonspecific problems with subtle impairments in social cognition	May affect either role, interpersonal, or vocational functioning and social integration with peers through physical and social anhedonia, reduced peer contact, and social anxiety
Stage Ia	Attenuated psychotic symptoms, negative, neurocognitive and social cognitive symptoms, depressed mood and other psychological and behavioral abnormalities	Duration of attenuated symptoms is limited, ability to discriminate between ideas and perception, fantasy partially preserved	Possibly clinical disorders, like mood or anxiety disorders	More severe impact on role, interpersonal, and vocational functioning, including difficulties concentrating, dysfunction in peer contact, excessive rumination, and significant social anxiety and withdrawal
Stage Ib	Brief self-limiting psychotic symptoms, negative, neurocognitive and social cognitive symptoms, depressed mood and other psychological and behavioral abnormalities	Duration of psychotic symptoms is limited, loss of ability to discriminate between ideas and perception, fantasy (during brief symptoms episodes)	Likely clinical disorders, like mood or anxiety disorders; likely emerging personality disorder	Relevant impact on the development of social skills and abilities, ruptures with engagement in role, interpersonal, and vocational areas; significant impairments in mentalizing abilities affecting interpretation of social interactions, problems arise in several areas sustaining development (role, interpersonal, and vocational)
Stage II	First episode of psychosis	First episode of psychosis. Long-term loss of ability to differentiate between reality and thoughts	Likely clinical disorders, like mood or anxiety disorders; likely emerging personality disorder	Severe impact on social functioning and school functioning; clear arrest of developmental engagement role, interpersonal, and vocational areas, and severe impairments in mentalizing
Stage III	Chronic psychosis	Chronic duration of total illness, progressive decline in cognitive and social functioning	Comorbidity as a rule rather than an exception	Severe and chronic impairment in role, interpersonal, and vocational functioning; restricted functional recovery

Note. Adapted from Armando et al., 2019, Table 1. Copyright © 2019 by Armando, Hutsebaut, and Debbané.

TABLE 3. Staging personalized interventions with specified MBT framework and treatment modules integrated in treatment plan

Stage	Type(s) of mentalizing intervention	Setting and timing	Targets and goals for mentalizing interventions
Stage 0	School-, peer-, and family-based preventive strategies aimed at information on risk factors and mentalization skills as protective factors	Nonspecific strategies to develop and reinforce emotion regulation through mentalization skills, education in primary prevention large-scale campaigns	Providing psychoeducation about the links between emotional and cognitive domains affecting perception and belief formation, introducing mentalizing skills as sustaining emotion regulation and balanced belief formation
Stage Ia	Psycho-education MBT-CHR-P MBT-A / MBT-G / MBT-F	Short intervention, including psychoeducation, skills strengthening in adolescent groups, and/or family therapy	Psychoeducation personalized to individual case formulation on emotional and cognitive symptoms, linking triggers of inefficient mentalizing, linking to CHR symptoms psychotic symptoms Patients are told about the key aspects of MBT, including the meaning of mentalizing and its sensitivity to arousal
Stage Ib	As for 1a Medications targeted to treat comorbid disorders (e.g., anxiety, depression) Take into account low doses of neuroleptic treatment in accordance to severity of BLIPS	More intensive intervention including individual psychotherapeutic work, combined with intervention at multiple levels (school, family, social network, etc.)	Starting from stage Ib the intervention is progressively focused on (1) regulating one's state of mind as central to the rehabilitation of the capacity for social understanding; (2) the emphasis on the role of idiosyncratic triggers (affect, belief formation, other) in disruptions of the ability to mentalize; and (3) the importance given to understanding the links between the quality of mentalization and specific Interpersonal/ attachment contexts.
Stage II	As for Ib MBT-G for psychosis (Weijers et al., 2020) Neuroleptic treatment	Intensive interventions, between 12 and 24 months	Five problem areas are developed and routinely reviewed with the patient, including: commitment to treatment, psychiatric symptoms, social interaction/relationships, harmful behavior, and community functioning.
Stage III	As for II AMBIT	Long-term interventions with an explicit focus on case management and an outreaching approach (see AMBIT description in note)	

Note. MBT-CHR-P = mentalization-based therapy individual psychotherapy targeting CHR-P; MBT-A = mentalization-based therapy for adolescents; MBT-F = mentalization-based therapy for families; MBT-G = mentalization-based therapy for groups; AMBIT = adaptive mentalization- based integrative treatment. *AMBIT* is a manualized mentalization-based approach aimed at working with hard-to-reach people at risk of a wide range of life adversities. It uses mentalization as an organizing framework for integrating a range of specific techniques and practices derived from different evidence-based modalities of intervention. Integration is principally achieved through a focus on delivery of multiple modalities through a single worker, and mentalization-based practices developed to enhance team and network functioning. BLIPS = brief limited intermittent psychotic symptoms.

