

# Food for thought

Co-morbidity of  
eating disorders  
with anxiety and  
depression



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# Food for thought: Co-morbidity of eating disorders with anxiety and depression

Research Report

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# **Food For Thought:** Co-morbidity of Eating Disorders with Anxiety and Depression

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# 1 Background

*beyondblue*: the national depression initiative recognises that people with an eating disorder are a group in the community who often experience depression and anxiety. *beyondblue* is therefore interested in obtaining up-to-date information about the availability of, and access to, resources for people with an eating disorder who experience co-morbid anxiety and depression. *beyondblue* contracted Research Matters to undertake a study to identify organisations around Australia that provide services, treatments or resources for people with an eating disorder who experience anxiety and depression, and to provide information about prevalence rates and evidence-based treatments.

Research Matters designed a project with three components:

1. Literature Review

Recent literature was reviewed to ascertain prevalence rates and treatment options for people with an eating disorder who experience co-morbid anxiety and depression.

2. Scoping exercise

Ninety organisations were identified that provide resources/services for people with eating disorders in Australia. Some organisations focus solely on people with eating disorders, others include eating disorders as part of their core work.

Appendix 4 provides a short description of each eating disorder organisation, including whether or not the organisation provides an eating disorder specific service.

Qualitative research methods were used to determine:

- What resources and services are currently available for people with an eating disorder and co-morbid anxiety and depression;
- What resources are currently available for:
  - Consumers and carers;
  - Clinicians (general practitioners, dietitians, psychologists; psychiatrists and social workers); and
  - Other professionals (e.g. school counsellors, sports coaches).
- What are the resources that consumers, carers, clinicians and other professionals find useful and necessary;
- Evidence about what works, and what does not work;
- Current gaps in service delivery; and
- Perceived research priorities.

3. Disseminate information

The final component involves sharing a summary of the findings with all participating organisations. It is hoped that this process may improve communication between organisations that provide resources, services and treatments for people with co-occurring eating disorder and depression and anxiety. In addition, a contact list is provided at the end of the report. ❖

# 2 Summary of Key Findings

People with an eating disorder often experience anxiety and depression though the exact prevalence is difficult to determine. Many participants in the qualitative component of this scoping exercise (i.e. professionals from eating disorder organisations/health care services) stated that “almost everyone” with an eating disorder experiences anxiety and depression. One participant stated that “our experience is that most people suffering with an eating disorder are also experiencing some degree of anxiety and depression, so we always address it.” However, systematic reviews of the literature indicate that the association between eating disorders and anxiety/depression is complex.

This report draws on 32 completed questionnaires and 9 key systematic literature reviews that deal specifically with co-morbidity of eating disorder with anxiety and depression. The systematic reviews note that research on eating disorders often has methodological limitations such as small sample sizes and problems with diagnostic criteria. In addition, many studies do not include a control group. Given these general methodological issues, conclusions about prevalence rates and effective treatments are made with caution.

It is important to also note that clinical samples may artificially identify significant associations that do not exist in the community because of ‘differential referral’<sup>1</sup>. Although anecdotal accounts

suggest that up to 5% of women attending a GP have an eating disorder, this statistic cannot be generalised to a community sample. To illustrate this point: Although 5% of GP clients may have a sporting injury, 5% of people in the community do not have a sporting injury.

Unlike research that focuses only on clinical samples, systematic reviews provide estimates of prevalence rates of co-morbidity that are not confounded by differential referral. The evidence in systematic reviews is from studies of strong design; results are both clinically important and consistent; and results are free from serious doubts about generalisability, bias, or flaws in research design. A systematic review for eating disorders undertaken by the University of North Carolina at Chapel Hill Evidence-based Practice Center is one of the most comprehensive evidence-based reports on the management and outcomes related to eating disorders to date. Berkman et al. reviewed all studies of people with an eating disorder aged 10 years and older, of both sexes, published in all languages from all nations between 1980 and 2005<sup>2</sup>. In this 1200 page systematic review, the mean prevalence of anorexia nervosa is 0.3% of the community; the mean prevalence of bulimia nervosa is 1.0% of the community.

Systematic literature reviews on eating disorders focus mainly on anorexia nervosa and bulimia nervosa. In fact, only two eating disorders are officially defined by the American

1. Differential referral is used to describe the differences between a treatment seeking population sample and a community based sample. The use of treatment seeking samples can overestimate co-morbidity.

2. Berkman ND, Bulik CM, Brownley KA, Lohr KN, Sedway JA, Rooks A, Gartlehner G.(2006) Management of Eating Disorders. Evidence Report/Technology Assessment No. 135. (Prepared by the RTI International-University of North Carolina Evidence-Based Practice Center under Contract No. 290-02-0016.) Agency for Healthcare Research and Quality. Publication No. 06-E010. Rockville, MD

Psychiatric Association: anorexia nervosa and bulimia nervosa. However, there is another category listed in the DSM-IV: eating disorders not otherwise specified. This category includes a variety of patients who do not meet all criteria for anorexia nervosa or bulimia nervosa but who have symptoms severe enough to qualify them as having a clinically significant eating disorder. In the United Kingdom, this condition is referred to as 'atypical eating disorders'. Binge-eating disorder is one of many combinations of symptoms that can justify a diagnosis of eating disorder not otherwise specified. Binge-eating disorder is currently being considered as a separate disorder with a unique diagnosis.

Although eating disorders not otherwise specified is the most common category of eating disorder encountered in routine clinical practice, rigorous epidemiological data are lacking for this category of patients. The heterogeneity of eating disorders not otherwise specified results in this category of eating disorder being largely neglected by researchers. However, there is some data on binge-eating disorder: Berkman et al. (2006) state that the mean prevalence of binge-eating disorder is 0.7% - 3% of the community.

According to Berkman et al. (2006), all eating disorders are associated with substantial morbidity and mortality. These potentially fatal disorders can have an impact on disability, productivity and quality of life.

## Prevalence rates of eating disorder with anxiety and depression

Epidemiological reviews suggest that women with eating disorders have higher rates of depression and anxiety disorders than in controls. However, these reviews report a large range in prevalence rates. In studies on co-morbidity published over the past decade, the lifetime prevalence of mood disorders varies considerably: from 24.1% to 90.5% in people with bulimia nervosa and from 31% to

88.9% in those with anorexia nervosa<sup>3</sup>. Similarly the literature reports widely ranging co-morbidity rates of anxiety disorders in patients with eating disorders. The lifetime prevalence of at least one anxiety disorder in people with bulimia nervosa varies from 25% to 75% and from 23% to 54% in people with anorexia nervosa<sup>4</sup>.

While prevalence data varies, studies demonstrate that depression and anxiety is a significant issue for at least one quarter of people with anorexia nervosa and bulimia nervosa. These findings have significant clinical implications.

It has been suggested that given this increased risk of lifetime co-morbidity in patients with eating disorders, clinicians should not only be aware of the likelihood of co-morbidity in patients with eating disorders but should also continue to assess for psychiatric disorders throughout the course of eating disorders treatment<sup>5</sup>. Co-morbidity should be carefully considered in both assessment and treatment planning as some symptoms of eating disorders seem similar to symptoms of other disorders (e.g. major depression and obsessive-compulsive disorder).

## Treatments

The types of treatments available for people with an eating disorder and co-morbid anxiety and depression that were reviewed in the literature and discussed during the qualitative component are:

- Medication
- Re-nutrition
- Cognitive behavioural therapy
- Family therapy (e.g. Maudsley approach)
- Dialectical behavioural therapy
- Interpersonal therapy
- Psychotherapy
- Self help
- Support groups

There is limited evidence about the effectiveness of these treatments for people with co-morbidity

3. Reviewed in Godart 2007, Kaye et al 2004, Herzog and Eddy 2007

4. Reviewed in Godart et al., 2002; Pallister and Waller, 2008

5. Herzog and Eddy, 2007

of eating disorders with anxiety and depression. No systematic reviews specifically addressing treatment for co-morbidity of eating disorders with anxiety and depression were identified. However, longitudinal studies generally indicate that increased co-morbidity is associated with a more severe outcome and increased treatment seeking.

The literature provides little guidance on how co-morbidity should be addressed in the treatment of individuals with eating disorders. For example it is not clear whether the eating disorders should be targeted first. Are there certain co-morbid disorders that should be targeted first to facilitate eating disorders treatment? Or should eating disorders and co-morbidity be addressed simultaneously in treatment?

One study suggests that if co-morbidity is secondary to the eating disorder then symptomatic improvement in the eating disorder may correspond to improvement of co-morbidity<sup>6</sup>. Some investigators have suggested that effective treatment for individuals with an eating disorder should address the underlying variable that may have contributed to the development and maintenance of the eating disorder and psychiatric co-morbidity<sup>7</sup>.

Woodside and Staab (2006) outline some general approaches and basic premises to be considered in treating co-morbidity in eating disorders. They stress that the effects of starvation have a profound effect on mood and cognition. Accordingly minimal change can be expected during treatment of co-morbid conditions if the patient is still starved.

## Depression

The first problem in treating depression in people with an eating disorder is in accurately diagnosing depression. It is extremely difficult to make an accurate diagnosis of depression in either anorexia nervosa or bulimia nervosa due to the confounding effects of starvation. In anorexia nervosa, most

patients will identify their mood as abnormal and often use the word 'depressed'. However, more careful investigations often reveal 'empty mood' or extreme lability of mood. In bulimia nervosa the most common presentation is labile mood, often with suicidality.

Woodside and Staab (2006) caution that resolution of mood symptoms is unlikely without concurrent resolution of the eating disorder. They also identify absorption of medication as another significant issue especially among patients with purging behaviours. According to reviews, there is a significant role for cognitive therapies for depression in these patients. However, there is no evidence to suggest that cognitive behavioural therapy is a superior treatment compared with pharmacological treatments.

## Anxiety Disorders

Woodside and Staab (2006) discuss treatment challenges for people with co-morbid eating disorders and anxiety disorders. They point out that, as is the case with mood disorders, the treatment of obsessive-compulsive disorder is generally not effective in people who are nutritionally compromised. Once changes in core symptoms have begun to occur, treatment with modern antidepressants is, in their view, the first line of treatment.

The table on the opposite page summarises suggested treatment approaches for co-morbidity of eating disorders with mood and anxiety disorders.

## Other key literature review findings

1. Anorexia nervosa and anxiety disorders
  - Anxiety in people with anorexia nervosa manifests in several forms - most commonly generalised anxiety disorder, obsessive compulsive disorder and social phobia.
  - Presence of anorexia nervosa significantly increases patients' risk of also suffering from a co-morbid anxiety disorder.

6. Ro et al., 2005

7. Western and Harnden-Fisher, 2001

**Table 1: Common areas of co-morbidity in eating disorders, and their treatment**

Condition	Lifetime prevalence estimate as a co-morbid condition	Treatment approach and cautions
Depression	Up to 75%	Antidepressants; cognitive therapy
Bipolar Disorder	10%	Anti-manic agents - be aware of effect of purging behaviours
Obsessive-compulsive disorder	40%	Antidepressants plus atypical antipsychotics as augmentation agents; cognitive therapy
Panic disorder	11%	Antidepressants; cognitive therapy
Social anxiety disorder/social phobia	15-20%	Cognitive therapy
Post-traumatic stress disorder	Prevalence varies with severity of eating disorder	Specialised trauma treatment - beware of excessive use of anxiolytics
Substance use disorders	15-40%, highest in BN	Concurrent treatment for eating disorder and substance use disorder most effective

Woodside, B., & Staab, R. (2006) *Management of Psychiatric Co-morbidity in Anorexia Nervosa and Bulimia Nervosa CNS Drugs, 20(8), p 662*

- Over half of women with anorexia nervosa report the life-time presence of an anxiety disorder.
  - Most common co-morbid anxiety disorders are generalised anxiety disorder, obsessive compulsive disorder and social phobia.
  - Most studies indicate that the onset of anxiety disorders usually precedes the onset of anorexia nervosa.
2. Anorexia nervosa and depression
    - Women with anorexia nervosa commonly reveal depressed or flat affect, feelings of hopelessness and guilt, a sense of worthlessness, low self-esteem, insomnia, suicidal ideation and suicidal attempts.
    - Major depression is the most commonly observed psychiatric disorder in women with anorexia nervosa.
    - Clinical samples report a wide range of estimates (20-80%) for the percentage of women who report at least one episode of major depression at some time in their life.
    - Retrospective studies report onset of anorexia nervosa occurs both before depression and vice versa.
    - Several medium and long-term outcome studies suggest that depression may persist even after recovery from anorexia nervosa.
  3. Bulimia nervosa and anxiety disorders
    - The most commonly observed co-morbid anxiety disorders in women with bulimia nervosa are social phobias and general anxiety disorders.
    - The most rigorous studies suggest the presence of lifetime anxiety disorders in well over half of women with bulimia nervosa in both clinical and community samples.
    - Anxiety disorders predate the emergence of bulimia nervosa in the majority of cases.
  4. Bulimia nervosa and depression
    - Individuals with bulimia nervosa-associated major depression have different depressive features compared to individuals with depression.
    - Chronology of presentation occurs both ways; depression prior to bulimia nervosa and vice versa.
    - Some individuals with bulimia nervosa continue to experience depression after recovering from the eating disorder.
    - Women with bulimia nervosa respond to antidepressant medication.

