COMMENTARY

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Additional Maintaining Mechanisms and the Coherence of the Transdiagnostic CBT-E Model: Reflections on Brown et al. and the Role of Minority Stress

Marco Massa

Centro Terapeutico Villa del Principe, Genoa, Italy

Key words

CBT-E
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Transdiagnostic Model
Therapeutic Drift
Treatment Fidelity

Abstract

The PRIDE protocol described by Brown et al. adapts enhanced cognitive behavioural therapy (CBT-E) for sexual minority individuals by addressing minority-stress processes while preserving the core CBT-E treatment. Although its uncontrolled design precludes firm conclusions about efficacy, the study supports feasibility and acceptability and raises a key theoretical question: how to incorporate additional maintaining mechanisms without compromising the coherence of a transdiagnostic, mechanism-based intervention such as CBT-E.

This paper argues that minority stress can be conceptualised as an additional maintaining domain within the broad form of CBT-E rather than as the integration of a separate therapeutic model. Internalised stigma, sexual-orientation concealment, and rejection-related hypervigilance may reinforce the overvaluation of shape and weight, dysfunctional emotion regulation, and interpersonal avoidance, thereby operating through the central mechanisms of the CBT-E model. Framing minority stress in this way would preserve treatment integrity, support individualised case formulation, and allow the development of a module to be activated only when clinically relevant, consistent with the mechanism-focused evolution of CBT-E.

Introduction

The paper by Brown and colleagues on the PRIDE protocol (Brown et al., 2024) represents an innovative and clinically relevant contribution to the treatment of eating disorders in sexual minority individuals. In this uncontrolled case series, the authors show that an intervention that retains the core procedures of CBT-E while introducing strategies specifically targeting minority stress, is feasible, well accepted, and associated with clinically significant improvements in eating-disorder psychopathology and psychosocial functioning.

Given the case-series design and the absence of a control condition, the findings do not allow conclusions to be drawn about the efficacy of the treatment. However, the study provides important preliminary indications regarding the clinical plausibility of the model and the acceptability of interventions that explicitly address processes related to minority stress.

A conceptual issue: integrating additional treatment models

Beyond its clinical relevance, this paper raises an important theoretical question: how additional maintaining factors can be incorporated into the treatment model while preserving the integrity of a transdiagnostic intervention guided by a clearly defined theory such as CBT-E.

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Marco Massa (✉) marxmassa@gmail.com

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In Brown et al., the PRIDE protocol is described as an integration of CBT-E and SM-affirmative cognitive behavioural therapy. While this formulation is understandable at a descriptive level, it raises a conceptual issue. CBT-E was developed as a treatment based on a transdiagnostic model that identifies specific maintaining mechanisms of eating-disorder psychopathology and translates them into targeted therapeutic procedures (Fairburn et al., 2003; Fairburn et al., 2009). Its efficacy, replicability, and dissemination in routine clinical practice largely depend on the clarity of the model and fidelity to its implementation (Dalle Grave et al., 2013; Waller, 2009).

The introduction of techniques derived from different models carries the risk of therapeutic drift, eclecticism, and a progressive loss of model specificity. This risk is particularly relevant in evidence-based treatments such as CBT-E, in which applicability in routine clinical settings represents a central goal (Murphy et al., 2010).

Minority stress as a potential maintaining domain within CBT-E

An alternative reading of the data presented by Brown and colleagues, more consistent with the CBT-E model, is nevertheless possible.

The "broad" form of CBT-E involves the activation of additional modules when further maintaining mechanisms interfere with therapeutic change, most notably core low self-esteem, clinical perfectionism, interpersonal difficulties, and mood intolerance (Fairburn, 2008; Fairburn et al., 2009). As is well established, these modules do not represent the integration of new psychotherapeutic models, but rather an extension of the transdiagnostic model based on the identification of additional clinically relevant maintaining factors.

Within this framework, the processes described in the minority-stress model could be conceptualised as an additional maintaining domain that, in specific subgroups of patients, contributes to the persistence of eating-disorder psychopathology.

Internalised stigma, sexual-orientation concealment, rejection-related hypervigilance, and appearance-based pressures may significantly influence the patient's system of self-evaluation. In particular, these factors may increase the extent to which self-evaluation is dependent on weight, shape, and the control of eating, thereby reinforcing the core eating-disorder psychopathology. Moreover, they may maintain the use of dysfunctional emotion-regulation strategies (another maintaining mechanism) and contribute to the avoidance of relevant interpersonal contexts. In other words, they appear to operate as factors that interact with the central mechanisms of the CBT-E model rather than as independent processes.

Clinical and research implications

Conceptualising minority stress as a maintaining domain may offer several advantages.

First, it would preserve the theoretical and procedural integrity of CBT-E by maintaining the focus on empirically validated mechanisms of change. Second, it would allow these processes to be incorporated into the individualised case formulation, which represents the central element guiding treatment. Third, it would maintain adequate levels of standardisation and replicability, avoiding the proliferation of population-specific treatment protocols.

Such a reconceptualisation would be consistent with the strategy that has guided the development of CBT-E: identifying new maintaining mechanisms, empirically testing their role, and only subsequently translating them into specific clinical procedures (Fairburn, 2008).

From this perspective, the findings of the PRIDE protocol may be interpreted as preliminary empirical support for the possibility of developing and testing a minority-stress module within the broad form of CBT-E, to be activated only when this domain emerges as a clinically relevant maintaining mechanism in the individual formulation (in the same way as when the treatment moves from the focused to the broad form of CBT-E).

Such an evolution would have important clinical and research implications. Clinically, it would increase the fit of the treatment to the needs of specific patient subgroups while maintaining its applicability in real-world clinical settings. From a research perspective, it would make it possible to test whether reductions in minority-stress-related processes lead to improvements in eating-disorder psychopathology, in line with a mechanism-focused approach.

Conclusion

In conclusion, Brown and colleagues should be credited with suggesting the existence of a maintaining domain that has so far been little explored in the treatment of eating disorders. Conceptualising minority stress as a module within the broad form of CBT-E, rather than as an integration of distinct models, may represent a development consistent with the theoretical architecture of the treatment and with its transdiagnostic nature.

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