PRZEGLĄD PSYCHOLOGICZNY – THE REVIEW OF PSYCHOLOGY
2026, VOL. 69, NO. 3, 137–149
DOI: 10.31648/przegldpsychologiczny.13340
Received: 26.01.2026 ● Revised: 25.08.2026 ● Accepted: 15.09.2026

MANTRA as a Treatment Protocol for Anorexia Nervosa in Adults: The Cognitive-Interpersonal Model, Therapy Structure, and Empirical Evidence

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Abstract

Aim: This paper provides a concise overview of MANTRA (Maudsley Anorexia Nervosa Treatment for Adults) as a manualised psychotherapy for adults with anorexia nervosa (AN) and offers a critical synthesis of its theoretical foundations and available empirical evidence.

Theses: MANTRA is grounded in the cognitive-interpersonal maintenance model of AN, in which a characteristic cognitive style (including rigidity and detail-focused processing), difficulties in identifying and regulating emotions, relational patterns that increase the risk of isolation, and positive beliefs about the functions of symptoms and their relationship to identity coexist and reinforce one another. The protocol combines cognitive-behavioural techniques with motivational work and interpersonal interventions and, in selected cases, includes the systematic involvement of support persons.

Conclusion: MANTRA is a conceptually coherent and empirically evaluated protocol and one of the recommended outpatient treatment options for adults with AN. Randomised trials have documented increases in body mass index (BMI) and reductions in symptom severity. They have not demonstrated the superiority of MANTRA over other active treatments; however, the available trials were not designed to establish formal equivalence between treatments. Methodological quality is variable and the risk of bias is elevated

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(Fernández García & Quiles Marcos, 2024). Further research should examine moderators of outcome, mechanisms of change, and implementation in routine care.

Keywords: anorexia nervosa, psychotherapy, MANTRA, cognitive-interpersonal model, SSCM, CBT-E

Anorexia nervosa (AN) is a mental disorder associated with a high risk of medical complications and mortality. In adults, its course is often characterised by chronicity, relapse, and a substantial risk of premature treatment discontinuation (Agras & Robinson, 2008). Despite the development of specialised psychotherapeutic protocols, outcomes of outpatient treatment remain modest, and differences between active interventions are generally small. The National Institute for Health and Care Excellence guidelines (NICE, 2017) recommend manualised therapies delivered within multidisciplinary care, taking into account patients' preferences and clinical circumstances.

One approach developed to address the specific features of AN in adults is MANTRA (Maudsley Anorexia Nervosa Treatment for Adults), a manualised individual psychotherapy protocol grounded in the cognitive-interpersonal maintenance model of the disorder (Schmidt & Treasure, 2006; Treasure & Schmidt, 2013). NICE identifies MANTRA as one of three principal treatment options for adults with AN, alongside eating-disorder-focused cognitive behavioural therapy (CBT-ED) and Specialist Supportive Clinical Management (SSCM). The maintenance model of AN was published in 2006 (Schmidt & Treasure, 2006), and the first findings from the clinical application of MANTRA were reported in an outpatient case series published in 2011 (Wade et al., 2011). The protocol was subsequently evaluated in a pilot randomised controlled trial (Schmidt et al., 2012) and described in a paper addressing its development, structure, and preliminary empirical evidence (Schmidt et al., 2014). The full treatment manual was published in 2018 (Schmidt et al., 2018), followed by the Polish edition in 2026 (Schmidt et al., 2026). The evidence base primarily concerns outpatient treatment. Inpatient, group, and hybrid applications are adaptations of the protocol, and the available data do not permit comparisons of MANTRA's effectiveness across levels of care (Fernández García & Quiles Marcos, 2024).