## Eating disorder organisations

The research identified ninety organisations around Australia that provide resources/services for people with eating disorders, including urban, regional and rural organisations. Some organisations focus solely on people with eating disorders, others include eating disorders as part of their work. A contact list, including the name of a contact person from each organisation, is provided at the end of the report. These organisations are categorized as:

- National organisations
- Public hospitals
- Private hospitals and clinics
- Community, Divisions of General Practice and other Health Services
- Foundations/Associations
- Universities/Centres
- Support Groups
- For profit non government health services
- Not for profit government health services

A brief questionnaire was designed to scope the services and resources provided by agencies working with people with eating disorders (Appendix 1). This questionnaire was sent to thirty-nine organisations. A 'snowball effect' also occurred in which a representative passed on the questionnaire to colleagues in other organisations. A total of thirty-two completed questionnaires were received and analysed. The following section reports some of the key findings from the questionnaire, including its limitations.

### Limitations

- Some participants described the questionnaire as "not brief" and indicated that they would have liked more time to provide a more detailed response.
- Several participants expressed difficulties with the diagnostic criteria of co-morbidity of an eating disorder with anxiety and depression.

- This project focused on non clinical services. Self-help groups and general counselling groups are therefore reported in more depth than the hospital based treatment settings. The narrow sampling should not be seen to be representative (Michael Baigent, personal communication, 2008).
- Generally speaking, the more severely affected as well as those less severely affected are treated in hospital based treatment settings (Michael Baigent, personal communication, 2008).

### Resource Availability

Question 1 asked participants to describe the resources that their organisation has available for people with an eating disorder who experience anxiety and depression. They indicated that they had only limited resources that specifically address co-morbidity of an eating disorder with anxiety and depression. Participants stated that access to resources that specifically assist people with an eating disorder who experience anxiety and depression would be welcomed.

The range of resources currently available includes:

#### Talking therapies

- Cognitive Behavioural Therapy
- Counselling
  - Individual
  - Family (e.g. Maudsley Approach<sup>8</sup>)
- Psychotherapy
- Psychoeducation

#### Medical and complementary therapies

- Medication
- Naturopathy

#### Group work

- Art therapy
- Music therapy
- Expressive therapies

8. The Maudsley approach is as an intensive outpatient treatment in which parents play an active role

### Relaxation therapies

- Experiential mindfulness techniques
- Breathing strategies

### Information

- Referrals
- Phone support
- Internet resources (including internet delivered interventions)
- Library resources
- Eating Services Directory (Community Nutrition Unit and EDNA network, DHHS, 2005)

### Self management strategies

- Guided self help
- Centre for Clinical Interventions Self Help Program

### Usefulness of Resources

Question 2 asked which of these resources were most useful, and why. Several participants described the importance of support groups. In addition, many participants listed resources from Eating Disorders Foundation of Victoria (EDFV). EDFV has a large range of resources listed on their website - books, videos, posters, booklets, brochures, and professional information. These resources were described as useful, depending on the situation and knowledge of the service user. However, many of these resources do not specifically target the issue of anxiety and depression.

Several participants stated that they would be interested in receiving a list of resources that other organisations find the most useful. They described not having the time (or staff) to do this research themselves. Research Matters has made a list of available resources (e.g. books, Fact Sheets). This is provided in Appendix 2, together with information about how they can be either purchased or downloaded free of charge from the internet.

### Carer Information

Question 3 asked participants to describe resources for non-professional carers of people with an eating disorder who experience anxiety and depression.

The following resources were identified, but, again, these resources are mostly for eating disorders in general rather than specifically for co-morbidities of eating disorders and anxiety and depression:

- Telephone and email support
- Referral
- Counselling (both individual and group)
- Friends and relatives support groups
- Family information nights
- Library resources
- Newsletters
- Internet
- Carers Retreats
- Information sheets (e.g. Fact Sheets)
- Handouts describing signs/symptoms and ways they can help.
- Psychoeducation for parents of young people with an eating disorder
- Books

### Information for professionals

Question 4 asked participants to describe resources for professionals. Several organisations stated that they provide resources for clinicians (GPs, dieticians, psychologists, psychiatrists and social workers). For example, the Centre of Excellence in Eating Disorders has a manual for GPs: "Eating Disorders Resource for Health Professionals: A manual to promote the early identification, assessment and treatment of eating disorders." (2004).

In addition, Eating Disorders Foundation of Victoria publishes books to assist other professionals (e.g. school counsellors, sports coaches). These books focus on the identification, early intervention, support and prevention of eating disorders.

### Effective treatments

Question 5 asked participant to describe the treatments/programs that they consider to be the most effective for people with an eating disorder who experience anxiety and depression.

Most participants said that there was little research evidence to support their claims about

effective treatments. Responses about effective treatments were frequently couched in terms of “my best guess,” or “it seems to be worthwhile to give [insert treatment] a go.” However, ‘guided self help’ (e.g. Centre for Clinical Interventions Self Help Program) was described as based on current evidence-based best practice.

Several participants stressed the importance of “integrating services” to treat the co-morbidity of eating disorders with anxiety and depression. They stated that it was important to have a multi-disciplinary team “on-site”. Participants described multi-disciplinary teams including physicians (e.g. paediatricians), dietitians, clinical psychologists, psychiatrists, social worker, teacher, art and music therapists and physiotherapy, as required.

In terms of training, several organisations provide training to health care professionals on eating disorders, though only a few explicitly referred to training in co-morbidity of eating disorders with anxiety and depression. Royal Brisbane Hospital Eating Disorders Outreach Service was one of the few organisations that described anxiety and depression as “very much an integral part” of their training.

### Effective strategies

Question 6 asked participants to describe strategies/lifestyles that they consider to be the most effective for people with an eating disorder who experience anxiety and depression. It was generally agreed that an eating disorder with co-existing anxiety and depression can not be resolved without appropriate support from family, friends, community and professionals. However, several participants said that the answer to this question depends on a client’s interests and the degree of impact of their disorders on the individual. It was stated that people need to find what works best for them, and that this is different for different people.

### Gaps in service delivery

Question 7 asked participants to describe any difficulties in the provision of services for people with an eating disorder who experience anxiety

and depression. Participants identified numerous gaps in service delivery. Participants described the lack of financial resources (particularly in rural areas) and inadequate training. Many of the current gaps were attributed, in part, to the increase in the demand for services. For example, a participant said that children/adolescents admitted to the Royal Children’s Hospital (Melbourne, Victoria) with an eating disorder had increased by 250% over the past five years.

In summary, participants identified two key themes in their responses to our questionnaire. These were:

- There are many different treatments available for people with eating disorders, but no consensus on which are the most effective; and
- There are few specific resources available for people with a co-morbid eating disorder and depression/anxiety and their carers.

Both the literature review and organisations who completed the questionnaire suggest that the most effective treatment strategies for co-morbidity of eating disorder and anxiety and depression are those that take a multi-disciplinary and integrated approach.

### Research priorities

Question 8 asked participants which area of research on eating disorders/anxiety and depression should be a priority. A long list of research ideas was generated. Many of these suggestions concern the effectiveness of specific treatments. However, several participants said that they did not read academic literature, and were not aware of recent research.

## Suggestions for improving resources

Recommendations to improve the availability of, and access to, resources for people with an eating disorder who experience anxiety and depression include:

- Developing written and online resources (e.g. Fact Sheets) that deal specifically with co-morbidity of eating disorders with anxiety and depression and ensuring that these are disseminated widely to organisations working in this area.
- Improving education and training of professionals specifically in co-morbidity of eating disorders with anxiety and depression.
- Improving communication between organisations that provide resources for people with an eating disorder who experience anxiety and depression (e.g. centralised newsletter from a co-ordinating body).
- Providing in-service education and training for professionals who provide treatment for people with an eating disorder who experience anxiety and depression.
- Translating epidemiological literature and disseminating current research findings to reduce the theory-practice gap. ❖

# 3

# Methods

## Literature review

A manual and computerised search using MEDLINE, PsychINFO and CINAHL databases and “Google Scholar” was undertaken for all published studies on co-morbidities of eating disorders, anxiety disorders and mood disorders. This search identified 6,000 papers published during the period 2000-2008. The literature review focused on nine key articles.

## Mapping

The following methods were used to locate representatives from ninety eating disorder organisations around Australia:

- Internet search
- White/Yellow pages
- Snowballing (representatives passing on questionnaire to colleagues in other organisations)<sup>9</sup>

- Information from *beyondblue*'s clinical advisor

Information about each organisation was obtained from the internet. In some cases, this information was later updated by representatives from respective organisations.

A representative from 39 organisations was contacted, and then invited to complete a questionnaire (Appendix 1). This resulted in thirty-two completed questionnaires, a response rate of 82%.

## Professionals

To assist in the identification of resources for professionals, a rural GP, dietitian, school counselor, sports coach, and volunteer were asked to describe resources that they use to assist them to support people with an eating disorder who experience anxiety and depression. ❖

9. Unsolicited responses to the questionnaire were received from five organisations, two of which withdrew.

# 4

# Literature Review

The literature review in this report is not a systematic review but rather a descriptive summary of the key literature, including systematic reviews.

Our literature review focuses on two questions:

1. What is the prevalence of co-morbidity of anxiety disorders, mood and depression and eating disorders?
2. What are the current treatment approaches for this co-morbidity and which are more efficacious?

The literature review is presented in 4 sections:

1. Overview from recent literature reviews of the clinical manifestations and prevalence of eating, mood and anxiety disorder co-morbidity.
2. A summary of different theories present in the current literature to explain the aetiology of these co-morbidities.
3. A comprehensive summary of recent studies on prevalence including references.
4. A summary of recent systematic reviews of treatment approaches for co-morbidity and their efficacy.

## Methodological issues

Systematic literature reviews exclude all but the most rigorous and methodologically reliable results in their analyses. Many published studies on eating disorders are excluded from systematic reviews due to their methodological limitations. These limitations include small sample sizes, and problems with diagnostic criteria. Diagnoses were often made by clinical or semi-structured interview - occasionally diagnosis relied solely on questionnaires (e.g. EDE-Q). Few studies

used a diagnostic instrument (or, if a diagnostic instrument was used, there were differences in diagnostic instruments used over time). In addition, changes of diagnostic criteria for eating, mood and anxiety disorders over the past 15 years have had an impact on patient selection and co-morbidity findings. In addition some researchers make their own alterations to usual diagnostic criteria. As a result, inclusion and exclusion criteria vary in the literature.

Other methodological problems with many studies on eating disorders are the lack of representativeness and generalisability of the research findings. According to the systematic reviews, this is due to a failure to report refusals to participate, inclusion of both male and females in some reports, longitudinal studies with loss of follow up and lack of a control group or control groups are not matched for age, gender or socio-economic status. Many studies use samples of referred patients including both inpatients or outpatients, or both. However, the use of 'treatment seeking' samples can overestimate co-morbidity. In addition, these patient groups can not be considered together as inpatients are likely to have more severe eating disorders and higher rates of mood and anxiety disorders than outpatients.

## Limitations of Literature Review

Although eating disorders not otherwise specified is the most common category of eating disorder encountered in routine clinical practice, there is hardly any reliable epidemiologic information available for this category of patients. Eating disorders not otherwise specified is an eating pattern that does not meet all the criteria for

anorexia nervosa or bulimia nervosa (in the UK this condition is referred to as atypical eating disorders). This diagnosis is defined very loosely and covers many combinations of symptoms. The heterogeneity of eating disorders not otherwise specified results in this category of eating disorder being largely neglected by researchers<sup>10</sup>.

## Overview of recent reviews of co-morbidity

This section is substantially based on the work of Bulik (2002), Kaye et al. (2004), Godart et al. (2002, 2007) and Pallister and Waller (2008). See bibliography for full citations.

### Anorexia Nervosa and Anxiety Disorders

#### Clinical Background

Anxiety in anorexia nervosa manifests in several forms. During the acute phase of illness, women with anorexia nervosa are persistently anxious about issues related to shape, weight or food. Slight increases in weight or breaking of rigid dietary rules result in severe anxiety. Parallels have been drawn with obsessive-compulsive disorder, because individuals with anorexia nervosa display preoccupation with food, eating, weight and exercise. Retrospective clinical information suggests that women with anorexia nervosa have premorbid obsessional traits that become exaggerated during the acute phase of the illness, possibly secondary to starvation. Outcome studies indicate that those who remain ill retain high scores on obsessional indices, whereas for people who recover from anorexia nervosa, these scores are similar to those of health controls.

#### Nature of Co-morbidity

Both clinical and epidemiological data support substantial co-morbidity between anorexia nervosa and anxiety disorders. Clinical studies consistently report high rates of anxiety disorders in women with anorexia nervosa. The most methodologically sophisticated studies suggest that over half of

women with anorexia nervosa report the lifetime presence of an anxiety disorder- most commonly these are generalised anxiety disorder, obsessive compulsive disorder and social phobia. Most studies indicate that the onset of anxiety disorders usually precedes the onset of anorexia nervosa. However, it is not clear whether this pattern of onset reflects the natural course of the two disorders (i.e. the average age of onset of some anxiety disorders is younger than the average age of onset of anorexia nervosa) - or it may indicate that childhood anxiety is a pathway toward the development of anorexia nervosa.

