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RESEARCH ARTICLE

Therapists' perspectives on the Maudsley model anorexia nervosa treatment for adolescents and young adults (MANTRa): A qualitative interview study

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Abstract

Objectives: A rising incidence of eating disorders in the young population and limited effectiveness of available treatment approaches underscore the need for innovative therapies. This study explores therapists' perspectives regarding a promising new manualized psychotherapeutic treatment (MANTRa) for adolescents and young adults with anorexia nervosa (AN).

Methods: Semi-structured qualitative interviews were conducted with 10 therapists (nine female) who provided 24–34 sessions of MANTRa per patient. Interview topics included positive and negative experiences with MANTRa in general, with the workbook and other components. Reflexive thematic analysis was used to interpret the data. Furthermore, written notes taken by the therapists after each sessions were analysed.

Results: The thematic analysis revealed five overarching themes: (1) Variety of therapeutic tools and content elements included in the workbook; (2) Getting the therapeutic process going; (3) Flexibility in use of the workbook; (4) Impact of the scientific and multidisciplinary framework on quality assurance; (5) Formal design of the workbook.

Therapists' case formulation letters to the patients were regarded as powerful tools to strengthen therapeutic alliance and promote recovery. In-depth therapists' training, regular supervision and a multi-professional treatment setting were important factors to ensure high treatment quality.
Conclusions: The findings suggest how the MANTRa content (e.g. inclusion of additional therapeutic tools), the therapists' training and the format (e.g. provision of a digital version) can be improved to reach maximum impact. Therapists' formulation letters may be an effective therapeutic tool not only for AN but also across the spectrum of psychiatric disorders in adolescents and young adults.

KEYWORDS
adolescents, anorexia nervosa, case formulation, cognitive behavioural therapy, manualized psychotherapy, Maudsley model, therapeutic alliance

INTRODUCTION

Anorexia nervosa (AN) is one of the most severe psychiatric disorders beginning in adolescence and, if not adequately treated, leads to chronicity in 20% of cases (Herpertz-Dahlmann et al., 2018). The state-of-the-art treatment in adolescence is family therapy for anorexia nervosa (FT-AN) (Blessitt et al., 2015) with alternative treatments such as enhanced cognitive behavioural therapy for eating disorders (CBT-E) emerging (Dalle Grave et al., 2019). In general, reported full recovery rates following psychotherapeutic treatments for adolescents with AN are not higher than 50% at last recorded follow-up (Brockmeyer et al., 2018), suggesting the need for the development of and research on alternative therapeutic approaches. This seems all the more important as the prevalence of eating disorders in young people is on the rise (Galmiche et al., 2019), which has been recently observed across several European countries and other countries including USA, Australia and Canada following the COVID-19 pandemic (Devoe et al., 2023; Gilsbach et al., 2022). Improving interventions for children and adolescents with eating disorders is therefore regarded as a top priority (Davey et al., 2023).

The Maudsley Model Anorexia Nervosa Treatment for Adults (MANTRA) is a manualized psychological treatment based on a bio-psycho-social and cognitive interpersonal maintenance model of AN (Schmidt & Treasure, 2006; Treasure & Schmidt, 2013) and was originally developed for adult patients. It addresses four intra- and interpersonal maintaining factors of eating disorders including thinking style (cognitive inflexibility and focus on details), emotional deficits, positive beliefs about AN and unhelpful communications styles of parents or close others. The core therapeutic work is centered around a workbook which is worked through jointly by the patient and therapist. The workbook is organized in several chapters of which some of them constitute the core and some optional parts of the therapy: The chapters on introduction, therapy motivation, parental support, physical health and nutrition, individual case formulation with etiologic and maintaining factors (graphically illustrated using a 'vicious flower', more details below), defining therapeutic aims and recovery (characteristics of the healthy/recovered self are illustrated using a 'virtuous flower') comprise the core part while the chapters on emotions and social relationships, thinking styles, and identity are optional and can be chosen by the patient together with the therapist, depending on clinical need. Each chapter included psychoeducational information about a topic, a couple of suggested exercises as well as sections of reflective questions (e.g. questions regarding own behaviour/thoughts the patient should think about and that should be reflected on together with the therapist). The therapy consists of 24–34 weekly outpatient sessions depending on the illness severity. The therapist style is that of motivational interviewing (MI) (Miller & Rollnick, 2002)

which is collaborative, reflective and responsive. All MANTRA therapists therefore undergo a specific MI training and some exercises in the workbook directly use MI techniques to promote motivation to change (e.g. Pro vs. Contra AN letters written by the patient). Apart from choosing optional chapters from the workbook, the therapist is also flexible regarding how many therapy sessions are dedicated to each chapter (e.g. if the patient lacks sufficient treatment motivation, more time can be dedicated for the 'motivation' chapter; e.g. not all exercises suggested in each chapter have to be selected) regarding the sequence in how chapters are addressed and regarding how often parents are invited to join the therapy sessions (a minimum of two times is recommended). Individual case formulation including the definition of therapeutic aims is a central element within standard cognitive behavioural therapy (CBT). The formulation covers the hypothesis about the causes, precipitants and maintaining factors of the patient's AN (Allen et al., 2016). In MANTRA, it is represented as a 'vicious flower' with the flower-pot representing what the patient brings to the illness in terms of personal resources and strengths as well as critical life events and challenges (Schmidt et al., 2019; Treasure et al., 2019). The petals refer to the different circles of inter- and intrapersonal maintaining factors (for an example, see Figure 1). Moreover, the therapists prepare a written case formulation as a letter that is read in person to the client and handed over to him/her. The letter is written from a motivational stance (using principals of MI) and serves the purpose of enhancing therapeutic alliance and motivating change. In general, it has been argued that case formulations improve the understanding of the individual problems to the patient, strengthen the therapeutic relationship and offer a person centered intervention planning (Gladwin & Evangeli, 2013). At the end of therapy, therapists formulate a good-bye letter to the patient summarizing the therapeutic journey and giving future prospects.

The MANTRA treatment was evaluated for its efficacy in the UK (Schmidt et al., 2015, 2016) and Australia (Byrne et al., 2017) in adult patients. This led to MANTRA being included in the NICE guidelines (National Institute for Health and Care Excellence, 2017) as first line treatment for adult AN.

