TABLE 10.2 From Dalle Grave R & Calugi S, *Cognitive Behavior Therapy for Adolescents with Eating Disorders*, Guilford Press, New York, 2020.

Obstacles to Change and Strategies Used to Address them

- *Fear of changing* (e.g., fear of no longer being 'special'; fear of losing an excuse for not addressing other things in life; fear of not knowing who one is without the eating problem; fear of losing control over eating and continuing to gain weight) can be addressed using the strategies described in Chapter 8 to evaluate the pros and cons to address weight regain.
- *Resistance to change in general* (e.g., fear of the consequences of change or a general resistance to any form of change). If the former, then the fear needs to be explored and addressed. If the latter, the resistance may be attributable to the psychological effects of being underweight or the influence of clinical perfectionism.
- *Competing commitments* (e.g., pressure of school) can be addressed by stressing the importance of giving treatment priority.
- *External events and interpersonal difficulties.* Consider implementing the Interpersonal Difficulties module of broad CBT-E (see Chapter 17).
- *Poor planning.* Helping the patient become more organized.
- *Clinical depression.* Treating the depression if necessary (see Chapter 20).
- *Core low self-esteem.* Patients with severe low self-esteem tend not to believe that they are capable of making changes nor do they think that they deserve the therapist's efforts. (These features may also been seen in those with a clinical depression.). Consider implementing the Core Low Self-Esteem module of broad CBT-E (see Chapter 17).
- *Clinical perfectionism*. Patients with clinical perfectionism apply their extremely demanding standards to all aspects of life that they value. If they have an eating disorder, they apply their high standards to their dieting, weight and appearance. This makes change especially difficult. They also apply their standards to the treatment itself, which tends to complicate matters and slow progress. The broad version of CBT-E can be used to address clinical perfectionism (see Chapter 17).
- *Substance misuse*. Persistent substance misuse undermines a patient's ability to make the most of treatment. If it is proving a barrier to change, it needs to be addressed in its own right and CBT-E suspended or postponed. However, intermittent substance misuse can often be addressed in the context of CBT-E.
- *Dislike of CBT*. In our experience this is unusual. Occasionally patients who have received extensive prior exposure to other forms of therapy (e.g., psychodynamic psychotherapy) have difficulty adjusting to the different rationale and mode of treatment, but this is uncommon. Under these circumstances we ask patients to try to suspend their skepticism and simply accept that this is an empirically supported treatment that has a good chance of helping them if they commit themselves to it.
- *Poor implementation of the treatment by the therapist*. It is advisable to have weekly peer supervision meetings in the form of a 'closed' group (i.e., restricted to CBT-E therapists), to listen to the recordings of each others' treatment sessions, and seek out training and ongoing peer supervision.