Clinical samples may artificially identify significant associations that do not exist in the community because of 'differential referral'. With co-morbidities, there is a selection bias due to fact that individuals with both an eating disorder and a co-morbid disorder are more likely to seek treatment than those with an eating disorder alone. However epidemiological studies provide estimates of co-morbidity that are not confounded by treatment seeking. In a population based sample of over 2,000 female twins, statistical measure of associations for general anxiety disorders, phobias and panic disorder were significantly elevated in women with anorexia nervosa (although definitions of anorexia nervosa varied in stringency). According to this twin study, presence of anorexia nervosa significantly increases patients' risk of also suffering from a co-morbid anxiety disorder.

### Anorexia Nervosa and Depression

#### Clinical Background

Clinical observations of women with anorexia nervosa commonly reveal depressed or flat affect, feelings of hopelessness and guilt, a sense of worthlessness, paralysing low self-esteem, insomnia, suicidal ideation and suicidal attempts. These symptoms increase with increasing severity of the eating disorder. Baigent (2008) describes a 'spectrum' (personal communication). He states that people with anorexia nervosa have different

10. Fairburn C Bohn K (2005) Eating disorder NOS (EDNOS): an example of the troublesome "not otherwise specified" (NOS) category in DSM-IV Volume 43, Issue 6, Pages 691-829

cognitive processes and physical symptoms depending on the severity of the eating disorder.

Retrospective studies report that both patterns of onset occur - anorexia nervosa before depression and vice versa. Although depressed mood can occasionally improve with improved feeding, several medium and long-term outcome studies suggest that depression may persist even after recovery. In addition to the frequent co-morbid pattern, family history studies have shown that relatives with anorexia nervosa are at significantly greater risk for major depression than relatives and healthy controls.

### Nature of Co-morbidity

Studies have investigated the association between anorexia nervosa and major depression using structured psychiatric diagnostic instruments. In clinical samples, these studies report a wide range of estimates (20-80%) for the percentage of women who report at least one episode of major depression at some time in their life. There are few epidemiological studies on this association due to the rarity of anorexia nervosa in the general population. However, existing studies suggest that major depression is the most commonly observed psychiatric disorder in women with anorexia nervosa.

The nature of this association has been explored using twin studies. This approach allows investigation of the extent to which shared genetic and shared environmental factors contribute to the development of each disorder. The results of these studies suggest both - that unique sets of genes contribute independently to anorexia nervosa and depression, and also a shared genetic component - indicating that some genes contribute to both depression and anorexia nervosa.

## Bulimia Nervosa and Anxiety Disorders

### Clinical Background

The high prevalence of anxiety disorders in women with bulimia nervosa has given rise to a number of aetiological theories. These include:

- The 'anxiety reduction model' which focuses on the potential anxiety relieving

effects (axiolytic effects) of both bingeing and purging behaviours

- Models that liken bingeing and purging to obsessive compulsive behaviours
- Models that focus on heightened social anxiety as a possible cause of body dissatisfaction and bulimic eating behaviours and attitudes.

Clinically the most commonly observed co-morbid anxiety disorders in women with bulimia nervosa are social phobias and general anxiety disorders.

### Nature of Co-morbidity

The most rigorous studies using structured diagnostic tools suggest the presence of lifetime anxiety disorders in well over half of women with bulimia nervosa in both clinical and community samples. Anxiety disorders predate the emergence of an eating disorder in the majority of cases. These findings have led some researchers to suggest that early-onset anxiety disorder may be a causal factor for bulimia nervosa. Genetic epidemiological studies have explored the nature of the association between bulimia nervosa and general anxiety disorders, phobias, panic disorder, major depression and alcoholism. The reports have identified shared genetic factors across bulimia nervosa, phobias and panic disorders suggesting that bulimia nervosa is part of the genetic family of anxiety disorders.

## Bulimia Nervosa and Depression

### Clinical Background

Depression is common in women with bulimia nervosa. Psychometric data suggests that individuals with major depression have different depressive features compared to individuals with bulimia nervosa-associated depression. Like anorexia nervosa, the chronology of presentation occurs both ways; depression prior to bulimia nervosa and vice versa. Some individuals with bulimia nervosa continue to experience depression even after recovering from the eating disorder. Further, relatives of women with bulimia nervosa are at significantly greater risk for

depression than healthy women. While treatment responses do not necessarily reflect aetiology, an association between bulimia nervosa and depression has been inferred from the observation that women with bulimia nervosa respond to antidepressant medication.

### Nature of Co-morbidity

Clinical samples of women with bulimia nervosa have routinely reported high prevalence of lifetime co-morbid mood disorders. These high rates have been shown to be in part overestimated as a result of Berkson's bias (also called admission rate bias)<sup>11</sup>. For example, studies comparing women with bulimia nervosa from clinical samples with a randomly selected population sample of group of women with bulimia nervosa found that the prevalence of mood disorders in the clinical sample to be significantly higher. However the prevalence of depression in the community sample of women with bulimia nervosa was still significantly higher than the rates of depression in population-based controls. Other population based studies have consistently reported that depression is the most commonly observed co-morbid condition in women with bulimia nervosa.

The nature of the association between bulimia nervosa and depression has been investigated directly using twin studies. As with the twin study of study of depression and anorexia nervosa, results reveal a moderate genetic correlation between bulimia nervosa and major depression - suggesting either the presence of some genes that predispose to both disorders or a shared genetic effect. The results also suggest that bulimia nervosa and depression are not the result of the same environmental risk factors predisposing to both disorders.

### Overview of current models explaining aetiology of co-morbidity

This section is substantially based on the work of Bulik (2002), Godart et al. (2002, 2007) and Pallister and Waller (2008). See bibliography for full citations.

The relationship between eating disorders, mood disorders and anxiety disorders is currently unclear. Several different types of arguments and models in favour of a link between these categories of disorders have been put forward. Of the many possible models of co-morbidity, five are particularly plausible to explain the relation among eating mood and anxiety disorders, each of which gives rise to unique predictions.

### Models

**Model A** proposes that eating disorders are sequelae of depression and anxiety and that eating disorders produce or exacerbate mood and anxiety disorders. It predicts that a pattern of onset in which depression or anxiety manifest prior to the onset of eating disorders and either cause or exacerbate eating disorders.

**Model B** is the converse of model A and proposes that depression and anxiety are a sequelae of eating disorders. It predicts that depression and anxiety would not be apparent in individuals with eating disorders prior to the development of an eating disorder. Barring any permanent scarring effect, this model predicts the alleviation of anxiety and depression with recovery from the eating disorder.

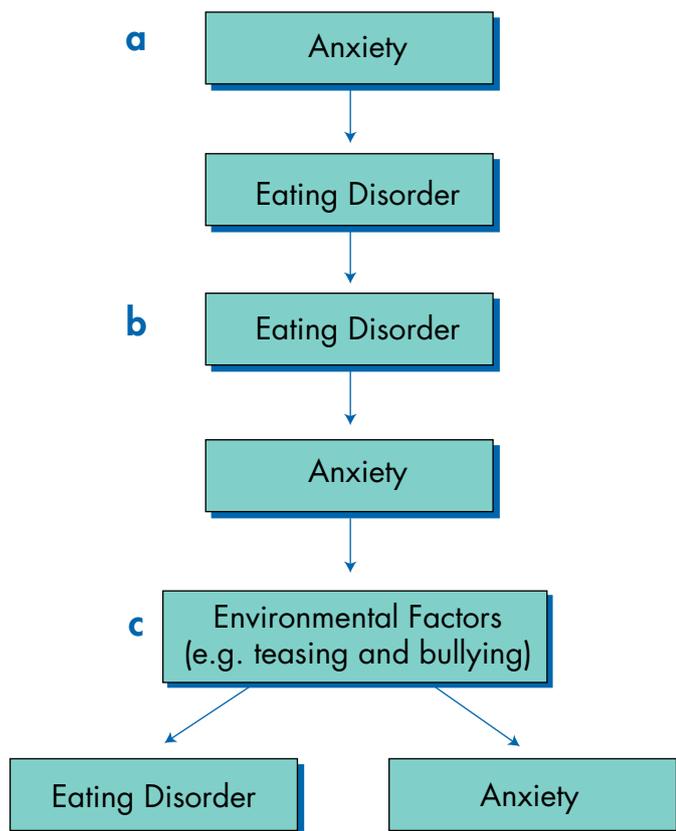
**Model C** proposes that eating, mood and anxiety disorders are unique sets of conditions they may share some vulnerabilities and aetiological factors. This model makes no predictions about whether the eating, depressive or anxiety disorder manifests first but predicts the existence of both shared and independent aetiological factors across the disorders.

The diagram opposite is from a recent review by Pallister and Waller (2008). It is helpful in conceptualising these three different models explaining co-morbidity of eating disorder and depression and anxiety disorders. Although Pallister's paper focuses on eating disorder with co-morbidity of anxiety disorder only, the same models have been proposed for co-morbidity with depression.

**Model D**, the 'forme frustes' (i.e. an incomplete or unusual form of a disease), proposes that eating

11. The concept underlying this bias is that patients with more than one disease or condition are more likely to seek clinical care than patients with only one disease or condition thereby artificially inflating the co-morbidity rates observed in clinical sample.

Figure 1: Possible phenomenological links between anxiety and eating disorders (from Pallister and Waller, 2008).



disorders are a form of mood or anxiety disorders. Eating disorders may be age and gender specific manifestations of depression or anxiety with completely shared aetiological factors. This model suggests that anxiety or depression is an expression of underlying depressive or anxiety disorders.

**Model E** proposes that eating, anxiety and mood disorders are different expressions of the same underlying casual factor (e.g. neuroticism or neuroendocrine disturbances). According to Model E, people with a neuroendocrine disturbance might develop an eating, anxiety and/or mood disorder.

### Aetiology of Co-morbidity

Reviews of the current literature draw tentative conclusions regarding the nature of the co-morbid relationship among eating mood and anxiety disorders. There is little evidence to support the theory that depression and anxiety are simply sequelae of eating disorders (model B). The strongest counter-evidence to this hypothesis is the frequent observation that depression and

anxiety disorders predate the onset of both anorexia nervosa and bulimia nervosa.

There is reasonable support for the notion that anxiety may represent a pathway of risk for the development of eating disorders in a substantial number of cases (model A).

There is little support for idea that anorexia nervosa or bulimia nervosa represents a 'forme fruste,' an incomplete or unusual form of anxiety disorders or depression (model D). These disorders are not universally co-morbid and genetic epidemiological studies do not confirm the hypothesis of a single shared causal factor.

Support for model E is less clear. Further research is required to determine whether a single causal mechanism predisposes individuals to each of these sets of disorders.

According to some researchers there is some evidence of shared genetic factors among eating disorders, mood disorders and anxiety disorders and the most compelling model is model C because it allows for the existence of both shared and specific causal factors.

## Prevalence

This section provides a more comprehensive summary of recent literature on prevalence of co-morbidity, including references. It begins by summarising recent studies investigating the co-morbidity of eating disorders and anxiety disorders (based on Pallister and Waller, 2008). It then provides a summary of co-morbidity studies of eating disorders and mood disorders (based on Godart et al., 2007).

### Co-morbidity of eating disorders and anxiety disorders

#### Co-morbidity with generalised anxiety disorder

According to DSM-IV (American Psychiatric Association, 1994), generalised anxiety disorder is characterised by excessive anxiety and worry on a variety of topics, occurring on more days than not for at least six months.

Some studies have reported high rates of general anxiety disorder amongst women with an eating

disorder. However, as noted by Godart, Flament, Perdereau, and Jeammet (2002), there are wide variations in the estimated prevalence rates of general anxiety disorder across eating disorder studies. In their review of anxiety co-morbidity in eating disorders, Godart et al. (2002) highlight the heterogeneous nature of the samples, methods, and results of previous research on general anxiety disorders, and suggest that it is difficult to come to any firm conclusions about prevalence rates.

In response, Godart, Flament, Curt, Perdereau, Lang, Venisee et al. (2003) designed another controlled study, in which a larger sample size was used (271 women with a current eating disorder diagnosis, and 271 matched controls from the community). They investigated a range of DSM-IV co-morbid anxiety disorders in this study, including general anxiety disorder. Godart et al. (2003) reported significantly higher lifetime prevalence rates for general anxiety disorders amongst referred women with anorexia nervosa compared to controls (48.6% in the restricting subtype compared to 3.6% amongst matched controls, and 45.4% in the binge/purge subtype compared to 10.9% amongst matched controls). They also reported significantly higher rates of general anxiety disorders amongst women with bulimia nervosa of the purging subtype (32.6% compared to 7% amongst matched controls). There were too few women with bulimia nervosa of the non-purging subtype to detect differences in the rates of particular anxiety disorders.