Recently, the MANTRA workbook was adapted for adolescents (subsequently termed MANTRa). Adaptations refer to a simplified language suitable for the developmental level of teenagers, the inclusion

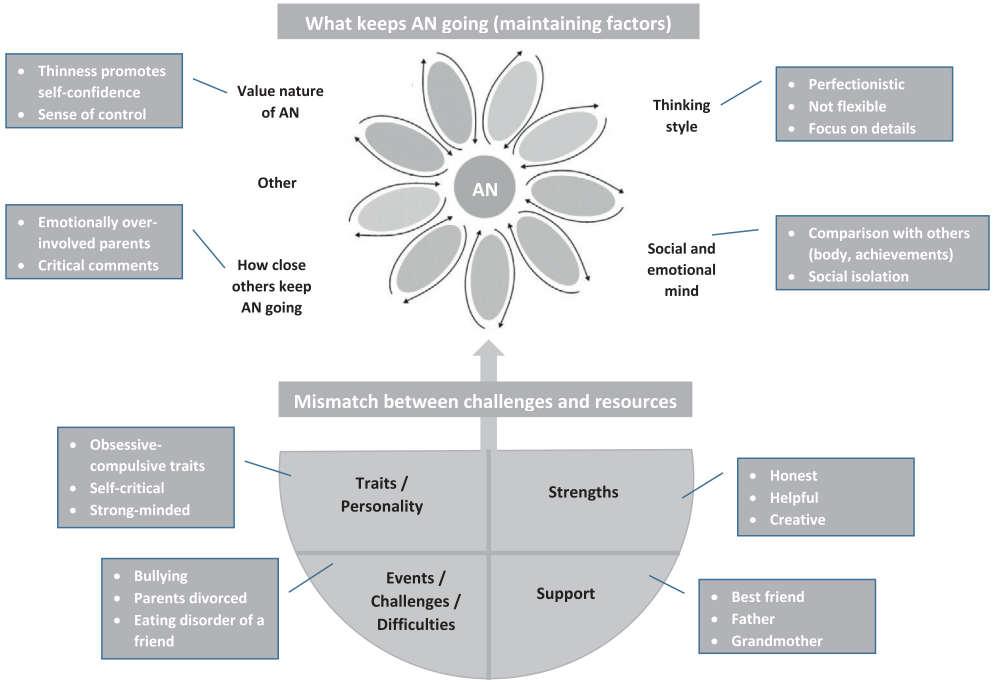

FIGURE 1 Exemplary and simplified vicious flower used in the MANTRa case formulation (figure based on Treasure et al., 2019, p. 1408).

of three case vignettes of adolescent AN patients to enable identification with role models and a colourful layout including a wide range of images and exercises to be appealing for youths. Moreover, an additional optional chapter on social media use was developed and added to the workbook. The adolescent version of the workbook contains 11 chapters on 316 pages. The general therapeutic elements described above for the adult version (e.g. 24–34 sessions, illustration of the case formulation in form of a 'vicious flower', MI training for therapists, use of therapist letters) were the same in the adapted version for adolescents. However, MANTRa therapy was accompanied by regular medical checks with a (child- and adolescent) psychiatrist, sessions with a dietician and an 8-week skills training ('SUCCEAT', Franta et al., 2018) for parents. Training and regular supervision was provided by one of the developers of the intervention (U.S.).

In a first cohort study, adolescents and young adults having received the adolescent version of MANTRa showed a higher remission rate as well as greater reductions in eating disorder pathology at 18-month follow-up compared to patients having received conventional psychotherapy (Wittek et al., 2023). These promising findings qualify MANTRa as a candidate for a new and innovative psychotherapeutic approach also in adolescents with AN.

Although randomized controlled trials are the gold standard in the evaluation of therapeutic interventions, process evaluations provide important information regarding factors relevant to the therapeutic process (Craig et al., 2008). It is recommended to involve perspectives of clinicians and patients to evaluate and, if necessary, adapt the therapeutic intervention and therapist training. In general, the exploration of therapists' experiences has been neglected in eating disorders intervention research, especially regarding AN treatment. The MOSAIC trial group integrated therapists' and patients' experiences in the process evaluation of MANTRA for adults with AN and specialist supportive clinical management (Lose et al., 2014; Waterman-Collins et al., 2014). From the patients' perspective both therapies were experienced as credible and helpful whereas MANTRA was seen as particularly structured and flexible. However, therapists reported that it could also be demanding regarding time and skills.

The aim of the present study was to qualitatively evaluate the applicability of MANTRa for adolescent and young adult patients including the advantages of MANTRa as well as potential challenges from the perspective of the therapists who have applied this psychotherapeutic approach for the first time. We were interested in the therapists' experiences regarding the therapeutic process in general as well as regarding the MANTRa workbook specifically. Moreover, we wanted to find out which chapters of the MANTRa workbook were used more or less frequently using a quantitative approach. The motivation behind this study was—after a first period of using MANTRa—to reflect on how well MANTRa was applicable for adolescents, how the therapy can potentially be improved to reach maximum impact and to gain insight to potential therapeutic mechanisms of MANTRa. This research therefore represents an important step towards the wider implementation of MANTRa for adolescents with AN.

MATERIALS AND METHODS

Study design

This is a qualitative study using semi-structured interviews with MANTRa therapists and a separate analysis of written notes taken by the MANTRa therapists after each therapy session.

Participants

Ten out of 14 therapists (9 females, 1 male; mean age: 43.5 years, SD: 11.2) who provided MANTRa therapy in the trial conducted by Wittek et al. (2023) participated in the interview study. Nine participants were CBT therapists, one therapist was a clinical psychologist (average years since training was completed: 5.7, SD: 4.1). Most therapists worked in an outpatient private practice ($n = 7$), one at a psychiatric inpatient

ward and two in both settings. The number of years of experience in the field of eating disorders prior to the start of the MANTRa study ranged from 0 to 19 years (mean: 7.4, SD: 6.5, only one therapist did not have any prior experience in the treatment of eating disorder patients). The therapists conducted MANTRa with 3–4 patients with AN on average (range: 1–8 patients per therapist), while 76% were adolescents and 24% were young adults. Detailed characteristics about the patients are published in Wittek et al. (2023). Of the four therapists who did not participate in the interview, two could not be reached, one was sick and one did not finish MANTRa therapy for any patient.

Interview topic guide and procedures

The semi-structured interview topic guide (see supplementary material) was developed in discussions between the first, last and the author who conducted the interviews and was informed by therapists' informal feedback about the use of MANTRa prior to this this study. The topic guide served as a collection of broad topics considering aspects that could have impacted that applicability of MANTRa and included (1) expectations towards the MANTRa treatment prior to its start, (2) positive and helpful aspects as well as negative aspects (e.g. difficulties) of the treatment and the workbook including suggestions for improvements, (3) experiences with developing the case formulation (using the 'vicious flower') and therapist letters, (4) advantages and disadvantages of MANTRa compared with other used therapeutic approaches, (5) attitudes towards manualized psychotherapy in general, (6) situations in which the therapists had to deviate from the treatment workbook, (7) satisfaction with the MANTRa training and supervision, and (8) impact of the COVID-19 pandemic on the implementation of MANTRa. However, this topic guide was used flexibly, meaning that the interview participants were encouraged to tell freely about their experiences when using MANTRa with patients including positive and negative aspects, respectively what worked well or less well. Questions from the topic guide were primarily used when the narrative flow has stalled.