The aim of this article is to provide a critical narrative review of the theoretical foundations, protocol structure, and empirical evidence concerning MANTRA in the treatment of adults with anorexia nervosa. Publications were purposively selected on the basis of their relevance to the article's aim: to examine MANTRA's theoretical model, protocol structure, and findings from research on its use in adults with anorexia nervosa. The collection of relevant literature was completed on 31 December 2025. The article covers (a) the cognitive-interpersonal maintenance model of AN, (b) the main components of MANTRA and its proposed mechanisms of change, and (c) findings from randomised, observational, and qualitative studies, with particular attention to comparisons with enhanced cognitive behavioural therapy (CBT-E) and SSCM. The aim is not to establish the superiority of MANTRA or to advocate its use unconditionally, but to describe

the protocol and critically evaluate its evidence base. The limitations of the comparative evidence are explicitly identified.

Analytical Section

The Cognitive-Interpersonal Maintenance Model of AN

MANTRA is grounded in the cognitive-interpersonal maintenance model of AN, in which symptoms are maintained by interacting cognitive, socio-emotional, and interpersonal factors, as well as by positive beliefs about the functions of the illness (Schmidt & Treasure, 2006; Treasure & Schmidt, 2013). The model does not assume that these factors are unique to AN or that they are wholly causal. Rather, it emphasises their role as processes that, under conditions of starvation, stress, and isolation, may form self-reinforcing loops that maintain restrictive behaviours.

In the cognitive domain, the model highlights difficulties in flexibly switching between strategies (set-shifting) and a tendency towards highly detail-focused information processing, accompanied by difficulties in integrating the "bigger picture" (weak central coherence). Neuropsychological studies indicate difficulties on tasks requiring cognitive flexibility and suggest that some features of this cognitive profile may also be present in younger patients (Lang et al., 2015; Tchanturia et al., 2004). At the same time, some features of this "analytical" style may serve as strengths in other contexts, an understanding that MANTRA draws on to reduce stigma and build the therapeutic alliance.

The second pillar of the model concerns difficulties in emotional and social functioning. A meta-analysis of self-report data suggests that individuals with AN more frequently report reduced emotional awareness and clarity, greater use of regulation strategies considered less adaptive, and less frequent use of more flexible strategies (Oldershaw et al., 2015). In terms of the processes maintaining the disorder, the combination of difficulties in identifying emotions and avoidance of interpersonal exposure is particularly relevant: dietary restriction, rituals, and withdrawal may reduce arousal in the short term, but increase isolation over time and reinforce reliance on symptoms as the primary coping strategy (Treasure & Schmidt, 2013). A study combining neuroimaging with assessments of everyday experiences found that greater downregulation of ventral striatal activity during positive emotion regulation was associated, in individuals with AN, with more severe body-related rumination and negative affect, as well as smaller increases in BMI at follow-up (Seidel et al., 2018). It has also been proposed that worry and rumination may function as forms of cognitive avoidance of emotions in AN and are associated with the severity of eating disorder psychopathology (Startup et al., 2013).

The third component of the model concerns relationships and the interpersonal context. AN symptoms are visible and alarming to others, which may elicit responses characterised by high emotional arousal (e.g., pressure, control, or withdrawal). Although intended to help, these responses may sometimes reinforce

cycles of conflict or avoidance. Accommodation of disorder-related behaviours by close others is also clinically relevant, as it may provide short-term relief while maintaining symptoms in the longer term (Treasure & Schmidt, 2013).

Positive beliefs about the functions of symptoms and identity-related processes warrant separate consideration. In AN, symptoms are often ego-syntonic, and the illness may be experienced as a source of control, safety, or agency. From the MANTRA perspective, ambivalence towards change is therefore expected and becomes a focus of therapeutic work. This work incorporates consideration of benefits and costs, exploration of values, and the development of an identity "beyond anorexia". A version of the protocol for younger patients (MANTRa) has been described in the literature as an attempt to adapt the model to the context of adolescence and early adulthood. However, evidence concerning MANTRa should not be used as a substitute for evidence on the effectiveness of MANTRA in adults (Zeiler et al., 2025).