Despite the fact that the above findings are not entirely consistent, general anxiety disorder appears to be a relatively common co-morbidity amongst eating disorder samples. Moreover, the results suggest that general anxiety disorder is associated with the full range of eating pathologies, and is not just associated with particular behaviours such as purging, bingeing, or restriction.

### Co-morbidity of eating disorders with social phobia

Social phobia is characterised by a fear of social or performance situations owing to excessive concern over negative evaluation by others (DSM IV; American Psychiatric Association, 1994).

A number of studies have demonstrated associations between social phobia and eating disorders. For example, Godart et al. (2003) observed similarly high lifetime and current rates of social phobia amongst their clients with eating disorders, and reported that social phobia was the most frequent anxiety disorder in bulimia nervosa (lifetime prevalence of 36.0% in the purging subtype compared to 8.1% amongst matched controls, and 36.8% in the nonpurging subtype; though this group was too small to detect differences with the controls).

Social phobia was also the second most frequent anxiety disorder in anorexia nervosa (lifetime prevalence rates of 37.8% in the restricting subtype compared to 5.4% amongst matched controls, and 41.8% in the binge/purge subtype compared to 12.7% amongst matched controls).

Similar results have also been found in community based studies. For example, Garfinkel et al. (1995) found significantly different prevalence rates between individuals with eating difficulties and those without (45.5% in women with full-syndrome bulimia nervosa, 54.5% in women with partial-syndrome bulimia nervosa, and 15.2% amongst controls). However, not all studies have reported this pattern of results. For example, whilst Bulik, Sullivan, Fear, and Joyce (1997) found a significantly higher rate of social phobia amongst women with bulimia nervosa (30.2%) compared to normal controls (6.1%), they did not find an increased rate amongst women with anorexia nervosa (5.9%). Bulik et al. (1997) acknowledge that this latter finding is inconsistent with other co-morbidity studies. By way of explanation, they propose that despite an increased vulnerability, social phobia may not be expressed in women with anorexia nervosa because situations that provoke social anxiety are typically avoided. Consequently, they suggest that the low prevalence rate reported might reflect a lack of social interactions rather than a lack of social anxiety. It should be noted that the two eating disorder groups in this study were selected using quite different methods. Whilst the bulimia nervosa group consisted of consecutive referrals to an outpatient treatment trial (for bulimia nervosa), the anorexia nervosa

group were identified and contacted on the basis of a retrospective review of clinical files. It is possible that this group of women with anorexia nervosa was therefore 'atypical' in some way.

### Co-morbidity of eating disorders with obsessive-compulsive pathology

The main feature of obsessive-compulsive disorder is the occurrence of persistent and time-consuming obsessions or compulsions (DSM IV; American Psychiatric Association, 1994). Obsessions may be inappropriate and intrusive thoughts, impulses, or images (such as concern over contamination). Compulsions are repetitive behaviours (either overt or covert), whose goal is to prevent or reduce anxiety or distress.

In their review of obsessive-compulsive disorder and anorexia nervosa, Serpell, Livingstone, Neiderman, and Lask (2002) conclude that a substantial number of clients with anorexia nervosa display current obsessive and compulsive features, with an even greater proportion meeting obsessive-compulsive disorder criteria during their lifetimes. Godart et al. (2002) report that obsessive-compulsive disorder has been the most extensively studied anxiety disorder in eating disorder samples, with significantly higher co-morbidity rates consistently reported in clinical samples compared to controls. For example, Halmi et al. (1991) report a lifetime prevalence rate of 25.8% amongst women with a history of anorexia (followed up after ten years) compared to 6.5% amongst controls. However, other research in this area suggests that increased obsessive-compulsive disorder prevalence is more consistently related to restrictive eating pathologies. For example, Godart et al. (2003) found significantly higher lifetime rates of obsessive-compulsive disorder in women with anorexia nervosa compared to controls (24.3% in the restrictive subtype compared to 2.7% amongst matched controls, and 23.6% in the binge/purge subtype compared to 5.4% amongst matched controls). However, they did not find significant differences between women with bulimia nervosa and controls. Whilst they found obsessive-compulsive disorder prevalence rates of 16.7% in women with non-purging bulimia nervosa, this

was based on a small sample size (N=19) and was therefore not significantly different to matched controls (5.3%). Among women with bulimia nervosa of the purging subtype, the lifetime prevalence rate for obsessive-compulsive disorder was 9.4%, which was again not significantly different to matched controls (3.5%). Bulik et al. (1997) reported a similar pattern of results, finding a significantly higher prevalence rate for obsessive-compulsive disorder among women with anorexia nervosa (16.2%) compared to women with bulimia nervosa (3.5%), and community controls (2%).

Despite finding a higher rate of eating disorders amongst anxious clients, Becker et al. (2004) did not find that obsessive-compulsive disorder contributed unique variance in their regression analysis. In light of this, they suggest that researchers should consider that apparent relationships between obsessive-compulsive disorder and eating disorders might be due to other co-morbid anxiety disorders, rather than being due to obsessive-compulsive disorder per se.

In summary, it appears that obsessive-compulsive disorder has been more clearly associated with restrictive eating disorder presentations, as opposed to more bulimic presentations.

### Conclusion

Whilst the co-morbidity literature is certainly not entirely consistent, the evidence reviewed suggests that women with eating disorders do have higher rates of anxiety disorders compared to controls. In particular, higher rates of generalised anxiety disorder, social phobia, and agoraphobia appear to be associated with all types of eating pathology. On the other hand, obsessive-compulsive disorder has been more consistently associated with restrictive eating pathologies.

The majority of studies reviewed were based on clinical samples, which means that co-morbidity might be over represented. In addition, clinicians may be more likely to refer individuals with multiple diagnoses. However, whilst these factors might limit the generalisability of clinical co-morbidity studies to community samples, they are likely to give an accurate representation of the

levels of co-morbidity typically seen in routine clinical practice.

## Co-morbidity of eating disorders and mood disorders

### Co-morbidity with major depressive disorder

The lifetime rate of major depressive disorder for patients referred with anorexia nervosa and bulimia nervosa is between 50% (Laessle et al 1989) and 71.3% (Herzog 1999). This prevalence rate is significantly higher than the lifetime rate of major depressive disorder in controls. In addition, studies in which participants are inpatients or outpatients (i.e. 'referred sample') estimate the lifetime prevalence of major depressive disorder in patients with anorexia nervosa (restricting type) to be between 9.5% (Laessle et al., 1989) and 64.7% (Herzog et al., 1999).

The current prevalence of major depressive disorder in seven follow-up studies of people with anorexia varies from 2.2% to 35.3%, and differs significantly from that in controls in one of three of the controlled studies. In the community, the lifetime prevalence of major depressive disorder is found to be 2.6 to 4 times higher in anorexia nervosa than in control subjects.

In 12 studies of referred bulimia nervosa[*o*] subjects, the range of lifetime prevalence estimates for major depressive disorder varies in inverse proportion to the number of subjects included in the sample. The range in the smallest samples is 20% to 80% while it is 60.7% to 70% in the five of 12 samples that include more than 50 patients (Godart, 2007). Four controlled studies find significantly lower prevalence in controls. In the community, the lifetime prevalence of major depressive disorder ranges from 30% to 51% in bulimia nervosa or "partial bulimia nervosa syndrome". Current prevalence is 20% for bulimia nervosa and 18.2% for partial bulimia nervosa syndrome. Both lifetime and current prevalence in bulimia nervosa or partial bulimia nervosa syndrome are significantly higher than in controls in all studies (Godart, 2007; Herzog and Eddy, 2007).

### Co-morbidity with bipolar disorder

Bipolar disorder was assessed only 11 times in 24 studies. In clinical samples, no cases are found in anorexia nervosa (restricting type). In anorexia nervosa and bulimia nervosa, lifetime prevalence bipolar disorder is estimated at 6% for bipolar II disorder and 3% for bipolar I disorder. One outcome study of patients with anorexia nervosa evaluates the lifetime and current prevalence of bipolar disorder at 3.2%, significantly more than controls, while one other study found no cases. Rastam et al. (1995), in a follow-up of their sample over 6.7 years, found no cases, as compared with 6% after 10 years for Ivarsson et al. (2000). For bulimia nervosa, the lifetime frequency of bipolar disorder varies, in eight referred samples, from 0% to 17% (Godart 2007). Inpatients with bulimia nervosa had higher rates of bipolar disorders (36%) than outpatients with bulimia nervosa.

### Co-morbidity across subtypes of eating disorders

Prevalence of mood disorders differs across diagnostic types or subtypes of eating disorders. Research findings are contradictory in the studies examined, sample numbers are very small, and the age of subjects and their outpatient/inpatient status are not taken into account. However, concerning the prevalence of major depressive disorder in anorexia nervosa subtypes (restricting type and binge-eating/purging type), the studies often found no differences except for one. Halmi et al. (1991) found a difference, with major depression occurring more frequently in a group of 62 patients with anorexia nervosa who had at some time engaged in bingeing compared to those who never binged.

In bulimia nervosa, one study found no significant differences in the rates for any disorder between subjects with and without a past history of anorexia nervosa. No differences were found for the lifetime prevalence of mood disorders between current bulimia nervosa and patients with a past history of bulimia nervosa, between bulimia nervosa (purging) and bulimia nervosa (non-purging), between clinical bulimia nervosa and bulimia nervosa from the general population. However, Garfinkel et al. (1996) noted significantly higher rates of major depressive disorder in bulimia nervosa (purging) (64%) than in bulimia

nervosa (non-purging) (24.4%). Two studies found increased presence of depression in bulimia nervosa compared to anorexia nervosa (restricting type); conversely, three other studies found no differences between bulimia nervosa and anorexia nervosa (restricting type) regarding the prevalence of mood disorders (Godart et al., 2007).

## Conclusion

Regarding overall lifetime prevalence of mood disorders, studies on patients with anorexia nervosa who have been referred found rates of around 40%. This is about twice as high as in the community (23.9%; Kessler et al., 1994). However, there are no controlled studies on this subject. In addition, outcome studies show contradictory results.

Major depressive disorder appears significantly more frequently in anorexia nervosa than in controls in all types of studies (clinical population, outcome studies, and general population) but malnutrition is a major factor that is often neglected in studies exploring co-morbidity between eating disorders and depression. However, most of the patients included in clinical studies are extremely malnourished, and it is widely thought that malnourishment leads to depressive symptoms.

There is also a correlation between severity of eating disorder and severity of depression (Herpertz-Dahlmann and Remschmidt, 1993). Although the impact of malnutrition on the presence of depressive symptoms has been widely studied, its impact on depressive co-morbidity has not. It is therefore possible that the present (and lifetime) frequency of depressive disorders in malnourished (or previously malnourished) subjects is overestimated due to the many depressive symptoms present. In a group of undernourished people with anorexia nervosa, the current prevalence of depression was about 40% upon entry into the study while it was about 1.9% in a group of people with anorexia nervosa seen 10 years later (Ivarsson et al., 2000). In addition, Ivarsson notes that long-term resolution of the eating disorder was associated with the absence of mood disorder and vice versa. It remains unclear what proportion of major depressive disorder

diagnoses can be seen as an artifact related to malnutrition, or at least to symptom overlap.

A recent review concludes that there is little doubt that bipolar disorder and eating disorders are related, particularly bulimia nervosa and bipolar II (McElroy et al., 2005). On the basis of the study by Ivarsson et al. (2000) 56% of the subjects with anorexia nervosa onset in adolescence had suffered major depressive disorder by the age of 24, but only 6% (or only 11% of subjects with major depressive disorder) with bipolar disorder.

The relative chronology of onset for mood disorders and eating disorders is an element that requires consideration in relation to the links between these disorders. However, in interpreting onset chronology, it is important to consider the following: (i) the average age of eating disorders onset is usually younger in anorexia nervosa (mean=17 years) than in bulimia nervosa (mean=18 years; APA, 1994); (ii) the age of onset for depressive disorder varies according to type of disorder [e.g., major depressive disorder generally starts during adulthood, while depressive disorder appears in childhood (APA, 1994)]. Therefore, it is not certain that the relative chronology of onset between mood disorders and eating disorders derives solely from the natural course of each disorder.

## Treatment approaches for co-morbidity and their efficacy

This section provides a summary of recent systematic reviews of treatment approaches for co-morbidity of eating disorders and anxiety and depression and their efficacy. However, literature on treatment of co-morbid eating disorders, anxiety disorders and mood disorders is sparse. No systematic reviews specifically addressing treatment for these co-morbid disorders were identified for the purpose of this literature review. Conversely, there currently exist over 2,000 titles (dating back to 1990s) addressing the general topic of treatment for eating disorders. However despite this large body of literature, the data on treatment efficacy for eating disorders is of highly variable quality.

A recent systematic review of treatment efficacy for eating disorders was undertaken by the RTI International - University of North Carolina at Chapel Hill Evidence-based Practice Center (RTI-UNC EPC), sponsored by the US Agency for Healthcare Research and Quality (AHRQ). While the RTI-UNC EPC review excludes data from studies that combined diseases (i.e. co-morbidity), it represents one of the most comprehensive evidence-based reports on the management and outcomes related to eating disorders to date.