Ethical approval for this study was granted in the course of the overarching MANTRa trial by the Ethics Commission of the Medical University of Vienna. Interviews were conducted via a videoconference call due to COVID-19 related preventive measures between November 2020 and March 2021 by a clinical psychologist (T.W.) who had received MANTRa training and conducted MANTRa therapy with two patients herself. The therapists provided written informed consent for participating in the study and audio recording of the interviews. The interviews lasted 33 min on average (SD: 8).

Qualitative data analysis

The interviews were transcribed verbatim, and the transcripts were organized in the NVIVO 12 Pro software (QSR International, Burlington, MA, USA) for analysis. An inductive reflexive thematic analysis approach according to Braun and Clarke (2006, 2019) was used to explore patterns of meaning. According to the reflexive thematic analysis, a critical realist framework was used assuming the existence of 'truth and realities' while also acknowledging the researchers' own knowledge and experiences. The core work of the qualitative analysis was performed by the first and last author, while both of them were clinical psychologists working in the ED field, had knowledge about the principles and content of MANTRa, were involved in the adaptation of the workbook for adolescents (the first author only to a small extent), but did not conduct MANTRa therapy themselves. In the further process, also another CBT psychotherapist experienced in using the MANTRa approach was involved. This procedure was chosen to consider as many views on the data as possible and to avoid that the constructed themes are shaped by researchers with more vs. less experience regarding this type of therapeutic approach only. The motivation behind the individuals involved in the analytic process was to improve the MANTRa therapy for adolescents and young adults meaning that they were interested in reflecting about positive and negative experiences with using MANTRa to the same extent.

The qualitative data analysis consisted of the following steps which were iteratively performed until the final thematic structure was created: (1) The first and last author familiarized themselves with the transcripts by reading through them individually without a specific focus and noting ideas regarding the data and potential codes. Following this, (2) the two researchers inductively generated initial codes by coding segments of the data focusing on the research question (therapists' experiences with regard to the applicability of MANTRA in general and the workbook). Coding was done collaboratively which supported reflexive discussions about the codes already at this stage. Codes were organized using the NVIVO software. (3) Next, the first and last author developed initial themes and subthemes by clustering the previously generated codes and all data segments relating to each theme were collected together. Themes and subthemes were iteratively generated in several discussion sessions between the two researchers using paper-pencil illustrations (e.g. grouping similar codes together like in a 'mind map') and categorizing codes under themes in NVIVO. The thematic structure was iteratively refined by checking the themes back against the original data and checking against each other. Once a preliminary final thematic structure was developed, a description for each (sub)theme was formulated and illustrative quotes from participants were selected and translated into English. (4) The thematic structure including the description of themes and subthemes and participants' quotes was then discussed with a psychotherapist (P.S.-P.) having conducted MANTRa therapy herself, and further refined until consensus on the final thematic structure was reached.

Quantitative analysis of MANTRa therapeutic session notes

During the MANTRa study, the therapists were asked to complete a short form after each therapy session. In this form, they selected the chapter(s) of the MANTRa workbook they addressed in each session, noted whether they addressed topics that were not included in the workbook, whether or not a session was held together with the parents and whether patients received 'homework' between the sessions (and to which chapters of the workbook the homework referred to). In total, written session notes of 29 treated patients were available and descriptively analysed. Specifically, we calculated the proportion of therapy sessions and homework exercises that was dedicated to each MANTRa chapter or other topics not addressed in the workbook (averaged across all patients). Moreover, we calculated how often parents were invited to join the therapy sessions. The descriptive analysis of these session notes was performed separately and independently from the qualitative analysis of the interviews.

RESULTS

Results of the thematic analysis

We identified five overall themes with various subthemes, which are described in detail below. An overview is shown in Table 1.

Theme (1). Variety of therapeutic tools and content elements included in the MANTRa workbook

This overall theme describes the therapists' views on the MANTRa content, its contribution to therapists' professionalism and therapeutic quality, specific helpful and less helpful elements as well as missing content.

TABLE 1 Overview of themes and subthemes.

1. Varity of therapeutic tools and content elements included in the MANTRa workbook	1a. Expansion of expertise and treatment quality through a variety of therapeutic tools
	1b. Specific helpful and less used content
	1c. Missing or insufficient content to be expanded in the future
2. Getting the therapeutic process going	2a. Visualized case formulation improving insight and therapeutic flow
	2b. Therapist letters facilitation in-depth reflection on the patient
	2c. Promotion of therapeutic alliance and emotion expression through therapist letters
	2d. Keeping patients motivated for therapy
3. Flexibility in use of the workbook	3a. Balance between working on the workbook, relationship and current topics
	3b. Flexible sequence and priorities of chapters
4. Impact of the general framework on quality assurance of the treatment	4a. Benefits of a multi-professional treatment setting
	4b. Supervision and intervision facilitating mutual learning
	4c. Advantages and disadvantages of the scientific study context
	4d. Initiating and continuing therapy during the COVID-19 lock-down
5. Formal and verbal design of the workbook	5a. Reconsidering size and scope
	5b. Visual design and case examples appealing for patients
	5c. Simplicity of language appropriate for everyone

(1a) Expansion of expertise and treatment quality through a variety of therapeutic tools

The therapists highlighted the variety of tools and exercises specifically designed for eating disorder patients, which are compiled from several therapeutic approaches and go beyond conventional behavioural therapy. The MANTRa workbook was described as a '*treasure trove of possibilities and ideas*' (#05) and a '*buffet from which you can choose what suits to the patient*' (#03). Moreover, therapeutic tools for all phases of the illness are available: '*I had the feeling that the workbook is so comprehensive that no matter what stage she [the patient] is in, you can pick her up*' (#02). The variety of topics addressed in the workbook also provided an overview of areas '*that may be affected by the disorder and where the disorder can play a role*' (#06), which is particularly relevant for therapists with less experience in the treatment of adolescent eating disorder patients. In this sense, the workbook helps not to overlook relevant topics, which provides the therapist with confidence and professionalism. '*For me, it is important to know all these things [all aspects associated with eating disorders], I must have an idea. It [the workbook] 'soothes' me, so to say'* (#07). The therapists also acknowledged the '*very competent, extensive and intensive [MANTRa] training*' (#06) provided by MANTRa trainer (US) in which '*you have really shown us what you mean by the individual chapters and exercises, what is behind them*' (#01). Moreover, the therapists reported benefiting from the training in MI and the collaborative stance in working with the patient.