Adapted from Armando et al., 2019, Table 2. Copyright © 2019 by Armando, Hutsebaut, and Debbané.

facilitate calibrated mentalizing within a social context. Incorporating group sessions enhances the application of learned skills to real-life situations. In this context, what are the treatment objectives of MBT for CHR-P? Situated within the realm of clinical studies for CHR, the primary outcome follows the trend of other studies regarding the transition to clinical psychosis. However, a broader interest lies in the general mental health of youth in treatment, encompassing those who do not transition. Importantly, it is thought that approximately half of those individuals not transitioning to a SSPD still remain in a CHR-P (de Pablo et al., 2022). Notwithstanding the clinical phenomenology linked to psychosis, accompanying psychiatric comorbidity represents the rule rather than the exception in CHR-P. More than a third of individuals diagnosed with CHR-P present with a concurring mood disorder, a quarter with cannabis dependance, and anxiety disorders are also common, while personality disorders should not be underestimated (Fusar-Poli et al., 2014; Fusar-Poli & Yung, 2012).

Clinical Case Illustration with Group-Session Transcript

To illustrate our MBT approach to CHR-P we present the case of Gina, a 16-year-old female who reported subclinical psychotic symptoms for approximately 6 months and received a diagnosis of CHR-P during an emergency hospitalization motivated by suicidal ideation, low mood, and delusional ideation.* MBT therapy began upon discharge from the hospital. At the initiation of psychotherapeutic treatment, the therapists adopted a collaborative, low-demand therapeutic stance aimed at fostering epistemic trust, that is, to instill a sense of confidence that they represent a legitimate and valuable source of information that can support Gina to reflect on (i.e., mentalize) her distressing experiences. This involved conveying genuine curiosity about Gina's experiences, being sensitive to instances of high emotional arousal, and helping Gina regulate these in the moment, as well as avoiding communications that may be felt by the patient as too demanding, critical, or judgmental. In the case of Gina's initiation to MBT, the first two individual sessions focused on co-constructing a formulation of her difficulties and how she wished to engage in therapy, which can be summarized by the following sentences offered by Gina:

> I need to get to know and understand myself better, because I often feel like I'm not myself. Often I find myself doing things or thinking things

*All personal/identifiable information has been disguised to preserve confidentiality.

without wanting to . . . or even, despite my will . . . and that can make me feel alone, and also, different from girls my age.

The first sentence captures the core self-disturbance experienced by Gina, who can sometimes feel as "I'm not myself." The second sentence describes her experiences of altered agency, which she tentatively connects to feeling different from her peers. The therapist suggested that in order to address these difficulties, the first step would be to join a therapeutic group of youth reporting similar experiences to hers, in order to help her reflect more explicitly on how these experiences come about, and think together with other group participants and therapists on how to manage them. Within this clinical context, the inclusion in a psychoeducation peer group aims to promote the sharing of distressing experiences with others who are going through similar experiences, a process that can generate epistemic trust insofar as the emotional arousal evoked during the sessions is successfully regulated by group therapists. The MBT psychoeducation group focuses on emotions, mentalizing, and psychotic symptoms, with the aim to build shared representations of the underlying mental states and processes associated with episodes involving core self disturbances, specifically for Gina, episodes where she felt she completely lost control of her actions. The overall goal is to identify and define the contours of how core self disturbances emerge, and what factors may help with containing these experiences within the psychotherapeutic setting and beyond. Furthermore, the group setting allows for the idiosyncratic episodes described by each participant to be thought about in relation to those reported by other members of the group, thus supporting the development of mentalizing abilities within a safe therapeutic context that sustains epistemic trust.