A summary of the main findings of the RTI-UNC EPC review are presented in this literature review for the purpose of informing treatment strategies for eating disorders in general. Following that summary some general comments based on the few studies addressing treatment of co-morbid eating disorders with anxiety and depression are presented.

### RTI-UNC EPC review

The RTI-UNC EPC review reports on 30 treatment studies for anorexia nervosa, 47 for bulimia nervosa, 25 for binge eating disorder, and 34 outcome studies for anorexia nervosa, 13 for bulimia nervosa, 7 addressing both anorexia nervosa and bulimia nervosa, and 3 for binge eating disorder. This review focused on the following key questions:

1. What is the evidence for the efficacy of treatments or combination of treatments for each of the following eating disorders: anorexia nervosa, bulimia nervosa, and binge eating disorder?
2. What is the evidence of harms associated with the treatment or combination of treatments for each of the following eating disorders: anorexia nervosa, bulimia nervosa, and binge eating disorder?
3. What factors are associated with the efficacy of treatment among patients with the following eating disorders: anorexia nervosa, bulimia nervosa, and binge eating disorder?
4. Does the efficacy of treatment for anorexia nervosa, bulimia nervosa, and binge eating

disorder differ by sex, gender, age, race, ethnicity, or cultural group?

The following is a summary of the authors conclusions based on their extensive and systematic review of treatment approaches for eating disorders.

### Managing patients with medication alone

Managing individuals with anorexia nervosa with medication only is inappropriate, based on evidence reviewed. No pharmacological intervention for anorexia nervosa has a significant impact on weight gain or the psychological features of anorexia nervosa. Although mood may improve with tricyclic antidepressants, this outcome is not associated with improved weight gain. Moreover, medication treatment for anorexia nervosa is associated with high dropout rates, suggesting that the currently available medications are not acceptable to individuals with anorexia nervosa.

For bulimia nervosa, good evidence indicates that fluoxetine (60 mg/day) reduces core bulimic symptoms of binge eating and purging and associated psychological features of the eating disorder in the short term. Based on two studies, the 60 mg dose performs better than lower doses and may contribute to decreased relapse at 1 year; however, patients do not tend to remain on the drug. Preliminary evidence exists for other second-generation antidepressants (e.g. fluvoxamine), an anticonvulsant (topiramate), and a tricyclic antidepressant (desipramine). Preliminary evidence exists that monoamine oxidase inhibitors are associated with decreased vomiting in the treatment of bulimia nervosa, although diet should be closely monitored.

Medication trials for binge eating disorder have focused primarily on overweight individuals with binge eating disorder. In these individuals, desired outcomes are twofold: weight loss and abstinence from binge eating. The majority of medication research for binge eating disorder reflects short-term trials. Preliminary efficacy has been shown for selective serotonin reuptake inhibitors, one serotonin, dopamine, and norepinephrine uptake

inhibitor, one tricyclic antidepressant, one anticonvulsant, and one appetite suppressant. In the absence of abstinence data and long-term follow-up, however, it is not known whether observed changes in binge eating, depression, and weight persist.

### Managing patients with behavioural interventions alone

For adults with anorexia nervosa, there is tentative evidence that cognitive behavioural therapy reduces relapse risk for adults with anorexia nervosa after weight restoration has been accomplished. By contrast, the extent to which cognitive behavioural therapy is helpful in the acutely underweight state is not known, as one study found that a manual-based form of nonspecific supportive clinical management was more effective than cognitive behavioural therapy and interpersonal psychotherapy in terms of global outcomes during the acute phase. No replications of these studies exist.

Family therapy as currently practiced has no supportive evidence for adults with anorexia nervosa and a comparatively long duration of illness. Overall, family therapy focusing on parental control of re-nutrition is efficacious in treating younger patients with anorexia nervosa; these approaches lead to clinically meaningful weight gain and psychological improvement. Although most studies of family therapy compared one variant of family therapy with another, two studies produced results suggesting that family therapy was superior to an individual therapy for adolescent patients with shorter duration of illness.

For bulimia nervosa, evidence for cognitive behavioural therapy is strong. Although interpersonal psychotherapy is also as effective, at 1-year follow-up, based on one study (Fairburn et al., 1991), symptomatic change appears to be more rapid with cognitive behavioural therapy. This factor decreases the time that patients are exposed to the symptoms of bulimia nervosa. Dialectical behavioral therapy and guided imagery both show preliminary promise for patients with bulimia nervosa.

For binge eating disorder, cognitive behavioural therapy decreases the target symptom of binge eating. It does not, as currently delivered, promote weight loss in overweight patients. Dialectical behavioral therapy may hold promise for binge eating disorder patients as well.

### Managing patients with combination interventions

Although many of the medication trials for anorexia nervosa were conducted within the context of basic clinical management, no study that systematically studied medication plus psychotherapy for anorexia nervosa met the reviews' inclusion criteria.

For bulimia nervosa, the combined drug plus behavioral intervention studies provide only preliminary evidence regarding the optimal combination of medication and psychotherapy or self-help. Although some preliminary evidence exists for incremental efficacy with combined treatment, given the variety of designs used and lack of replication, evidence remains weak.

For binge eating disorder, the combination of cognitive behavioural therapy plus medication may improve both binge eating and weight loss outcomes. Sufficient trials have not been done to determine definitively which medications are best at producing and maintaining weight loss in this population. Moreover, the optimal duration of medication treatment for abstinence from binge eating and sustained weight loss has not yet been addressed empirically, yet weight-loss effects of medication are generally known to cease when the medication is discontinued.

### Summary

The anorexia nervosa literature on medications is sparse and inconclusive. Some forms of family therapy are efficacious in treating adolescents. Cognitive behavioral therapy may reduce relapse risk for adults after weight restoration.

For bulimia nervosa, fluoxetine (60 mg/day) reduces core bulimic symptoms (binge eating and purging) and associated psychological features in the short term. Individual or group cognitive behavioural therapy decreases core

behavioral symptoms and psychological features in both the short and long term. How best to treat individuals who do not respond to cognitive behavioural therapy or fluoxetine remains unknown.

In binge eating disorder, individual or group cognitive behavioural therapy reduces binge eating and improves abstinence rates for up to 4 months after treatment; however, cognitive behavioural therapy is not associated with weight loss. Medications may play a role in treating binge eating disorder patients. Further research addressing how best to achieve both abstinence from binge eating and weight loss in overweight patients is needed.

Higher levels of depression and compulsivity were associated with poorer outcomes in anxiety disorders; higher mortality was associated with concurrent alcohol and substance use disorders. Only depression was consistently associated with poorer outcomes in bulimia nervosa; bulimia nervosa was not associated with an increased risk of death. Because of sparse data, no conclusions were reached concerning binge eating disorder outcomes.

### Other systematic review of treatments for eating disorders

The RTI-UNC EPC review supports and extends previous systematic reviews on treatment of eating disorders, including several Cochrane reports. Broadly, Cochrane reviews of anxiety disorders treatment concur that the literature is weak, made no specific recommendations regarding anxiety disorders treatment, and encouraged larger well-designed trials.

For psychotherapy for bulimia nervosa and binge eating, a Cochrane review supported cognitive behavioral therapy for bulimia nervosa,

in individual or group format, and encouraged further study of self-help.

For antidepressant treatment, Cochrane reviewers concluded that single antidepressant agents were clinically effective for bulimia nervosa in comparison to placebo, with greater remission rate but also greater dropouts. No differential effect regarding efficacy and tolerability among the various classes of antidepressants was reported.

Examining combinations of psychotherapy and antidepressants for bulimia nervosa, another Cochrane review reported that combination treatments were superior to psychotherapy alone, that psychotherapy appeared to be more acceptable to participants, and that the addition of antidepressants to psychological treatments decreased the acceptability of the psychological intervention.

In addition, guidelines from the National Institute of Clinical Effectiveness in the United Kingdom concur that anorexia nervosa treatment evidence is weak. The authors assigned high grades to cognitive behavioural therapy for bulimia nervosa and binge eating disorder and to antidepressants for bulimia nervosa. For both bulimia nervosa and binge eating disorder, the guidelines recommended self-help as an initial treatment step.

### Conclusions

Authors of systematic reviews on treatment approaches for eating disorders note that the literature regarding treatment efficacy and outcomes for anorexia nervosa, bulimia nervosa, and binge eating disorder is of highly variable quality. In future studies, researchers must attend to issues of statistical power, research design, standardized outcome measures, and sophistication and appropriateness of statistical methodology. ❖

# 5

## Who's Who in Eating Disorders?

The following section provides a brief description of ninety eating disorder organisations from around Australia. Some of these organisations are dedicated solely to people with eating disorders while other organisations offer services to a range of clients, including those with an eating disorder. A contact list, including the name of a contact person from each organisation, is provided at the end of the report. This list is not exhaustive but serves to provide a snapshot of the services and support organisations available in Australia. Organisations marked with “\*” indicate a completed, or semi-completed, questionnaire. In some cases, the data was collected via a phone interview.

### National organisations

#### 1. Australia and New Zealand Assembly of Eating Disorders (ANZAED)

ANZAED is a multidisciplinary organisation that aims to represent and support the activities of all professionals working in the field of eating disorders and related issues. ANZAED recently undertook a mapping exercise of eating disorder inpatient beds in Australia.

#### 2. Australian Institute of Sport

The Australian Institute of Sport has developed a coach's manual with reference to eating disorders.

#### 3. \*Australian Women's Health Network (AWHN)

The Australian Women's Health Network (AWHN) is the peak organisation for women's health in Australia. AWHN is a not-for-profit network run primarily by volunteers to maintain and advance a national voice on women's health through advocacy and information sharing.

#### 4. Dietitians Association of Australia (DAA)

The Dietitians Association of Australia (DAA) is the national Association of the profession, with branches in each State and Territory. DAA provides a range of publications to keep members informed about the profession and current issues in nutrition and dietetics. These include Nutrition & Dietetics (previously titled the Australian Journal of Nutrition and Dietetics), website, newsletters, conference proceedings, handbooks and pamphlets.

#### 5. \*The Butterfly Foundation

The Foundation is a national based charitable organisation that supports people with eating disorder and their carers through direct financial relief, advocacy and lobbying, awareness campaigns, health promotion and early intervention work. The foundation also provides professional training in primary and secondary schools.

## Victoria

### Public Hospitals

#### 6. \*Austin Health, acute psychiatric unit

The acute psychiatric unit is a general psychiatric unit containing nine beds allocated for eating disorders. According to the unit manager, these beds are not used exclusively for people with eating disorders, but also for people with anxiety and depression, bipolar disorder and obsessive compulsive disorder (personal communication).

#### 7. Frankston Hospital

Frankston Hospital has one bed in an inpatient unit. The inpatient unit has a short term medical re-feeding program for children and adolescents

less than 16 years of age. Individual nutrition counselling for all patients with eating disorders is provided by a dietitian.

#### 8. Geelong Clinic

A 32-bed hospital with an inpatient eating disorder program. Patients are admitted under the supervision of a consultant psychiatrist. The eating disorder inpatient program is a specialised 40 day program that has been developed and designed to provide a comprehensive treatment program delivered by trained staff and tailored to the needs of individual clients. The program has been developed on the "LEAP philosophy". The Geelong Clinic also has a Day Program.

#### 9. \*Royal Children's Hospital Adolescent Unit

The Centre for Adolescent Health is an outpatient setting that is separate to the main Royal Children's Hospital. The Healthy Eating Program at the Centre for Adolescent Health is a state-wide service that offers assessment, consultation and treatment services to young people (11 - 17 years old) with a variety of eating concerns. The team involves an adolescent physician, specialist nutritional support and individual and family therapy. The focus is on outpatient management but when necessary, inpatient care is provided at the Royal Children's Hospital through the Adolescent Unit. This is the largest inpatient/outpatient specialist treatment centre for adolescents in Victoria. Over the past 5 years, there has been a 250% increase in number of clients treated with eating disorders (personal communication). Although beds are not allocated specifically for eating disorders, there is an average of 6 people admitted with an eating disorder at any one time.

#### 10. \*Royal Melbourne Hospital, Eating Disorder inpatient and outpatient units

The Eating Disorders Unit at the Royal Melbourne Hospital provides treatment for adults who live in the North West Mental Health region. It provides treatment for people with anorexia nervosa, bulimia nervosa or eating disorder not otherwise specified. The service offers 3 levels of support.

- An outpatient service supports people living in the community. Four psychiatrists and a dietician provide assessment and treatment to new patients and support current patients discharged from the inpatient unit. Limited resources impose constraints on the number and frequency of appointments.
- A Day Patient Program is available to people who require more intensive support than community support. This is a group program that runs 5 days per week in 10-week blocks and is designed to support people with eating disorders to restore normal eating patterns and behaviours. It adopts a variety of interventions including; CBT, behavioural therapy, mindfulness, circus skills and psycho-education. Treatment periods for individual patients vary but usually involve at least 2 groups.
- An 8 bed Inpatient Unit that offers intensive structured support to sufferers of an Eating Disorder who are medically unstable or who have severe mental health problems or issues. Daily activities are focused on promoting recovery and physical stability.