(1b) Specific helpful and less used content

Chapters of the MANTRa workbook that the therapists found particularly helpful were those on emotions and social relationships ('*I also often realized that social competences are extremely impaired, and that they also have an extreme avoidant behavior'*, #09), thinking styles ('*I found it very helpful to consider one's thinking style and what flexibility actually means, for example, when they should try / use a different shampoo*', #03), identity ('*It is extremely important in this age because it is a topic which involves a lot around this confusion: Who am I?, What am I capable of? What do I want? Or what should I want?'*, #06) and the chapter on work with parents/the family ('[I liked] *how parents were woven in through the animal models; it made it much easier to talk about the parents*', #06 [Note: In the MANTRa workbook different parental caregiving styles are reflected by using animal metaphors]). A chapter that was used less was that on social media '[…] *because the awareness of the patients regarding this topic [problems with social media use] is often not so bad*' (#02).

Nevertheless, it was suggested to keep this chapter in the workbook and expand it by incorporating videos illustrating how body representations are altered in the media. Moreover, the chapter on physical health and nutrition was also less used as '*this was already partly covered through nutritional counselling*' (#09).

Furthermore, the therapists discussed specific tools that they regarded as helpful including the reflective questions included in every chapter and after exercises, the patients' letter to the AN as their friend and foe to externalize the illness and increase motivation and the 'WOOP' technique (note: WOOP stands for Wish-Outcome-Obstacle-Plan and is a technique through which patients can learn how to set goals, foresee and overcome obstacles; Oettingen, 2014). An example of a helpful reflective question was the distinction between importance and confidence of change and their assessment on a visual analogue scale: *'I can be highly motivated, but not at all confident. This is important to understand. Or I can be very confident that I will be successful if I want to, but the motivation to do so is maybe low. Worlds are opening up with these apparently harmless questions'* (#06).

(1c) Missing or insufficient content to be expanded in the future

For patients in the adolescent age, therapists wished to include more content around parents and family and to have more therapy sessions together with the parents: '*There would be potential to incorporate more [content around family] into the workbook, as I believe that the family is a crucial resource, but it also often involves pursuit of autonomy, detachment, and unspoken conflicts*' (#10). Role-plays with patients and parents were suggested as an additional tool for working through conflict situations. Moreover, therapists listed the inclusion of body-oriented tools (e.g. mirror confrontation), mindfulness and relaxation exercises as additional beneficial tools. For young adult patients, the incorporation of schema therapeutic work (e.g. working with the inner child) was regarded as potentially beneficial. Furthermore, it was felt that the '*workbook is definitely not suitable when there are severe traumas, when other [psychiatric] diagnoses take precedence, when someone has a personality disorder, or engages in self-harming behavior*' (#04).

Theme (2). Getting the therapeutic process going

This overall theme comprises different factors that were discussed as influencing the therapeutic process. These factors mainly relate to the MANTRa-specific visualization of the case formulation and the letters that are written by the therapists to the patient. Moreover, the impact of the general treatment motivation is described.

(2a) Visualized case formulation improving insight and therapeutic flow

Most therapists described the visualized case formulation in the form of a vicious flower as the central part in the MANTRa therapy ('*the heart of the workbook*', #10) allowing to '*gain insight into how the whole thing [AN] works, what positive aspects the illness holds and how it is maintained*' (#08). Although case formulations are regarded as a fundamental part in behavioural therapy in general, the benefits of the visualized form used in MANTRa were repeatedly highlighted in order to obtain a comprehensive picture of the patient and that guides the ongoing therapeutic process: '*The idea of the vicious flower, creating a comprehensive picture and having it on the table where you can refer to it repeatedly, I found very helpful*' (#08). Moreover, the process of drawing the vicious flower also helped to initiate a therapeutic conversation and to regulate emotions: '*That also facilitated a flow of conversation: 'Okay, how does this (maintaining factor) look like, and this?' And because it was a flower, you could create a bit of distance if things got too emotional, but it was also sometimes helpful to evoke emotions when someone was too reserved*' (#05). However, the case formulation was also described as a challenging interactive hypotheses generating process for both the patient and therapist that often took several sessions. During this process, some patients also sought frequent reassurance which was connected to their perfectionism.

(2b) Therapist letters facilitating in-depth reflection on the patient

Although perceived as challenging and time-consuming, writing the therapist letters to the patients (after finalizing the case formulation and by the end of therapy) allowed the therapists to deeply reflect about the patients and gain new insights more so than in a conventional case formulation: '*That was great and a new experience for me because I hadn't encountered that in other therapeutic approaches. Namely, sitting down as a therapist and summarizing for oneself: How did you get to know the patient? What are triggering and maintaining factors?'* (#10). Furthermore, the letters supported the therapists in a unique way to adopt a perspective of appreciation towards the patient. '*You are compelled to genuinely reflect upon the patient […]. It [the letter] needs to be appropriately framed and formulated in a resource-oriented way, aligning with a very appreciative stance towards the patient'* (#01).

(2c) Promotion of therapeutic alliance and emotion expression through therapist letters

The therapists described that their letters have elicited strong, mainly positive, emotions in some patients that have also strengthened the therapeutic relationship. Two factors were repeatedly mentioned as pivotal: (1) the written form instead of a verbal feedback only (the letter was perceived as '*a little treasure […] something you can hold in your hand and read again at home […] and this has an reinforcing effect*', #04 and '*is even more effective compared to a verbal message*', #10) and (2) reading of the letter during a therapy session ('*It's something very personal, something highly emotionally activating, even for the therapist. […] It was very intimate, I think, to write such a letter and then to read it aloud, and it worked really well for the patient'*, #09). Patients felt touched ('*One can put a lot of appreciation for the patient into these letters and as therapist you feel this emotional touch'*, #04) and motivated ('*It motivated her a lot to eventually recover'*, #05). One therapist described the patient's reaction as '*an unspoken thank you*' (#07) and for another therapist the letters were an opportunity for '*giving them something back at the end of their journey and providing them with a feedback like how brave they were engaging into this journey, summarizing the shared journey and explaining the wishes for the future'* (#10).