In the particular child psychiatry service attended by Gina, the MBT psychoeducation group was framed as "learning to manage my emotions" and ran in parallel to the individual therapy sessions over 6 weeks: 6 group sessions of 60 minutes each. The group comprised five adolescents and two specialist psychotherapists trained in MBT. The group aimed to explore material that could evoke strong emotions, which tended to be linked to impairments in mentalizing, leading to the expression of subclinical psychotic symptoms. In this specific group, Gina participated alongside two boys ages 15 and 17, and two girls ages 16 and 17, all having received a CHR-P diagnosis (Table 2: 1a). The format of the group was designed to be engaging and interactive, with a focus on processes rather than content, or in other words, on *how* difficulties come about rather than *what* types of difficulties appear. The intention was to stimulate shared experiences among participants by

employing material such as games, video clips, audio, or other age-relevant media that promote interaction between group members. The overarching goal was to create a process of *being together* (we-ness), within a framework where core values such as not judging and being kind and respectful of others' experience lay at the core of the group process. Through developing shared representations of the mental states that underlie their behaviors, with an emphasis on the process of affect and belief formation underlying each episode, the group worked on strengthening mentalizing skills in a safe space.

During the first psychoeducation group session, the therapists proposed to work on formulating the task for psychoeducation, and building a joint definition of what is meant by the expression "psychotic symptoms." In this session the group task went as follows: "To be able to talk about difficult moments and feelings without being judged, and to better understand how others deal with these kinds of difficulties." By acknowledging the participants' different perspectives on psychotic symptoms, a common definition was put forward: "Symptoms are moments in which we experience a break with regular thinking, and with shared reality with others." This definition resonated with Gina, as it is similar to the words she employed with her individual therapist.

The illustration below shows a sequence from the third session, titled "anatomy of a crisis." The aim of this session, as discussed by the group therapists, was to deconstruct an episode in which a crisis was experienced, and to try to closely examine the key moments and sequences that led up to symptom expression. The session was conducted by carefully validating the experiences and, above all, the mental states reported by participants, shared on a common blackboard where a process grid was used to chart the mental states that accompanied each sequence of the crisis episode. The focus of the session remained on supporting group members to develop the capacity to reflect on the intentional mental states that underlie their complex experiences. Participants were asked to identify and keep in mind a moment from the previous week during which they had the impression of losing touch with their thoughts and with reality (experienced as a crisis). The psychotherapists (Th1 and Th2) introduced the task and presented a joint attention tool (Table 4).

Gina proposed a situation, an episode experienced the day prior to the session:

> G: It was yesterday, at school. I was with my girlfriends in the courtyard, during the break. We were having a good time . . . talking about the weekend and stuff . . . and joking with each other . . . joking about the other girls at school, the teachers. . . . It was cool. (*G laughs loudly*) All

TABLE 4. Rendering of the observation tool (blackboard) to promote joint mental states involved in an episode

Sequences	Situation/background/ behaviors	Gina'smental states: emotions/ thoughts/ intentions	Gina's friends' mental states: emotions/ thoughts/ intentions	Other girls' mental states: emotions/thoughts/ intentions
1	Feeling cold	Feeling cold	Feeling cold	Feeling cold
	School playground	All together/part of the group	Teasing attitude	Amused
	Group of friends		Fun	
	Jokes/mockery	Fun	Amused	
		Amused		
2	School playground	. . .	. . .	Fun
	G pulls friend's hair	Disconnected?	Fun	Amused?
	Teachers get involved	Humiliated?	Amused	Surprised?
	the other girls, too	Judged?	Surprised?	Afraid?
		Intention?	Afraid?	Bizarre?
		Defend yourself?	Run away?	
		Hurting people?		
3	Manager's office	Surprised?	Find Gina weird?	Find Gina weird?
	Call mother	Guilty		
	Formulating an apology			
Session	Summarizing the situation	Sad	Moving away from Gina?	Moving away from Gina?
	Helping others to understand			

of a sudden, one of the girls made a comment about my clothes and everyone laughed, . . . except me. (*G marks a silence*) The next thing I knew, I was charging my friend's head, trying to pull her hair out! (*G mimes the gesture with emphasis*)

Th1: Really! It does sound like a crisis . . . and what happened next?

G: Well . . . the teachers were there. . . . They all tried to take a hold of my hands . . . and make me let go of her hair.

Th1: Hmmm (*mirroring the affect expressed by G*) . . . how did that go?

G: It all happened so fast . . . but I was so lost . . .

Th1: Well, thanks Gina for sharing this episode with us, this "little crisis." [*Th1 mimes the quotation marks with her fingers.*] It must have been an intense moment for everyone . . . for you, for the other girl, for the other girls around.