#### 11. \*Southern Health, Monash Medical Centre, Eating Disorders Program

Monash Medical Centre has 2 beds in the psychiatric specialty unit allocated for adults (over 16 years of age) with an eating disorder. In addition, there are 6 acute beds for young people with an Eating Disorder on an adolescent unit who require management of the physical complications of the illness. There are also 2 beds in the Adolescent Psychiatry Inpatient Unit (Stepping Stone) for those patients with an Eating Disorder who have an additional psychiatric co-morbidity.

#### 12. \*The Butterfly/Southern Health Day Program

A publicly funded day program for young people with eating disorders. The day program is a community based specialised service providing client centred holistic support and intervention to individuals with eating disorders and their families.

## Private Hospitals/Clinics

### 13. Melbourne Clinic, Eating Disorders Unit

The Eating Disorders Unit has seven inpatient beds. The eating disorders program fosters the restoration of health and weight and explores the underlying issues that accompany the illness.

### 14. \*The Oak House

The Oak House is a specialist outpatient facility providing recovery programs for people with eating disorders.

## Community, GP and other Health Services

### 15. Bouverie Centre

The Bouverie Centre provides family therapy for mental health issues including eating disorders.

### 16. \*Geelong Disordered Eating Service

Geelong Disordered Eating Service (DES) supports and educates local health professionals to recognise, refer and treat people with eating disorders. The service is run by Barwon Health.

### 17. \*Recovery is Possible for Everyone - RIPE

RIPE brings together a counsellor and dietitian to offer a coordinated, multidisciplinary approach for people who are struggling with eating disorders and body image issues. RIPE offers group therapy for eating disorders, individual counselling sessions, individual dietetics sessions. It also provides general counselling for depression and anxiety, relationship concerns and self-esteem issues.

### 18. Mooroolbark Dietetic Services

A private practice included as an unsolicited response.

### 19. MonashLink Community Health Service

MonashLink provides treatment for people with mild to moderate eating disorders (including binge eating disorder, bulimia, and anorexia) and disordered eating. The treatment involves psychology and dietetics and deals with anxiety and depression as both causal and consequent to disordered eating. The service prioritises those with low incomes and those from the local government area (Monash City).

### 20. \*Rich River Health Group (Murray Plains Division of General Practice)

An amalgamation The Murray River Medical Centre, Moama Medical Centre, Heygarth Street Medical Clinic and Percy Street Medical Centre.

### 21. \* Goulburn Valley Child & Adolescent Mental Health Service

In Victoria, specialist child and adolescent mental health services (CAMHS) play a lead role in promoting quality mental health responses.

### 22. \*Murray-Plains Division of General Practice

Our division is funded under the Commonwealth Access to Allied Psychological Services (ATAPS) program to provide free (up to 12 sessions) CBT counselling services in general practices, to a range of clients with diagnosed mental health conditions - including anxiety and depression in eating disorders, if the referring GP considers they would benefit.

### 23. Sunraysia Community Health Services

Sunraysia Community Health Services is listed on the Centre of Excellence in Eating Disorders web page as providing rural services for people with an eating disorder.

### 24. Peninsula Health Mental Health Services

Peninsula Health Services produced a video "Eating disorders: anorexia/bulimia nervosa" which is available in several hospital libraries.

## Foundations/Associations

### 25. \*Eating Disorders Foundation of Victoria (EDFV)

The EDFV respond to the needs of both people experiencing eating disorders and carers. The foundation provides information, knowledge, support and resources in order to encourage resilience and recovery and lessen the impact of the eating disorder on the quality of life of individuals and families. The foundation also raises awareness of eating disorders by means of general community education and specialist training for specific sectors. The EDFV website has a "Victorian eating disorder treatment services list" which contains a detailed description of services.

## Universities and Centres

### 26. \*The Bronte Centre at St. Vincent's Health

The centre offers intensive outpatient treatment for people with body image and eating disorders. Treatments include psychological counselling, dietetic management, behavioural challenges, medical management - using GPs and specialists within the community, psychiatric management - using consulting psychiatrists in the community, and transition planning and supported social, occupational and academic reintegration. The centre also provides community education programs and practitioner education and training.

### 27. \*Centre for Adolescent Health

The Centre for Adolescent Health is recognised nationally and internationally for its commitment and achievements in advancing young people's health and wellbeing.

The Centre responds to the health problems that affect young people between the ages of 10 and 24 years.

### 28. \*La Trobe University School of Psychological Science

There are three programs: (1) Eating Disorder and Body Image Research Group runs groups for mid-life women with body image problems. They have also developed similar group interventions for young women, both face to face and internet delivered interventions. (2) Set your body free program which is an 8 week intervention that offers free group therapy to women aged 30 to 60 with body image concerns and disordered eating. The effectiveness of the intervention for reducing body image concerns is being evaluated by a randomized controlled trial. (3) Mindful Moderate Eating Group is a low cost group program for people experiencing difficulties in controlling their eating behaviour.

### 29. \*Swinburne University of Technology, Psychology Clinic

The Swinburne Psychology Clinic offers a low cost group therapy program "The mindful moderate eating group (MMEG) for binge eating".

### 30. \*Victorian Centre of Excellence in Eating Disorders

The Victorian Centre of Excellence in Eating Disorders (CEED) is a key program within the Victorian government's response to the provision of quality services for those with eating disorders. CEED aims to undertake strategies to build quality, sustainable eating disorder treatment responses delivered by public specialist mental health services.

### 31. RMIT Choose Health Program

A cognitive behaviourally based lifestyle interventions for overweight and obese adolescents and adults. These interventions target improved eating and activity habits and address barriers to behaviour change and weight loss, including cognitive and emotional barriers.

## Support Groups

### 32. Malvern East (Inner South)

EDFV runs three distinct support groups at the Uniting Centre. (1) For people with an eating disorder; (2) Support group for families and friends of people with an eating disorder; (3) Combined support group. All groups meet fortnightly.

### 33. Watsonia (Northern region)

EDFV runs a support group for families and friends of people with an eating disorder. Meets monthly.

### 34. Collingwood

EDFV runs a support group for people with an eating disorder at Yarra Community Health Centre. Runs fortnightly.

### 35. Ballarat (Grampians region)

EDFV runs a support group for families and friends of people with an eating disorder. Meets fortnightly. Also run occasional social activities.

### 36. Leongatha (Gippsland Region)

EDFV runs a support group for people with an eating disorder and families and friends.

### 37. La Trobe Valley (Gippsland Region)

EDFV runs two support groups (1) for people with an eating disorder. Meets on a three weekly basis. (2) for families and friends. Meets monthly.

**38. \*Bendigo Eating Disorders Support Network**

The support was designed for family members of people with an eating disorder not those directly diagnosed with an eating disorder. Due to lack of attendees, the group is not currently meeting.

**39. Geelong Anorexia and Bulimia Support Group (Barwon South Region)**

EDFV runs a support group for parents and carers for people with an eating disorder

**40. Greater Shepparton Council**

The original support group (Shepparton Body Image Awareness Group) is no longer operating, but a representative at the Greater Shepparton Council said that a new eating disorder support group will be convened.

**For Profit Non Government Organisation****41. \*Mandometer Pty Ltd**

A program for the treatment of eating disorders developed at the Karolinska Institute in Sweden. The Australian office offers a full assessment service for patients contemplating intensive treatment overseas, out-patient treatment for moderately ill patients, and continuing care for patients returning from overseas intensive treatment. Information about mandometer, and the treatment offered, is available at [www.mandometer.com](http://www.mandometer.com)

**New South Wales**

Information in this section was sourced from the Centre of Eating and Dieting Disorder's website.

**Public Hospitals**

NSW is divided into nine Area Health Services. In each of these area health services, patients with eating disorders and co-morbidities are treated in generalist child and family health centers, community health centers and hospitals.

**42. Royal Prince Alfred Hospital**

The Missenden Unit is a 40 bed psychiatric inpatient facility attached to Royal Prince Alfred Hospital. Four beds are allocated for people with eating disorders, and are accessible for patients across NSW. Royal Prince Alfred Hospital also has an Eating Disorder Outpatient Clinic and a six bed Day Program.

**43. The Children's Hospital at Westmead**

The Children's Hospital at Westmead provides eating disorder services for children and adolescents across NSW. It has four inpatient beds for children aged 12 – 16 on a children's medical unit with a medical treatment and re-feeding program. It also has outpatient services which provide individual and family therapy for treatment of eating disorders. A specialist team of clinical psychologists, family therapists, psychiatrists and social workers deliver Maudsley Family Therapy treatment.

The Children's Hospital Institute of Sports Medicine provides individual outpatient treatment for anorexia nervosa, bulimia nervosa, eating disorder not otherwise specified, disordered eating, overweight, binge eating disorder and obesity.

**44. Westmead Hospital**

For adolescents aged between 14 -18, there are 4-6 beds on an adolescent medical unit and 2 beds on the adult acute psychiatric unit. Admission is accepted from across NSW. There is also an outpatient unit with weekly clinics for new patients, weekly follow up clinic and individual and family therapy. Multi-disciplinary team includes a dietitian and clinical psychologist.

Redbank House child, adolescent and family psychiatry provides an Adolescent mental health inpatient unit with one bed available for young people with an eating disorder.

The Adult Inpatient Program has 3 beds on general psychiatric ward. Admission is accepted for patients living in the Western Sydney Area Health Service catchment. Supervised meals for re-feeding/weight restoration and normalisation of eating (nasogastric tube feeding when required). Individual medical/psychiatric management and psychotherapy. There is also psychological group program.

**45. Westmead hospital outpatient eating disorder clinic**

Westmead hospital also has an outpatient eating disorder clinic with individual and group programs for bulimia and binge eating, and an Adult Eating Disorder Day Treatment Program. This provides up to 4 day per week structured recovery program for people over 18 years of

age. Includes supervised meals for re-feeding/ weight restoration and normalisation of eating, psychological group program, individual psychiatric management, and individual psychotherapy. Patients are transferred to inpatient services if required.

#### 46. Sydney Children's Hospital Randwick

Provides a broad range of mental health services, including 3-4 inpatient beds for young people (6-17 years) with an eating disorder living across NSW. Also an outpatient eating disorder program in a Mental Health Unit within an Adolescent general medical and surgical ward.

#### 47. Central Coast Eating Disorders Early Intervention Outpatient Service

An outpatient service with dietitian, clinical psychologist, and social worker. Individual and family therapy is provided to people of all ages, particularly early intervention for those at risk of any eating disorder. The services also has an 8 bed early intervention day program based at Gosford

#### 48. Illawarra Adolescent Mental Health Service

Outpatient management and family therapy for young people (12-18 years) with an eating disorder.

#### 49. Macarthur Mental Health Service Eating Disorders Clinic

An outpatient clinic that provides assessment and treatment of eating disorders for both adults and adolescents, and some admission to Campbelltown Hospital.

#### 50. Tamworth Base Hospital

Nutrition and Dietetics Department has an outpatient dietetic counselling for people with an eating disorder.

#### 51. Nepean Hospital, Eating Disorders Clinic

Patients requiring admission are admitted to a general ward. There is also an outpatient Eating Disorder Clinic.

#### 52. Lismore base Hospital

Lismore base Hospital paediatric ward has a number of non-dedicated beds and a program for eating disordered children and adolescents.

#### 53. Bathurst Paediatric Clinic

Bathurst Paediatric Clinic at Bathurst Base Hospital provides Paediatric and Adolescent Medical management, general counselling and case management of eating disorders across the spectrum.

#### 54. South West Area Health Service Adult Eating Disorder Day Treatment Program

Up to 4 day per week structured recovery program for people over 18 years of age. Includes supervised meals for re-feeding/ weight restoration and normalisation of eating, psychological group program, individual psychiatric management, and individual psychotherapy. Patients are transferred to inpatient services if required.

### Private Hospitals/Clinics

#### 55. Wesley Private Hospital

Wesley Private Hospital, Ashfield, is a 38-bed mental health facility with 10 inpatient beds for people with an eating disorder. Peter Beumont Centre for Eating Disorders at the Wesley Private Hospital also has a day program. The Eating Disorders Program aims to restore patients to normal eating patterns and behaviours utilizing a combination of techniques including psycho-education, cognitive behaviour therapy, mindfulness and other skills addressing not only on the eating disorder but enhancing the patients ability to regulate emotion, motivation and self-esteem.

#### 56. Northside Clinic

Northside Clinic, Greenwich, is a 98 bed psychiatric facility with 15 – 18 beds for people with an eating disorder. The hospital specialises in the treatment of mood and eating disorders.

### Community, GP and other Health Services

#### 57. Centre for Psychotherapy, Eating Disorders Service, Newcastle

The Eating Disorders Service at the Centre for Psychotherapy in Newcastle provides eating disorder assessment, individual and group treatment and information services for adults by a multidisciplinary team.

### 58. \*Lismore Eating Disorders and Women's Health Centre

Women's Health Centre provides assessment and treatment for women with eating disorders. The level of support given ranges from service visits to intensive support within a community and hospital based context. Support is also provided to family members.

### 59. Hunter Child and Adolescent Mental Health Service

Eating disorder outpatient service for 12-18 years olds. Family discussions as well as individual work with young people.