Structure and Mechanisms of Action of MANTRA

MANTRA is an individual, manualised, modular therapy. The protocol description emphasises a collaborative therapeutic style informed by the principles of motivational interviewing and the tailoring of interventions to an individual case formulation (Schmidt et al., 2015). Tools used to develop a shared understanding of vicious cycles that maintain the disorder, including the "maintenance flower" metaphor, guide the selection of exercises addressing nutrition and recovery, cognitive flexibility, emotions, and relationships. According to NICE (2017), MANTRA typically comprises 20 sessions: the first 10 are held weekly, while subsequent sessions follow a more flexible schedule; individuals with complex problems may be offered up to 10 additional sessions. In the MOSAIC trial, individuals with a BMI $\leq$ 15 kg/m^2 could receive up to 30 weekly sessions and four monthly booster sessions (Schmidt et al., 2015), whereas Byrne et al. (2017) offered 25–40 sessions over 10 months, depending on baseline BMI. Work on cognitive style, emotions, and relationships does not replace nutritional goals. The protocol includes normalisation of eating, improvement in nutritional status, and regular monitoring of body weight. Assessment of medical risk and decisions about treatment intensification fall within multidisciplinary care and require collaboration between the psychotherapist and a physician and, where needed, a dietitian (Schmidt et al., 2018).

The cognitive module uses interventions aimed at increasing flexibility in thinking and behaviour and broadening perspective, often through brief exercises and behavioural experiments. The socio-emotional module focuses on developing emotion identification skills, increasing tolerance of arousal, and expanding the repertoire of affect regulation strategies. The use of more experiential methods has also been described when therapeutic work remains overly intellectualised. The interpersonal component includes examining recurrent relational roles, emotional communication, and patterns of avoidance, as well as planning interpersonal experiments in ways that minimise the risk of escalating conflict.

The involvement of support persons is not mandatory in MANTRA, but is an important clinical option when relationships and the behaviours of close others actively contribute to cycles that maintain the disorder. Studies of digital augmentation drawing on elements of MANTRA and interventions for carers (ECHOMANTRA) indicate growing interest in hybrid formats and in developing the skills of patients and support persons, although the clinical findings for these interventions are mixed (Cardi et al., 2024; Cardi et al., 2025). These interventions are discussed in greater detail in a separate section devoted to adaptations and adjunctive interventions.

Empirical Evidence on the Efficacy of MANTRA

The principal UK evaluation of MANTRA was conducted as part of the Maudsley Outpatient Study of Treatments for Anorexia Nervosa and Related Conditions (MOSAIC). This randomised controlled trial compared MANTRA with SSCM in the outpatient treatment of adults with broadly defined AN (BMI ≤ 18.5 kg/m^2). The trial enrolled 142 participants, randomly allocated to MANTRA (n = 72) or SSCM (n = 70). Both treatment arms comprised 20–30 sessions, four booster sessions, and optional dietetic consultations and sessions involving close others; the primary outcome was BMI at 12 months. Treatment was completed by 75% of participants in the MANTRA group and 59% in the SSCM group. Both arms showed improvements in BMI, eating disorder symptoms, distress, and functioning, with no statistically significant between-group differences in the main outcomes. At 12 months after randomisation, participants receiving MANTRA rated their treatment as more acceptable and credible than those receiving SSCM (Schmidt et al., 2015). Data at 24 months after randomisation were obtained from 73.2% of participants. The estimated mean increase in BMI from baseline was 2.25 kg/m^2 for MANTRA and 2.16 kg/m^2 for SSCM; the corresponding effect sizes of 1.83 and 1.75 represent within-group changes rather than differences between treatments. Eighty-three per cent of participants did not require additional intensive treatment (Schmidt et al., 2016). These findings indicate improvement in both conditions but do not establish the specific efficacy of MANTRA. The absence of statistically significant differences also does not establish formal equivalence or non-inferiority, as the trial was not designed for either purpose.