G : Yeah.

Th1: Is it OK for you if we all reflect together on this experience you've recounted? Is it OK for everyone?

G and the other participants nod in agreement.

Th2: We now suggest that you rethink this scene together, a little as if we could watch it on a screen (in the form of a film) and have the possibility to "freeze frame" at any moment, when we want to understand, and zoom in on a scene, on one of the characters . . . even imagine what's going on inside the others. With my colleague (Th1), we'll note your observations on the blackboard to help us put together what's happening in each micro-sequence of the scene. And above all, what's going on in Gina's head, but also in the heads of the other participants.

Th1: So, if we go back to your story, at the beginning you were all at the playground having fun, right? [*Th2 notes in the blackboard: situation, context.*]

G: Yes.

Th1: And if we dive a little into this moment . . . How did you feel? At the beginning . . . what sensations? Can you identify an emotion?

G: I was cold. . . . We were all cold. But we were . . . well . . . having fun . . . [*G stands up and mimes a teenager who's cold and moves her feet while squeezing her shoulders and arms.*] I was happy because I felt like I was with the others, doing what the others were doing.

[*Th2 writes the identified feelings/emotions/intentions on the grid.*]

Th1: And this girlfriend (the one who made the joke), in your opinion, how was she? How did she feel?

G: I don't know . . . the same, I think. She couldn't stop talking . . . she'd make jokes all over the place . . . she'd hand out jokes, teasing jabs, to everyone!

Th1: Ah . . . and all of you were laughing at all her jokes?

G: Yes, we were all laughing . . .

Th1: Was everyone having fun?

G: Yes. [*Th2 records this on the observation table.*]

Th1: And then . . . how long did it last? This feeling of general amusement?

G: I don't know . . . 10 min? Half of the break?

Th1: And what happened next?

G: Well, there was this comment about my clothes . . .

Th1: Hmmm. Do you remember what she said?

G: No . . . no . . . I don't remember. [*Gina's face is tense.*]

Th1: But it looks like . . . your state of mind has changed?

G: Yes . . . [*Gina seems to be a bit stuck in her thoughts.*]

X1 (another young person in the group): It must have been a nasty thing . . . the way you reacted.

X2 (another young person in the group): Humiliating even!

Th2: Maybe . . . humiliating? Judging?

G: I don't know . . . maybe. [*G is reflective.*] I'm not even sure she was talking about me anymore . . .

Th1: Could it have been a joke not necessarily addressed to you? Did she say your first name or did she talk about something that everyone could relate directly to you?

G: No . . . But at the time, I was sure she was talking about me.

Th1: In any case . . . how can we understand, if we all think together, to explain this sudden change in G's behavior?

X3 (another group participant): Well . . . she must have felt bad . . . to react like that. . . . She must have felt . . . bad!

Th1: Is it just Gina? Do you think there was an emotion . . . that could be described as . . . negative?

G: But . . . I don't remember . . . at the time . . . but I do remember that afterward, I felt guilty. When I was in the director's office, I said to myself: This isn't right . . .

Th1: And if we think now . . . if you think now, can you explain this change?

G: . . . not too much . . .

Th2: If we look at the grid . . . we can see that at the beginning, everyone was more or less . . . "on the same wavelength," right? But then [*Th2 refers to the grid*], where I've written "Seq II": The emotions are clearly different among friends: On her side Gina perhaps feels "humiliated" when the girlfriend continues to feel "amused"? And maybe the others do, too . . .

X1: It's no longer the general agreement!

G: Yes, that was clear. She was proud of her joke . . . and me . . .

X2: Yes . . . she must have said something hurtful to you, but maybe she didn't even realize it?

G: Now I remember [*Gina laughs embarrassed*] . . . I remember what she said . . . but I don't really want to talk about it . . .

Th1: It's OK, you don't have to say everything. . . . You have the right to keep it to yourself. And thank you for sharing this moment with us . . . I remember you said you felt . . . lost? Or did you feel you'd lost control of your thoughts and actions. After that, how did it feel for you and the other girls?

G: Weird . . . after . . . I apologized. The teachers intervened and this girl was looking at me strangely . . . as if she was still having fun. . . . I don't know . . . she was laughing . . . but . . . I'm not sure she understood everything that had happened. They were all weird afterward . . . looking at me.

Th1: And you? Were you just as strange? Because you told us you had trouble understanding . . .