### 60. Shoalhaven Body Image and Eating Behaviour Service, Nowra Community Health Centre

Self-respect and personal needs underpins the Shoalhaven Body Image and Eating Behaviour Service approach. The service provides assessment, personal nutritional feedback and guidance, individual counselling, group treatment, information resources, family support, and cross-referral liaison.

### 61. \*Illawarra Eating Disorders Service

Type of Service: Assessments, Ongoing individual counselling, Nutrition counselling, Support for sufferers and carers, Group programs, Information and community activities.

## Universities/Centres

### 62. NSW Centre for Eating & Dieting Disorders (CEDD)

CEDD is an academic and service support centre based in Sydney, Australia resulting from a collaboration between the University of Sydney and Sydney South West Area Health Service. It is funded by the Mental Health and Drug & Alcohol Office, NSW Department of Health. In addition to the provision of a very informative web site, the Centre has a number of key functions:

- to promote awareness of eating disorders as serious mental illnesses, that require treatment and in many cases can be cured
- to contribute to policy development for the treatment, prevention and cure of eating disorders

- to improve access to services for people in NSW who have an eating disorder, and their carers
- to provide support to clinicians in NSW who have taken on the care of people who have an eating disorder
- to conduct and foster research into the eating disorders, their aetiology, treatment and cure.
- to educate and train the health workforce in evidence based medicines and treatments for people with eating disorders
- to support other organisations working for the betterment of those afflicted by these mental illnesses
- to contribute to the development of prevention and early intervention policy and interventions to reduce the incidence, duration and burden of eating disorders

## Foundations/Associations

### 63. Eating Disorders Foundation

The Foundation employs qualified staff with expertise in eating disorders to run programs to assist in recovery and provide links between hospitals, patients, family, schools and community.

## Queensland

### Public Hospitals

#### 64. Royal Brisbane and Women's Hospital

Five in-patient beds are available for the assessment and treatment of first admission eating disorder patients from all districts.

#### 65. \*Royal Brisbane Hospital Eating Disorders Outreach Service(EDOS)

The outreach service provides consultation and support services for other mental health services to assist them in managing their own patients locally.

#### 66. Mater Hospital

There are ten beds in the child youth mental health service. These are used for children and adolescents with a range of mental illnesses, including eating disorders. The beds are not designated.

## Private Hospitals/Clinics

### 67. New Farm Clinic

New Farm Clinic is a 90-bed specialist psychiatry facility. The Clinic offers a range of inpatient and day patient programs that specialise in the treatment of mood and eating disorders. The Eating Disorders unit is a ten bed facility that provides treatment to patients suffering from anorexia nervosa, bulimia nervosa and other disordered eating behaviours. The program is conducted in phases and includes re-feeding, nutrition, controlled exercise and a practical phase. New Farm Clinic is the only private facility in Queensland that offers a re-feeding phase in its Eating Disorder Program.

## Community, GP and other Health Services

### 68. \*Eating Disorder Nutrition Services

Organisation is a private practice staffed by dietitians only, with vision to more multidisciplinary. Services offered include: one on one, family support, supportive meal education, workshops, consultation, and research.

## Foundations/Associations

### 69. \*The Eating Disorders Association

EDA has developed a resource kit to assist health professionals, groups or individuals in establishing and maintaining a healthy support group for people affected by eating disorders. The kit contains information about eating disorders; a review of the literature and issues associated with eating disorders; a guide to establishing and maintaining healthy support groups for people affected by an eating disorder; and a training package for facilitators of support groups for people affected by an eating disorder.

## Support Group

### 70. \*Anorexia & Bulimia Support Resource Gold Coast

A small self funded support group.

## Centres

### 71. \*ISIS - Centre for Women's Action on Eating Issues

ISIS is a community based organisation funded by Queensland Health (Mental Health). ISIS developed a model of woman-centred or feminist group work practice with women who identify as having serious eating issues such as bulimia, anorexia, and compulsive eating.

## Northern Territory

## Foundations/Associations

### 72. Northern Territory Association for Mental Health

## ACT

## Community, GP and other Health Services

### 73. ACT Eating Disorders Program

A specialist, community-based, multi-disciplinary team providing a comprehensive assessment and treatment program for all eating disorders. Team includes: psychiatrist, psychologist, social worker, dietician, and teacher. Outpatient and day programs available to residents of both the ACT and surrounding NSW regions. Consultation/liason available to health professionals.

## Centres

### 74. \*Women's Centre for Health Matters (WCHM)

Women's Centre for Health matters works to improve the health and well-being in the ACT and region.

## Tasmania

### Community, GP and other Health Services

#### 75. \*Community Nutrition Unit, Department of Health and Human Services

The Community Nutrition Unit works with communities to improve nutritional and food related health. It recognises the role of personal, social, cultural, environmental and economic factors on nutritional and food related health. Support includes assistance with planning, implementation and evaluation of community nutrition programs. The unit also has extensive collection of nutrition education materials including kits, posters, pamphlets, videos etc. The unit offers a free telephone nutrition advisory service to the public.

### Support Groups

#### 76. Support Group for Family and Friends of People with Eating Disorders

## South Australia

### Public Hospitals

#### 77. Flinders Medical Centre Weight Disorder Unit (SA)

An academic unit which has six beds and provides a comprehensive service managing co-occurring depression and anxiety, in a multi-disciplinary setting for the state of SA. There is the nearby ICU support for people who are medically compromised. Severely underweight patients can be admitted and the unit also provides input to those patients admitted to general medical wards because of medical complications. It has an extensive outpatient service including two community nurse specialists in eating disorders providing outreach to the state (including outreach to country areas). It provides a subspecialty training rotation for psychiatric registrars and selected clinical psychology students that over many years has enhanced the capacity of the treating community to manage people with an eating disorder.

#### 78. Women's and Children's Hospital (WCH)

WCH adolescent ward has three inpatient beds for people with eating disorders.

### Private Hospitals

#### 79. Blackwood Private Hospital

Provides treatment for patients by a GP and counsellor. Admissions are possible

### Foundations/Associations

#### 80. \*Eating Disorders Association of South Australia (EDAsa)

The Eating Disorders Association of South Australia (EDAsa) is a not for profit community organisation established in 1983 with the aim of providing information and support to people with eating disorders, their friends and families as well as to better inform the community of the effects of these conditions. Today, EDAsa continues to respond to the needs of the community including individuals experiencing eating disorders, their parents, partners and supporters. EDAsa also advocates for systemic change by working on projects and programs that raise awareness of eating disorders in the community to improve prevention, increase early intervention and promote recovery and rehabilitation from eating disorders.

### Institutes

#### 81. South Australian Sports Institute (SASI)

### Universities and Centres

#### 82. Flinders University Services for Eating Disorders

Flinders University provides outpatient psychotherapy programs, treatments, training and conducts research.

#### 83. Private practitioner network

An unofficially grouped collection of clinicians working in private practice in South Australia who treat patients with an eating disorder. Most have affiliations or have trained with the Flinders Weight Disorders Unit.

### Not for Profit Organisation

#### 84. Lifehouse Australia

Lifehouse Australia is a not for profit organisation that offers a 6-month live in residential program to young women who are suffering from an eating disorder, self harm, abuse, depression, unplanned pregnancy or other life controlling issues. Lifehouse is a

non-clinical service that provides support and guidance to assist young women to overcome conditions and behaviours that have become life controlling.

## Western Australia

### Public Hospitals

#### 85. Princess Margaret Hospital for Children

The Princess Margaret Hospital for Children has 6 - 8 beds for eating disorders. The Eating Disorders Program is a specialised multidisciplinary team for the assessment and treatment of children and adolescents with eating disorders. A coordinated paediatric and psychological medicine approach provides a comprehensive, evidence based service involving a range of disciplines.

### Private Hospitals

#### 86. Hollywood Private Hospital

Hollywood Private Hospital, Nedlands is an acute-care private teaching hospital in, in Western Australia. It has 6 - 8 beds for people with eating disorders and an outpatient eating disorder program.

### Community, GP and other Health Services

#### 87. \*Joondalup Mental health Unit

Joondalup does not provide a service specific to eating disorders. However, in the unit, there is a therapy team including a clinical psychologist, psychiatric (consultants and registrars), nursing staff trained in mental health and dietitian review. On assessment, the client would be placed on an appropriate management plan for dietary intake and mood and anxiety management

### Centres

#### 88. Centre for Clinical Interventions (WA)

The Centre for Clinical Interventions (CCI) is a specialist state-wide program that is administered through North Metropolitan Health Services in Western Australia. They conduct clinically applied psychosocial research and provide training and supervision for various psychological interventions. They also offer a clinical service for adults suffering from anxiety, mood and eating disorders.

#### 89. Eating Disorders Centre

The Eating Disorders Centre is a psychology-based private practice. It offers treatment for eating disorders, particularly Anorexia, Bulimia, Obesity and Compulsive Eating. The Centre also offers lectures and presentations to groups interested in learning more about these disorders.

### Foundations/Associations

#### 90. Bridges Association Incorporated

Bridges Association was established to promote understanding and to provide support services for all people affected by eating disorders in Western Australia. It is an alliance of past sufferers, parents, carers and health professionals who are passionate about working together to advocate a holistic and team approach in the recovery process. ❖

# 6 Scoping Study

## Previous mapping

A mapping of eating disorder clinical services in Victoria has been undertaken by Dr Valerie Gerrand (DHS, 2007). In addition, a Program Management Circular describes the role of public specialist mental health services in responding to the needs of people of all ages who experience eating disorders (DHS, 2007).

Another relevant reference is a European review of where people with eating disorders access treatment by Matthias “Care provision for patients with eating disorders in Europe: What patients get treatment where?” published in the European Eating Disorders Review (2005).

In 2007, a scoping study of inpatient beds was undertaken by Australia and New Zealand Assembly of Eating Disorders. Research Matters updated this information (Appendix 3).

## Resources for people with an eating disorder who experience anxiety and depression.

Representatives from eating disorder organisations were asked to describe resources that they provide for people with an eating disorder who experience anxiety and depression (A summary of responses is reported in Table 2).

A number of resources for people with an eating disorder were identified, though less resources for people with co-morbidities of eating disorder with anxiety and depression. For example, Lismore Eating Disorders and Women’s Health indicated that they “have a number of books, but none that specifically deal with depression or anxiety as well as an eating disorder”. Mooroolbark Dietetic Services, Gold Coast Anorexia & Bulimia Support Resource Centre and indicated that they have

“very limited” resources that deal with anxiety and depression - they photocopy a general brochure titled “What is depression?”

Eating Disorders Foundation of Victoria (EDFV) was one of the few organisations to describe resources specifically on anxiety and depression. For example, books such as “Taming the black dog” and “Living with it” are available in their library. The library also has copies of Australian treatment guidelines for consumers and carers on ‘coping with depression’ and ‘panic disorder and agoraphobia’ by the Royal Australian and

**Table 2: Resources provide for people with an eating disorder who experience anxiety and depression**

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Talking therapies
• Cognitive Behavioural Therapy
• Counselling
• Individual
• Family (e.g. Maudsley Approach 13)
• Psychotherapy
• Psychoeducation
Medical and complementary therapies
• Medication
• Naturopathy
Group work
• Art therapy
• Music therapy
• Expressive therapies
Relaxation therapies
• Experiential mindfulness techniques
• Breathing strategies
Information
• Referrals
• Phone support
• Internet resources (including internet delivered interventions)
• Library resources
• Eating Services Directory (Community Nutrition Unit and EDNA network, DHHS, 2005)
Self management strategies
• Guided self help
• Centre for Clinical Interventions Self Help Program

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New Zealand College of Psychiatrists. In addition, information sheets (e.g. fact sheets) are downloaded from relevant websites, and people are referred to other organisations (e.g. beyondblue, depressionet, Blue pages, Reach out, ArcVic, Reconnexion, WIRE, Lifeline etc).

Oak House is another organisation that provides resources specifically on anxiety and depression. At Oak House, psychologists who work with people with eating disorders are all trained and experienced to also treat depression and anxiety. They are also trained to complete thorough assessments for co-morbid conditions. The assessment screening tool commonly used at Oak House is the Beck Depression Inventory. They refer clients to a psychiatrist if they are concerned about the severity of a client's depression or anxiety.

Several organisations (e.g. Lismore Eating Disorders and Women's Health) indicated that they were able to run groups for women with an eating disorder who also experience depression "when funding allows". Eating Disorder Association of South Australia currently shares premises with the Panic Anxiety Disorder Association and Obsessive Compulsive Disorder Support Service and plan to introduce more personal growth groups/courses.

Participants indicated that the resources that they recommend depend on factors such as age of client and severity of illness. MonashLink Community Health Service, for example, recommends family-based treatment for adolescents with anorexia nervosa. They recommend individual therapy (based on cognitive-behavioural therapy) and guided self-help resources for adult clients with bulimia nervosa.