The multicentre randomised trial by Byrne et al. (2017), conducted at five outpatient clinics across three Australian cities, directly compared MANTRA, CBT-E, and SSCM. The trial enrolled 120 adults with AN, who were offered 25–40 sessions over 10 months. Treatment was completed by 57.5% of participants receiving SSCM, 56.1% receiving MANTRA, and 66.7% receiving CBT-E; these differences were not statistically significant. The 12-month follow-up assessment was completed by 52.5% of the total sample. All groups showed improvements in BMI, eating disorder psychopathology, general psychopathology, and psychosocial functioning, with no statistically significant differences in continuous outcomes. The mean increase in BMI in the MANTRA group was 1.37 kg/m^2

at post-treatment and 1.50 kg/m^2 at 12-month follow-up. At 12 months after treatment completion, a normal body weight had been achieved by 47.5% of participants receiving SSCM, 44.0% receiving MANTRA, and 59.0% receiving CBT-E, while 32.5%, 22.0%, and 30.8%, respectively, met the criteria for remission; these differences were not statistically significant. The primary analyses did not demonstrate the superiority of any treatment, but the limited group sizes and high proportion of missing data reduced the ability to detect smaller differences. The findings do not establish formal equivalence between the therapies (Byrne et al., 2017).

The first systematic review devoted to MANTRA provides a synthesis of the current evidence base (Fernández García & Quiles Marcos, 2024). The authors conducted the review in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines and assessed risk of bias using Cochrane tools. Nine studies published between 2011 and 2023 were included. Improvements in BMI, eating disorder symptoms, and emotional state were observed during treatment, while comparative studies generally found no statistically significant differences between conditions. However, limited methodological quality, small samples, and elevated risk of bias preclude firm conclusions about the specific efficacy of the protocol or its equivalence to other therapies.

The combination of MANTRA with pharmacotherapy and comparisons with other psychotherapeutic approaches warrant separate consideration. No randomised trials were identified in which MANTRA combined with pharmacotherapy constituted a distinct treatment arm. Some trials permitted a stable dose of antidepressant medication, but the effects of pharmacotherapy were not analysed separately (Schmidt et al., 2012). Direct randomised comparisons of MANTRA with family therapy or psychodynamic therapy in adults are also lacking. For example, the Anorexia Nervosa Treatment of OutPatients (ANTOP) trial compared focal psychodynamic therapy, cognitive behavioural therapy, and optimised treatment as usual, but did not include MANTRA (Zipfel et al., 2014). Comparative evidence for MANTRA is therefore largely limited to CBT-E and SSCM.

The quantitative evidence is complemented by qualitative studies conducted within the MOSAIC programme, which provide a deeper understanding of how patients interpret mechanisms of change and which elements of therapy they perceive as helpful or burdensome (Lose et al., 2014).

Adaptations and Adjunctive Interventions

In addition to the core individual protocol, the literature describes adaptations of MANTRA and adjunctive interventions that draw on selected elements of the model; their findings should be interpreted separately from evidence concerning the full protocol. MANTRA is also implemented in clinical practice in modified formats (e.g., group or hybrid formats), although the evidence base for these adaptations is more heterogeneous and largely observational. For example, the feasibility of an integrated group format within public services has been reported, but such findings require cautious interpretation because of the absence of randomisation and sample selection (Startup et al., 2021).

In recent years, research has examined digital augmentation of care following intensive treatment, drawing on elements of MANTRA and interventions for carers. ECHOMANTRA is a digital supportive intervention that incorporates selected elements of MANTRA and involves close others. It does not constitute the full individual MANTRA protocol, and its findings should therefore not be interpreted as a direct test of MANTRA's efficacy. The pragmatic Transition Care in Anorexia Nervosa through Guidance Online from Peer and Carer Expertise (TRIANGLE) trial evaluated ECHOMANTRA as an adjunct to treatment as usual, supporting the transition from inpatient or day-patient treatment to community care. The trial enrolled 371 patient–carer dyads from 31 UK centres: 185 were allocated to ECHOMANTRA plus treatment as usual and 186 to treatment as usual alone. The primary outcome was patient distress at 12 months, measured using the Depression Anxiety Stress Scales (DASS-21). No statistically significant between-group difference was found: the estimated difference was 0.48 points, with a 95% confidence interval from −5.36 to 6.33; $p = .87$. DASS-21 data at 12 months were unavailable for approximately one-third of the sample, with missing data more frequent in the ECHOMANTRA group, limiting the precision of the conclusions. The intervention also had an unfavourable cost-effectiveness profile (Cardi et al., 2024). Qualitative findings indicate that some participants perceived the support as useful, while barriers included the burden experienced after discharge, family and work commitments, and a mismatch between the intervention format and participants' needs (Cardi et al., 2025; Clark Bryan et al., 2024).