G: Well, I was a bit out of it. I called my mother and came home.

Th1: And now, when you tell us . . . how do you feel?

G: I remembered what she said.

Th1: And that made you feel . . . how?

G: Sad . . . because they'll still look at me strangely. After what I've done.

Th2: If we go back to your emotions and intentions in the three sequences we've retained: First you feel happy, part of the group, amused; then this joke makes you feel . . . the other people in the group suggested "humiliated"? . . . Can we retain this emotion? [*G nods.*] And there you interpret a hostile intention on the part of the other girl, and you want to hurt her. Then, in the next sequence, the emotion is guilt . . . [*G nods*] and you want to apologize. And now, when you tell us, it's more sadness. . . . There's been a whole variation in emotions and intentions. We can see it clearly on the board.

X1: And the others have changed too . . . the other girls are asking questions too . . . maybe they don't feel well . . .?

G: They must be afraid of me.

Th1: You think so?

G: In any case, they won't be too keen on approaching me . . .

Th1: And that makes you sad?

G: Yes . . .

Th1: And . . . can we say that this emotion, "humiliated," was the trigger for losing control of your thinking and behavior?

G: That's clear! It still annoys me if I think . . . they judge me on how I dress and I shouldn't care, but I can't . . .

Th1: Maybe because when you feel judged, humiliated, it's too strong and it surges inside you and this strong emotion makes you lose control . . .

G: Hmmm . . .

Th1: And it's interesting because the other participants in the group helped us find that "emotion," which, in the first story, was "lost," cut off from your consciousness . . . right?

G: Yes.

X1: I've got a story, too . . .

The illustration shows how the therapists' interventions attempted to generate a process of reconstruction to help Gina form complex mental representations of herself and others during a crisis episode where the capacity to mentalize was lost due to high emotional arousal, leading to "mindless" action. This took place within a series of interactions with her fellow group members (peers), using an observation table to make explicit the different mental states that were evoked at different moments in this process (Table 4). Importantly, the above sequence

illustrates how Gina underwent a kind of mental rupture, an interruption, of her mentalizing processes, and literally with the connection to herself during the crisis episode itself. We frame this as a moment of core self disturbance. During the reconstruction of the episode, she was also vulnerable to such a disconnect, due to the emergence of an intrusive alien self-representation that produces a pervasive break in her ability to appraise the situation and communicate what she felt was a crisis situation with her friends. The intervention of the other participants in the group was key to foster trust that other youth may be safe, and also helpful, in trying to understand her experience. They attended and tried to understand her complex and often painful mental states, signifying the value of the participation (modeling) of peers in the process of elaborating mental representations of complex experiences. The group's objective is to build trust around the sharing of such episodes to prepare further work on elaborating the individual experiences of core self disturbances within a safe interpersonal space.

Conclusion

This article sought to present how MBT could potentially serve as a valuable psychotherapeutic intervention aimed at reducing transition rates to psychosis and improving both prognosis and functioning in young patients with a CHR-P condition. Based on the research evidence available, we framed mentalizing as a psychological process that may mitigate the risk for developing psychosis and to reduce the symptom–disability gap typically seen in such clinical contexts. Importantly, we attempted to formulate the core psychopathological problem as disturbances in core self experiences. This approach relates to both psychoanalytical and phenomenological theorizing of the psychotic illness. It also helps to frame the types of subjective alienating experiences that are lodged within the relationship to oneself, and that can be externalized to the relationships with others. The psychotherapeutic pathway put forward by MBT suggests beginning by securing an authentic alliance with the distress and pain lived in the "alien self" modality. The idea is to provide the conditions where the patient may experience not being alone in struggling, as illustrated in the clinical vignette. This may enable some mentalizing—some form of imagining how alienating self-experiences are shaped, what their functions are, and how they emerge in the individual's experience. By a process of befriending the negative state (Fonagy & Allison, 2023), working through expansion (characterizing the alienating self-state) and containment (helping the patient emotionally modulate this experience) may sustain further

mentalizing of the self, in relationship to both oneself and others. This work can bring about the opportunity to examine agency in modulating, regulating, and protecting oneself from alienating self experiences that result from disturbances in core self experience. Clinical research will evaluate whether working with the tools of MBT can help mitigate the risk of conversion from prodromal to psychotic disorders, and reduce the symptom–disability gap, especially the functional impairments that today represent the clinical frontiers of treatment along the continuum of psychosis.

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