However, for some patients, reading the letters and the emotions triggered by them were difficult to tolerate: '*I think it was challenging for her [the patient] to bear this closeness and these emotions. I also pulled back a bit, so I didn't formulate the letter too intimately*' (#09). Moreover, the therapists pointed to the potential risk, especially for adolescent patients, that the therapist is idealized through the effect of the therapist's letter on therapeutic alliance and that a professional therapist-client relation flips into a dependent relationship. Thus, appropriate proximity-distance-regulation measures must be set: '*This letter, I wouldn't say it was a sacred object, but it triggered very strong emotions […]. But in those moments, these [therapist-patient] roles need to be clarified, and a bit of distance needs to be reestablished*' (#05).

(2d) Keeping patients motivated for therapy

The general motivation for therapy impacted to what extent the patients were able to engage in the therapeutic process, the MANTRa-specific exercises and home exercises. The therapists told that for some patients much MI was necessary to initiate the therapeutic process. In this regard, the Pro and Contra letters were perceived as a good tool to *'externalize the eating disorder, […] to elicit ambivalence, to work on healthy and unhealthy parts […] and to build motivation to change'* (#05). However, lack of motivation could lead to termination of the psychotherapy: '*There was a patient who was unwilling to engage, was very skeptical about the entire project, […] and a significant amount of* MI *was necessary. However, it didn't work out, and she eventually dropped out*' (#05). Other therapy dropouts related to rejection of therapy by the parents due to a specific religious conviction and because patients moved to another city. Furthermore, in a few patients inpatient admissions due to a worsening of the eating disorder interrupted the therapeutic process.

Theme (3). Flexibility in use of the workbook

This theme includes to what extent the workbook was regarded flexible to integrate current topics and life events brought up by the patients as well as flexibility considering the sequence of MANTRa chapters.

(3a) Balance between working on the workbook, relationship and current topics

The therapists argued that there must be a balance between workbook-based work and work on what the patient presented. Indeed, deviations from the workbook were necessary when current topics were brought up by the patient, for example family conflicts, school problems, struggles with COVID-19 measures and being in love. Accompanying the patient '*in the here and now without deviating from the path, respectively the workbook*' (#10) was considered important. For some therapists, the MANTRa workbook provided enough flexibility to address such current needs; however, familiarity with the workbook is a prerequisite for being able to flexibly choose exercises from the workbook that fits the actual need. '*You must always think about: Does it [the workbook] fit now? Or does it need something else? And what I also noticed: It's quite beneficial to thoroughly study the workbook beforehand. Because it does make a difference if I know where the things are, because then I can very flexibly take what is needed*' (#04).

The therapist's experience in treating eating disorder patients in general and in using the MANTRa workbook specifically was also mentioned as an important factor for its flexible use: '*With more experience, you also feel more liberated […] and the workbook can increasingly be an enrichment. At the beginning, it provides orientation and tools, and later, you can distance yourself a bit more from it while still incorporating a lot of it into therapy*' (#06). According to some therapists, a general risk of manualized therapy is adhering too rigidly to a manual/a workbook and losing sight of individual needs. Some therapists felt that they had to strictly adhere to the MANTRa workbook as they were part of a research project, while others took the balance of working between current necessities and the workbook for granted.

(3b) Flexible sequence and priorities of chapters

The therapists acknowledged that the sequence in which MANTRa chapters are addressed and the priorities regarding the chapters can be flexibly agreed upon together with the patients. '*I really liked that the modules can be arranged individually based on priorities. For one patient, one topic might be more important, while for another, a different topic takes precedence. It allowed for a flexible structure rather than a rigid sequence*' (#06). Particularly the collaborative stance that allowed to come to a shared decision what to work on next was appreciated and perceived especially suitable for AN patients: '*I especially liked that clients could choose the individual chapters, […] that there was flexibility. This is particularly important for anorexia patients, as it involves learning flexibility and not rigidly adhering to the workbook*' (#03).

Theme (4). Impact of the general framework on quality assurance of the treatment

This overall theme draws attention to the general conditions in which the MANTRa therapy was embedded and discusses their contribution to quality assurance and therapy success.

(4a) Benefits of a multi-professional treatment setting

The therapists appreciated the exchange with a multi-professional treatment team, especially with the medical staff, which on the one hand ensured a high treatment standard and on the other hand facilitated the therapists' work. Moreover, inclusion of parents to an accompanying skills training workshop ('SUCCEAT') was mentioned as beneficial. '*It's not just working in isolation with the patient, but many people are putting in effort, and I believe that is often simply missing*' (#08). Another therapist emphasized that she '*didn't have to worry about the parents going somewhere, that there was a doctor responsible for the person, that they would also go to these doctors. […] That was simply covered without me having to do much*' (#05). Some therapists, however, would have wanted even more exchange with the medical staff.

(4b) Supervision and intervision facilitating mutual learning

The MANTRa supervision (conducted online during the COVID-19 lockdown) was generally well received: '*What I found very helpful and also exciting was that Prof. Ulrike Schmidt was present in some supervision session, and to receive the feedback from her: 'You are on the right track.' Because, of course, one reflects and wonders, 'Is this [what I'm doing] fitting?*' (#06). Overall, the extent of supervision was considered sufficient; however,

some therapists would have wished more peer supervision sessions and more (informal) exchange with other MANTRa therapists to learn from each other, particularly at the beginning of the project.

(4c) Advantages and disadvantages of the scientific study context

According to the therapists, the written notes taken after each session (explained in the methods section) and audio-recording of two therapy sessions (which was done to evaluate the therapist's compliance with a MI conversation style, data not yet analysed) increased the quality of therapy: '*I believe that the quality control is much higher, because it is expected to establish contact with the doctors, to supervise cases, and to document everything. In this context, the risk of spending an hour 'chatting' about 'how the week went' is very low*' (#08). However, audiotyping therapy sessions also increased some patients' feeling of not being able to talk freely resulting in a '*distorted […] rather emotionless therapy session*' (#05). Many therapists pointed to the limited number of therapy sessions predefined by the study context. This was regarded as disadvantageous for patients who would have needed longer treatment and stressful for the therapist: '*There are certainly patients who would benefit from 50 to 55 sessions, and that is a bit of a disadvantage when you know as a therapist: Okay, I have 30 hours plus booster sessions. And this somehow puts pressure on oneself as a therapist in terms of time*' (#08). Due to the time constraints, some therapists also felt that they had little time for building a therapeutic relationship or that they were insecure about how much time should be invested for which MANTRa chapter to finish therapy on time.