MANTRA in Comparison With CBT-E and SSCM

In the outpatient treatment of adults with AN, there is no conclusive evidence that one approach is superior to the others. A distinction should be drawn between CBT-E, a specific manualised protocol developed by Fairburn and colleagues (Fairburn, 2008), and the broader term CBT-ED, which NICE uses to denote a class of individual cognitive behavioural therapies focused on eating disorders. CBT-E is the most extensively studied therapy within this class, but the terms are not interchangeable. CBT-E has a relatively broad evidence base across eating disorder populations (Atwood & Friedman, 2020), and its implementation, including in patients with high symptom severity, has been described in routine clinical practice (Frostad et al., 2018; Frostad et al., 2021). SSCM is an active specialist treatment that combines clinical support, monitoring of physical health, and work towards normalising eating. The MOSAIC trial found no statistically significant differences between MANTRA and SSCM in the main outcomes (Schmidt et al., 2015). The trial by Byrne et al. (2017) remains the only randomised study directly comparing MANTRA, CBT-E, and SSCM. It found no statistically significant differences in continuous outcomes or in the proportions of participants achieving normal body weight or remission. However, its limited statistical power and study design do not permit conclusions about formal equivalence between the therapies.

Discussion

The evidence presented indicates that MANTRA is a conceptually coherent psychotherapy protocol that has undergone empirical evaluation and is one of the recommended options for the outpatient treatment of adults with anorexia nervosa. MANTRA is characterised by the systematic mapping of processes that maintain the disorder, attention to ambivalence towards change, and the integration of cognitive, emotional, and interpersonal work within an individualised case formulation. Studies have reported improvements during treatment, but have not demonstrated the superiority of MANTRA over SSCM or CBT-E. The available trials also do not establish formal equivalence between these treatments.

A critical consideration is that the cognitive-interpersonal maintenance model of AN, which underpins MANTRA, describes processes with limited diagnostic specificity. Cognitive rigidity, difficulties in emotion regulation, and patterns of interpersonal avoidance are also observed in other mental disorders and may be exacerbated by starvation and chronic stress. Thus, although the MANTRA model provides a useful clinical framework, its components should not be interpreted as clear predictors of treatment response or as mechanisms unique to anorexia nervosa. The current evidence also does not establish the extent to which the proposed processes function as mediators of change and the extent to which they are correlates of psychopathology.

MANTRA, CBT-E, and SSCM differ in their therapeutic emphases and the organisation of clinical work. CBT-E focuses on behaviours and beliefs directly related to eating, body weight, and eating disorder psychopathology; MANTRA explores the functions of symptoms and identity-related and relational processes more broadly; SSCM combines support with clinical management and the normalisation of eating. Direct comparative studies have not demonstrated a clear advantage of any one approach, but neither have they established equivalence. Treatment selection should therefore take into account patients' preferences, clinical presentation, readiness to engage with a given model, and the availability of an appropriately trained team.

MANTRA can be regarded as a reasonable and recommended option for the outpatient treatment of adults with AN. In the MOSAIC trial, patients rated it as more acceptable and credible than SSCM. However, this finding comes from a single trial and should not be generalised to comparisons with all therapies. Caution in evaluating the protocol is warranted by the small number of comparative studies, limited statistical power, and varying methodological quality of the available evidence (Fernández García & Quiles Marcos, 2024).