(4d) Initiating and continuing therapy during the COVID-19 lockdown

During the COVID-19 lockdown, the MANTRa therapy was conducted via videoconference, telephone or while walking outdoors. The switch to a remote setting was regarded as a useful interim but not permanent solution as remote therapy was not considered suitable for all patients. The therapists described that a remote MANTRa therapy, particularly in adolescent patients, did not have the same effects than a face-to-face therapy because therapeutic conversations were less in-depth, emotions were less palpable and some patients expressed privacy concerns when sitting at home: '*It's a major issue that she doesn't feel free to speak at home because she doesn't know if someone nearby might hear or if her younger brother is eavesdropping at the door, or if her mother might overhear what she's saying*' (#06). Remote therapy was regarded as particularly challenging during the start of therapy for establishing a therapeutic relationship and for the conclusion of therapy. However, the manualized approach of MANTRa facilitated the implementation of the therapy in an online setting: '*Actually, the workbook helped us because we both had the exercises in front of us at home, and I could say, 'Look at page 125!' or 'Fill out this table!' […] So, having a workbook in front of both of us was helpful*' (#01).

Theme (5). Formal and verbal design of the workbook

This overall theme describes discussions about the formal design of the MANTRa workbook including its size, visual appeal and simplicity of language.

(5a) Reconsidering size and scope

The workbook was perceived as too big and heavy ('*brick, phone book*', #07). The therapists suggested dividing the workbook into smaller sections (e.g. chapter-wise or two parts) that can be given to the patient separately. A digital version (e.g. e-book, app) would also be helpful as it might be more appealing for adolescents and as specific exercises can be printed out and handed over to the patient. Moreover, it would also be easier to work on it when a patient forgets to bring the printed workbook to the therapy session. It was also argued against providing the entire workbook to the patients at therapy start '*because this may trigger anxiety or perfectionism and may overwhelm the patient*' (#10). However, another therapist appreciated that the patients received all chapters of the workbook at once as they '*browse the workbook themselves and engage with it independently. They may come across things where they think: 'Okay, this is somehow applicable to me. I can relate to this'*'(#02). In this regard, the patients might come across a topic they would not have otherwise thought about.

(5b) Visual design and case examples appealing for patients

The therapists appreciated the colourful design of the workbook with numerous graphics and illustrations: '*I really liked that it was also visually well-presented, appealing to adolescents*' (#09). In particular, the three fictional case examples which are presented in the first chapter and which are woven through the entire workbook were regarded as pleasing. They also facilitated the start of therapy: '*They were supposed to read these three case examples and think about if and how they identify with them, how not at all, […] and with this [exercise], I could work very well and get to know them*' (#09).

(5c) Simplicity of language appropriate for everyone

The therapists generally acknowledged the use of simple language in the workbook and recommended it also for adult patients with eating disorders as treatment workbooks for adult patients are often regarded as too complex: '*They [the patients] are simply in a stress-mode […], one has to simplify many things […]. It requires simple sentences and explanations, and that is implemented well in the workbook. […] I would apply many things without hesitation for adults. I often feel that using worksheets or manuals designed for adults are too complicated*' (#05). Furthermore, the fictional cases that exemplify the exercises in the workbook help to reduce complexity and contribute to the understanding of the exercises. However, for patients with high perfectionism, it may be challenging to deviate from the exemplary solutions. For therapists, it was suggested that there could be added explanations accompanying the exercises *'explaining their purpose, how they should be filled out, or how they can be explained to the girls'* (#03).

Quantitative results regarding MANTRa session notes

Figure 2 shows how often each MANTRa chapter was addressed during and between therapy sessions (home exercises). Chapter 7 (emotions & social relationships) with about 6 sessions on average took up the largest portion in therapy followed by chapter 5 (case formulation) with about 5 sessions on average and chapter 2 (motivation) about 4 sessions on average. On average, 11.8% of the therapy time was dedicated to other topics not included in the MANTRa workbook. Other topics mainly included acute stressors (e.g. school problems, illness or death of a relative, romantic relationships, sexuality, bullying, argument with parents), psychological problems (e.g. suicidality, self-injury, obsessive-compulsive behaviour, anxiety) and the use of techniques not included in the workbook (e.g. relaxation exercises, social competence training, mindfulness exercises). Regarding home exercises, chapter 2 (motivation) was most frequently addressed, followed by chapter 7 (emotions & social relationships) and chapter 5 (case formulation). The chapters 10 (identity), 4 (nutrition), 1 (introduction) and 3 (parents & family) were least used. In 58.6% of patients, the parents never joined a therapy session, in 27.6%, 10.3% and 3.4% the parents joined once, twice and three times, respectively.

DISCUSSION

The aim of this study was to evaluate therapists' views on the applicability of MANTRa as a psychotherapeutic intervention for adolescent and young adult patients with AN, its advantages and potential challenges. Altogether, this study provides valuables insights into potential key therapeutic mechanisms of action and hints about how MANTRa can be improved further.

Evaluation of the MANTRa content in relation to therapists' and patients' needs

The therapists appreciated the variety of therapeutic tools in the workbook, the use of MI, the collaborative stance as well as the extensive training and supervision provided by one of the MANTRa

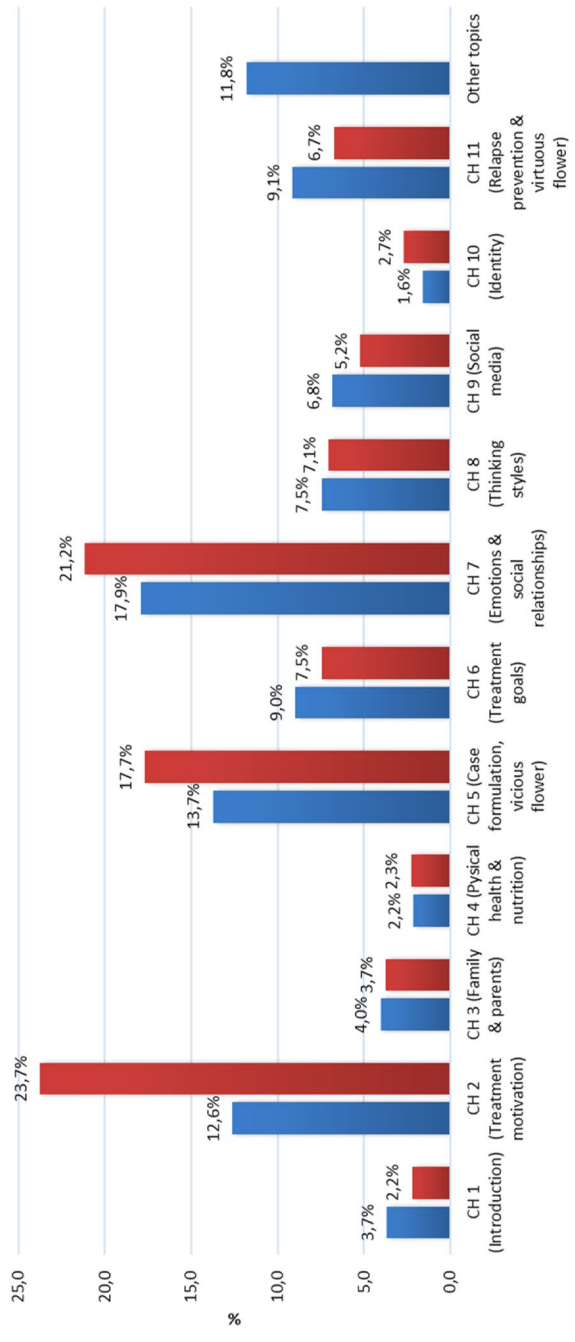

FIGURE 2 Proportion (%) of therapy time (blue) and home exercises (red) that was dedicated to each chapter of the MANTRa workbook and other topics (the percentages of the blue and red bars, respectively sum up to 100%). In a therapeutic cycle of 34 sessions, the percentages (blue bars) correspond to 1.3 sessions (CH 1), 4.3 sessions (CH 2), 1.4 sessions (CH 3), 0.7 sessions (CH 4), 4.7 sessions (CH 5), 3.1 sessions (CH 6), 6.1 sessions (CH 7), 2.6 sessions (CH 8), 2.3 sessions (CH 9), 0.5 sessions (CH 10), 3.1 sessions (CH 11) and 4.0 sessions (other topics).

developers. Collaborative care has been shown to be associated with patient satisfaction as well as improvements in motivation, eating disorder symptoms, and psychiatric functioning in different treatment settings of adult AN (Geller et al., 2021). Together with a multi-professional treatment setting and quality assurance measures, this leads to high quality standard of treatment.

Of the optional modules, the chapter on emotions and relationships were considered as particularly helpful and this was also reflected in the number of therapeutic sessions assigned to this chapter. The cognitive-interpersonal maintenance model of AN proposes that emotional avoidance through the avoidance of social interactions is also evident amongst individuals prior to AN onset (Schmidt & Treasure, 2006; Treasure & Schmidt, 2013). This model further assumes that engaging in eating disorder related behaviours and starvation further exacerbates these social and emotional deficits which contributes to the maintenance of this disorder. Thus, the recognition and handling of different emotions and training of social skills are key features in the treatment of AN (Henderson et al., 2019).

Although more therapy sessions with parents would have been needed in the view of some therapists, only 1–2 sessions on average were actually conducted together with the parents. However, in the multidisciplinary setting, all parents were offered participation in a caregiver skills training for 8 weeks. In these skills trainings, parents received psychoeducation about AN and were taught skills of non-confrontational communication using MI, which in turn leads to the reduction of high-expressed emotion in the family, and a calmer atmosphere in the home environment and is highly welcomed by AN patients (Goddard et al., 2011; Philipp et al., 2020). These skills training sessions additionally targeted the social component of maintaining factors. In total, 24% of the patients were young adults (18–21 years) and therefore potentially reluctant to involve their parents. In general, the importance of involving the parents into psychotherapy sessions especially with adolescents should be emphasized in future MANTRa trainings. The therapists should be motivated to invite parents to join more sessions. In CBT-E, involving parents in 8–12 sessions for 15–20 min at the end of a patient's individual session is suggested while strategies how parents can support the implementation of regular eating habits and other CBT-E modules are discussed (Dalle Grave et al., 2019). Although parents are usually regularly invited to join sessions with the case manager, the present results indicate that it seems important to tap the full potential of parental work also in MANTRa.

Specifically, body-oriented therapeutic work, mirror confrontation, mentalization and relaxation as well as general euthymic techniques (mindfulness, training of sensual enjoyment and pleasure), training in social competence and schema-therapeutic elements were missing for some therapists. Early maladaptive schemas such as 'failure' (believing that you are unlovable and worthless) and 'unrelenting standards' (believing that it is necessary to achieve extremely high standards to avoid criticism) have been linked to AN and could be relevant for both maintenance of the disorder and risk for relapse (Bär et al., 2023). Thus, the identification of early maladaptive schemas could be integrated in the treatment by indicating underlying unfulfilled needs of the patient that can be addressed by specific therapeutic techniques (Arntz & Jacob, 2017). In the course of the further development of the MANTRa workbook for adolescents it could be considered to split the workbook into two parts: One obligatory part integrating all chapters as in the current workbook potentially adding tools according to the schema theory and a second optional part which could be provided in an electronic form which can be extended by more optional elements. However, one has to be aware, that one workbook does not need to cover all potential intervention possibilities.

The therapists found MANTRa less suitable for patients with severe psychiatric comorbidities such as obsessive-compulsive disorder, non-suicidal self-injury, severe traumatization and personality disorders. In the NICE guidelines (2017), it is recommended that severe comorbidity should be treated in parallel with the eating disorder or the person should be referred to subsequent treatment. In some cases the treatment of the eating disorder is sufficient to ameliorate the comorbidity (National Institute for Health and Care Excellence, 2017). For comorbid personality disorders more intensive forms of psychotherapy have been suggested, such as transference-focused psychotherapy for adolescents (TFP-A), dialectic behavioural psychotherapy for adolescents (DBT-A) and mentalization-based psychotherapy for adolescents (MBT-A) to improve treatment outcome (Laczkovics et al., 2023).

While in our sample therapists had the impression that low treatment motivation and psychiatric comorbidity had an influence on how well therapists could work on the workbook with the patient, therapists who used MANTRA in adult patients considered this treatment applicable for a wider range of patients including those with poor motivation and more complex problems (Waterman-Collins et al., 2014). In the aforementioned study, the use of MI turned out as a key factor for building a positive therapeutic alliance, which is also supported by the results of the present study. Hence, the importance of teaching MI as a central conversation technique in therapist training seems to be critical, not only to keep patients in therapy but also to improve treatment outcome.

MANTRa chapters on nutrition and social media were used less in our study. As a consequence, the module on nutrition could be completely outsourced to a dietitian provided that a dietitian is available in the multi-professional team. However, there are also arguments for leaving the nutrition part in the responsibility of the MANTRa therapist as they may be able to address problems in this area more directly. Although the chapter on social media was used less, the therapists emphasized that social media play an important role in adolescence and thus also argued that this chapter should stay in the workbook in case it is needed. However, the utility of this chapter can be strengthened, for example by integrating videos on how manipulation of photos are realized in the media which can be realized when the workbook is implemented through a mobile application.