Findings from the digital adjunctive intervention ECHOMANTRA do not constitute evidence regarding the efficacy of the full MANTRA protocol. In TRIANGLE, adding ECHOMANTRA to treatment as usual did not demonstrate a benefit on the primary outcome: symptoms of depression, anxiety, and stress measured using the DASS-21 at 12 months. This finding should not automatically be extended to all possible clinical outcomes. Qualitative data indicate that some patients and close others found the support helpful, warranting further investigation of the timing of the intervention, the burden it places on participants, and its fit with users' needs.

From a clinical perspective, MANTRA may be particularly useful when working with patients for whom strong identification with the illness, ambivalence towards change, and difficulties in interpersonal relationships play a prominent role. However, these are clinical hypotheses rather than empirically established indications of differential treatment efficacy.

In Poland, the availability of specialised, manualised therapies for AN in adults remains limited, and therapists' levels of training vary. Organisational factors, time constraints, and the absence of systematic training and supervision pathways hinder the implementation of full protocols. Safe treatment also requires psychotherapy to be combined with regular medical assessment of physical health. The Polish edition of the manual *Terapia poznawczo-interpersonalna anoreksji u dorosłych* (Schmidt et al., 2026) increases access to MANTRA. Research into the adaptation, implementation, and outcomes of MANTRA within the Polish healthcare system is warranted.

Limitations and Directions for Future Research

The evidence base for MANTRA in adults remains limited by the number of randomised trials, small samples, differences in treatment intensity, and missing data resulting from premature treatment discontinuation. Implementing the protocol in resource-limited settings encourages adaptations whose fidelity and outcomes are not always systematically evaluated. Future research should address (a) moderators and mediators of treatment effects, (b) adequately powered comparative trials, including equivalence or non-inferiority designs, (c) analyses of individual protocol components, (d) maintenance of treatment gains following intensive treatment, and (e) implementation in routine care. Randomised comparisons of MANTRA with family therapy and psychodynamic therapy in adults are lacking, as are studies examining MANTRA combined with pharmacotherapy as a distinct treatment strategy.

Conclusions

MANTRA is one of the three principal psychotherapy options recommended by NICE for adults with AN, alongside CBT-ED and SSCM (NICE, 2017). Randomised trials have reported increases in BMI and reductions in symptom severity during MANTRA, without demonstrating superiority over active comparator treatments (Byrne et al., 2017; Schmidt et al., 2015). However, the absence of statistically significant differences does not establish formal equivalence between treatments. The first systematic review also highlights the limited methodological quality of the available evidence and elevated risk of bias (Fernández García & Quiles Marcos, 2024). MANTRA can therefore be regarded as a reasonable outpatient treatment option, but further research is needed to establish its specific effects, indications, and position relative to other therapies.

Declarations

Declaration of conflict of interest
The authors declare a potential conflict of interest related to the subject matter of this article. Kamila Grochowska-Kramek is the translator of the Polish edition of the MANTRA manual, and Izabela Pawłowska serves as its scientific editor. These professional roles relate to the treatment protocol discussed in the manuscript. The authors declare no other financial or non-financial interests related to the preparation or publication of this article.

Entities that contributed to the publication and their contribution
Not applicable

Ethical approval
Not applicable. This is a review article and does not report research involving human participants or animals. It did not involve the collection or analysis of individual participant data; therefore, ethics committee approval was not required.

Data availability statement
Not applicable. No research datasets were generated or analysed during the preparation of this article. This is a review article based on the sources cited in the reference list.

Financing statement
Not applicable

Statements and declarations regarding the use of AI
During the preparation of this article, the authors used ChatGPT (OpenAI) solely to correct the language, organise the structure of their own text, and improve its clarity. The tool was not used to search for or select literature, synthesise research findings, evaluate scientific evidence, or formulate conclusions or clinical recommendations. The authors independently verified all information, numerical data, interpretations, and bibliographic references and take full responsibility for the final content of the manuscript.

Declaration of authors' contributions to the manuscript
Izabela Pawłowska: Conceptualisation, Resources, Supervision, Writing – review and editing

Kamila Grochowska-Kramek: Conceptualisation, Resources, Writing – original draft, Writing – review and editing

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