While for some therapists the workbook provided enough flexibility to address current patient needs and to work on the core content, others felt compelled to stick to the workbook at the expense of individual needs because of the scientific framework. Indeed, a preference for strictly adhering to the manual was associated with less experience of therapists in treating patients with AN in the present study. Although previous findings were inconsistent, some studies observed that less years of therapeutic experience came along with the preference towards using manual-based treatment (Forbat et al., 2015) which may correspond to the results of this study. In interviews with adult patients having received MANTRA, patients felt that there was enough flexibility within the structure of the workbook and that the intervention was tailored to their needs. This allows the intervention to be perceived as personalized treatment and was therefore positively evaluated (Lose et al., 2014; Zainal et al., 2016).

MANTRa specific case formulation

The visualized case formulation in form of the vicious flower has been viewed as the central part in therapy. In general, individual case formulation is regarded as clinically relevant when it is elaborated and discussed collaboratively and leads to agreed points of view and therapeutic aims (Mitmansgruber et al., 2020).

The present study clearly showed that the therapist formulation letter that is read to the patient promoted therapeutic alliance, evoked deep emotions and was discussed as one factor supporting recovery. This is corroborated by a study analysing the quality of case formulations showing that more collaborative, reflective and respectful letters were associated with a bigger reduction in eating disorder psychopathology (Allen et al., 2016). As reported in the same study, formulation letters paying attention to the development of AN led to higher acceptability of the treatment. Regarding good-bye letters, higher quality letters with a more affirming stance were associated with better improvements in body-mass-index (Simmonds et al., 2020). Altogether, case formulation and good-bye letters are powerful means not only to understand the usefulness of certain therapeutic tools but also to strengthen therapeutic alliance and influence AN outcome. The importance of therapeutic alliance for treatment completion, for being able to open up for symptom change and treatment success has been previously shown in a systematic review (Werz et al., 2022) and the therapists' perception of the case formulation letters add to these findings. Rienecke et al. (2016) found that patients' therapeutic alliance was associated with lower symptomatology at treatment start which may indicate that the more severe the eating disorder is, the more important it is to work on therapeutic alliance. Written case formulations read to the patients may

thus be a powerful tool to strengthen the therapeutic relationship also in patients with low treatment motivation and high resistance to change.

However, in adolescent patients, therapists need to pay attention to regulate proximity-distance relations in case of having elicited overwhelming emotions and not to foster a dependency relationship. Thus, the use of written shared case formulations can be associated with both beneficial and potentially harmful therapeutic change (Gladwin & Evangeli, 2013) and therapists need to be aware of that. These are potential aspects that are being incorporated into therapist training.

Length of therapy and MANTRa workbook design aspects

Some therapists were unsure how much time should be dedicated to which part of MANTRa to meet the overall maximum limit of 34 sessions. This point has also been discussed in the MOSAIC trial, where therapists felt busy and rushed and an extension to 40 therapy sessions has been proposed, analogous to other treatment durations in adults (Fairburn et al., 2013) and adolescents with AN (Nyman-Carlsson et al., 2020) where 40 to 60 sessions were deemed appropriate. With regard to future adaptations of MANTRa, an extension to at least 40 sessions in more severe cases can be proposed.

Some therapists highlighted the adapted and simplified language style necessary for adolescent patients, but argued that adult patients would benefit from it as well. Indeed, a process evaluation of adult MANTRA has prompted to consider a simplification and abbreviation of the therapeutic material (Waterman-Collins et al., 2014). Moreover, simplicity and predictability are especially appreciated by AN patients (Vitousek & Ewald, 1993). In this regard, the simplified language in the MANTRa workbook designed for adolescents, may also be appropriate for use in adult patients.

In general, the workbook was perceived as visually appealing; however, too voluminous in size. It has been suggested not to offer the whole workbook at once at therapy start but to share only the mandatory chapters with the client and to provide the optional chapters step by step. Optional parts could be also provided as online materials that can be printed out or implemented in an online application (app). A digital format would also provide the opportunity to offer additional therapeutic material that was regarded as missing for some therapists and may also facilitate the delivery of therapeutic sessions in a remote setting if necessary (which has been received increasing attention since the COVID-19 pandemic; for example, see Waller et al., 2020). Moreover, by splitting the MANTRa workbook into separate parts, patients are prevented from being overwhelmed by the materials, which might be relevant for clients with high perfectionism. However, not presenting the entire workbook at once may also hamper the collaborative selection of chapters to be worked on which was also regarded as an important benefit of MANTRa.

Strengths and limitations

This study has the following strengths and limitations: Strengths are the inclusion of a diverse sample of therapists including therapists with more and less experiences in the eating disorder field. Moreover, the interviews were conducted relatively shortly after the end of the MANTRa trial to avoid memory gaps. Limitations include that not all therapists included in the MANTRa trial were available for an interview, that only one male therapist was included, as well as the focus on the therapists' perspective. Interviews with AN patients will be necessary and will follow to include the perspective of (adolescent) patients with AN.

CONCLUSION

MANTRa was perceived as suitable for therapists with more and or less eating disorder experience. High treatment quality is ensured when therapists undergo an in-depth training, receive regular

supervision and when MANTRa is offered within a multidisciplinary setting. In future, the MANTRa training may also more explicitly address the question how the MANTRa chapters can be used to work on current life topics brought up by the patients. More flexibility regarding the number of therapy sessions, more frequent involvement of adolescents' parents as well as an expansion of the workbook by additional optional tools (e.g. body-related, schema-therapeutic and relaxation exercises) may be beneficial in reaching the maximum impact. A different format of the workbook with a mandatory part provided by a printed book and optional parts provided digitally, for example via an app, might be the solution for divergent patients' needs. Written case formulations in the form of therapists' letters to the patients which are read aloud turned out as one of the key factors to strengthen therapeutic alliance and intensified the reflexive process about the patient's individual problems and needs. This currently unique part of MANTRa may also inspire other psychotherapeutic approaches for children and adolescents across the spectrum of psychiatric disorders.

AUTHOR CONTRIBUTIONS

Michael Zeiler: Writing – original draft; methodology; formal analysis; visualization. **Petra Sackl-Pammer:** Investigation; writing – review and editing. **Tanja Wittek:** Conceptualization; project administration. **Susanne Ohmann:** Supervision; writing – review and editing. **Sonja Werneck-Rohrer:** Writing – review and editing; investigation. **Stefanie Truttmann:** Investigation; resources. **Julia Philipp:** Investigation; resources. **Gabriele Schöfbeck:** Resources. **Konstantin Kopp:** Investigation; resources. **Helene Krauss:** Project administration. **Ulrike Schmidt:** Supervision; writing – review and editing. **Andreas Karwautz:** Funding acquisition; supervision; writing – review and editing. **Gudrun Wagner:** Funding acquisition; writing – original draft; conceptualization; formal analysis.

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CONFLICT OF INTEREST STATEMENT

The authors declare that they have no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

Data S1.

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