Several participants indicated that people with an eating disorder who were experiencing anxiety and depression were referred to appropriate services with resources to deal with anxiety and depression. For example, RMIT Good Health Program provides "biopsychosocial assessments also allow for the identification of anxiety and depression so we are able to refer for appropriate treatment". Other participants recommended "integrated services" that deal with both the eating disorder with anxiety and depression. For example, Royal Brisbane Hospital Eating Disorders

Outreach Service assesses and treats the depression and anxiety "as part of the overall plan". Centre for Adolescent Health Provide also stressed the importance of services being "integrated within the one assessment and site" (i.e. mental health, adolescent medicine and dietetics).

### Which resources are useful, and why?

Several participants stated that they would be interested in a list of resources (e.g. books, DVDs, Fact Sheets) that other organisations may use - "We just don't have any time to research this sort of thing ourselves given the huge demand for our service, and the very small staffing". In response to this need, Research Matters has prepared a list of useful resources to accompany this report. These resources are listed in Appendix 2, together with information about how they can be either purchased or downloaded free of charge from the internet.

Many organisations around Australia use resources from Eating Disorders Foundation of Victoria. Eating Disorders Foundation of Victoria has a large range of resources listed on their website - books, videos, posters, booklets, brochures, and professional information. These resources were all described as useful, depending on the situation and knowledge of the service user. However, many of these resources do not specifically target the issue of anxiety and depression.

Goulburn Valley Child and Adolescent Mental Health Service described internet resources on eating disorders as "very useful". However, it is frequently assumed that people, particularly young people, have easy access to the internet. A representative of Gold Coast Anorexia and Bulimia Support Resource Centre suggested that many people who access their support group do not have access to internet. In addition, she suggested that the "internet bombards people with information."

Rich River Health Group described "any specialist referral" as useful. Murray Plains Division of GP suggested that "local CBT counselling is probably most useful in rural and regional areas where access to specialist providers is limited and difficult".

Several participants described the importance of support groups. However, one participant described the need to improve marketing of these support groups.

*I am unsure how well eating disorder organisations market the support groups. I am an avid reader of local newspapers and I never see the groups advertised. I know eating disorder treatment centres and medical professionals are aware of the support groups, but I don't know that they are promoted effectively to the general public. If beyondblue can help raise awareness of support group and promote the services on offer, it would be most beneficial.*

## Resources for carers

Participants were asked to describe resources for non-professional carers (e.g. family members, friends) of people with an eating disorder who experience anxiety and depression. The following resources were identified, but, again, these resources are mostly for eating disorders in general rather than specifically for co-morbidities of eating disorders and anxiety and depression:

- Telephone and email support
- Referral
- Counselling (both individual and group)
- Friends and relatives support groups
- Family information nights
- Library and internet resources
- Information sheets (e.g. Fact Sheets, newsletters)
- Handouts describing signs/symptoms and ways they can help.
- Psychoeducation for parents of young people with an eating disorder
- Carers Retreats

In addition, books were recommended such as:

- Skills-based Learning for Caring for a Loved One with an Eating Disorder, 2007, Treasure, Smith and Crane. Published by Routledge
- Talking to Eating Disorders: simple ways to support someone with anorexia, bulimia, binge eating or body image issues, 2005, Heaton & Strauss. Published by New American Library

- The Secret Language of Eating Disorders, 1997, Claude-Pierre. Published by Vintage Books

Oak House delivers family support groups - these involve 1.5 hour sessions that address a variety of issues pertaining to an eating disorder including depression and anxiety. Family education sessions are usually 60 minute sessions with the client and their family, though not specifically on depression and anxiety but these issues are often covered.

South West Area Eating Disorder Service is currently designing a service for families and caregivers of clients with eating disorders involving an evidenced based group program.

A representative of the RMIT Choose Health Program stated that parents are involved in all aspects of the treatment of adolescents so that they are better able to support their adolescent to change their eating and activity behaviours. Parents are also involved in assessment and receive assessment results with the adolescent, as well as referral information as required.

## Resources for GPs

A rural GP was asked to describe how she would treat a patient with an eating disorder who also experienced anxiety and depression. This GP said that if the patient is under 18 years of age, she would refer them to a paediatrician. If the patient is older, she would refer them to a psychiatrist and a dietician. Since the introduction of a Medicare rebate, she may refer them to a psychologist instead of a psychiatrist.

One of the recommended strategies for treating a person with an eating disorder with anxiety and depression is to take a multi-disciplinary approach. However, when we asked the GP about working in a multi-disciplinary team, she replied "We are told to work in a team, but this is not realistic in a rural area".

She explained that she had learnt about eating disorders in medical school, and has since received general medical updates. She attended a continuing education session earlier this year which included one lecture on eating disorders delivered by Victorian Centre of Excellence in Eating Disorders (CEED). Her notes from this lecture referred to

CEED web page which she has since accessed and found to be useful. When asked about CEED manual: “Eating Disorders Resource for Health Professionals: A manual to promote the early identification, assessment and treatment of eating disorders.” (2004), she replied that she did not “have time to read manuals”.

In addition to the manual for health professionals, Victorian Centre of Excellence in Eating Disorders also provides other educational resources for GPs including:

- 2005 -2007 Short course in eating disorders: Module A - introduction to eating disorders management. Module B: Management of eating disorders for mental health clinicians; management of eating disorders for dietitians; Management of eating disorders for medical practitioners
- 2007 onwards, the short course evolved towards ‘foundation training’ in eating disorders for public mental health clinicians

Victorian Centre of Excellence in Eating Disorders also facilitates advanced seminars and workshops in eating disorders management.

Eating Disorder Foundations also provides resources for GPs. Eating Disorders Foundation of Victoria publishes a booklet “Information on Eating Disorders for Health Professionals” (1999). This 40-page booklet provides information useful to a range of health practitioners (and community workers). Eating Disorder Association of South Australia (EDAsa) states that the information that they provide for GPs is the same as the information provided for all health professionals. These resources include:

- Telephone and email support
- Information and referral.
- Library resources ,
- Quarterly newsletter

ESAsa also participate in GP training programs run by Adelaide University and speak to groups of other professionals.

Lismore Eating Disorders and Women’s Health state that they provide training “from time to time to GPs”. This training is usually in partnership with

another organisation that can fund the training (e.g. the local division of General Practice). This training is usually focused on eating disorders specifically. Whilst anxiety or depression may be referred to, there is not a specific section on these topics. At the end of this year, Lismore Eating Disorders and Women’s Health will be holding a two day training run by a world renowned expert in eating disorders. But there will not be a specific section on anxiety or depression.

In contrast, Royal Brisbane Hospital Eating Disorders Outreach Service offer training on eating disorders, and anxiety and depression is very much an integral part of that training. GPs receive professional points for attending the training workshop on “overcoming bulimia and binge eating” and they also have a manual specifically designed for GPs (developed by the Eating Disorders Association) for the assessment and management of eating disorders.

Psychologists at Oak House liaise with GPs regarding mental state and the need for medication. They also provide training seminars and supervision to GPS (and other health professionals) on the Maudsley Model of treatment of anorexia nervosa.

Shoalhaven body image and eating behaviour service use handouts and individual case discussions together with education sessions. However, they state that information sessions are poorly attended by medical professionals and suggest that other professionals may be more likely to attend these information sessions. South West Area Eating Disorder Service provides regular education breakfasts (3-monthly), telephone consultation, and a 6-hour online training program. Finally, Divisions of GPs, such as Murray Plains Division of GP, state that they receive information from a wide range of specialist areas, including eating disorders. They pass relevant information on to GP practices and GPs.

MonashLink Community Health Service organized a Centre of Excellence for Eating Disorders Seminar for GP’s in their area. MonashLink Community Health also recommends a recent book on cognitive behavioural therapy for eating disorders: “Cognitive Behavioural Therapy for Eating Disorders: A Comprehensive Treatment

Guide” by Glenn Waller, Helen Cordery, Emma Corstorphine, Hendrik Hinrichsen, Rachel Lawson, Victoria Mountford, and Katie Russell Cambridge, UK: Cambridge University Press, 2007.

## Resources for Dietitians

A dietitian was asked to describe how she would treat a patient with an eating disorder who also experienced anxiety and depression. She replied that “As a dietitian, I don’t get involved with giving advice regarding depression/ anxiety”. This supports the claim by Rich River Health Group that dietitians often feel that they are not “specialist trained to help”.

In Victoria, the Centre of Excellence in Eating Disorders offered short courses in eating disorders on Management of EDs for dietitians between 2005 and 2007. In addition, the Centre for Adolescent Health provides teaching and training to dietitians as part of the Royal Children’s Hospital’s training focus. In rural Victoria, Goulburn Valley Child & Adolescent Mental Health Service has professional meetings in regard to the co-morbidity of anxiety and depression (e.g. information sessions and Hospital Grand Round presentations).

In terms of non-clinical services, Eating Disorders Foundation of Victoria provides information for all health professionals, including dietitians. In addition, Recovery is Possible for Everyone offers peer support for dietitians which addresses anxiety and depression issues. This support includes information about where to refer clients.

In Northern NSW, dietitians are mostly employed by the health department. So, according to Lismore Eating Disorders and Women’s Health, dietitians usually access training through the health department.

Royal Brisbane Hospital Eating Disorders Outreach Service states that dietitians can attend their training workshop. In addition, they have 2 dietitians on staff who are available for consultation-liaison and education. South West Area Eating Disorder Service is currently developing a 6 hour online training program.

**Food for Thought:** Co-morbidity of Eating Disorders with Anxiety and Depression

They also provide an in-service program on eating disorders to local dietitians.

## Resources for Psychologists

In Victoria, the Centre for Adolescent Health provides clinical training opportunities, but not resources as such. Murray Plains Division of GP state that they pass on the same sorts of information as they provide to GPs to all clinicians employed under their Access to Allied Psychological Services counselling program.

In Queensland, psychologists receive professional points for attending Royal Brisbane Hospital Eating Disorders Outreach Service’s training workshop. In addition, they have one clinical psychologist on staff available for consultation-liaison and education.

In NSW, South West Area Eating Disorder Service delivers 3-monthly education breakfasts, telephone consultation and training in Maudsley family therapy.

## Resources for Psychiatrists

Few organisations indicated on the questionnaire that they provide resources specifically for psychiatrists. The Oak House provides training seminars for the Maudsley Model of treatment for anorexia nervosa.

The Royal Australian and New Zealand College of Psychiatrists publish clinical practice guidelines. These clinical practice guidelines:

- Systematically evaluate research evidence;
- Are developed by representatives from a range of professional groups, as well as consumers;
- Are specifically designed to assist, rather than dictate, clinical decision-making; and
- Are to be applied on a case-by-case basis.

Clinical practice guidelines have been published on “Anorexia nervosa: Australian treatment guide for consumers and carers and “Australia and New Zealand clinical practice guidelines for the treatment of anorexia nervosa”, though none has yet been published on co-morbidity of eating disorders and anxiety and depression.

In addition, a recent RANZCP Congress (2008) discussed Anorexia nervosa, disordered eating, body dissatisfaction and binge eating. This congress included a symposium of psychiatrists showcasing Australasian research in the nature and determinants of eating disorders. During the congress, a child and adolescent psychiatrist at Westmead Children's Hospital presented findings from a study that found "more children are presenting for treatment for anorexia and many are so sick they have to be hospitalized... at least 50 per cent of the children had very severe complications with their starvation, they were unable to maintain a normal heart rate, or blood pressure or temperature to the point that these children were at risk of dying for the complications of their eating disorder" (ABC radio, 28 May, 2008). Unfortunately, the ABC media report indicated that, like many other clinical studies on eating disorder, this study had a methodological problem of a small sample size.

### Resources for social workers

The data on resources for social workers is similar to other health care professionals such as GPs, psychologists and dietitians. Social workers are included in new Medicare program, Access to Allied Psychological Services counselling program. Murray Plains Division of GP, for example, provides the same information as they do to all clinicians employed under the Medicare counselling program. Social workers receive professional points for attending Royal Brisbane Hospital Eating Disorders Outreach Service's training workshop. They also have 2 social workers on staff available for consultation-liaison and education.

Organisations such as Eating Disorders Foundation of Victoria and Eating Disorder Association South Australia provide similar resources for all health care professionals, including social workers, though only a few resources deal with co-morbidity of eating disorders and anxiety and depression.

### Resources for complementary therapists

A naturopath was asked to describe how she would treat a patient with an eating disorder who also experienced anxiety and depression. She responded

by saying that she had not treated anyone for an eating disorder specifically, though she has had a few clients who have had an eating disorder and recovered to some extent. Her training, over 10 years ago, did not specifically address this area in any great depth and she did not offer natural treatment strategies to people with an eating disorder. She indicated that any resources on co-morbidity of eating disorders and anxiety and depression would be helpful, but especially referrals to support groups, networks, and programs.

Few organisations indicated that they provide training to complementary therapists. In fact, several organisations stated on the questionnaire that they have "no contact" with complementary therapists and some responded to the question about resources for complementary therapists with "not applicable."

Eating Disorder Association of South Australia and Eating Disorders Foundation of Victoria provide information about eating disorders to all health professionals, including complementary therapists. South West Area Eating Disorder Service provides complementary therapists with similar professional development to other health professionals - 3-monthly education breakfasts and telephone consultation. Finally, Royal Brisbane Hospital Eating Disorders Outreach Service stated that, if requested, complementary therapists are welcome to attend training workshop.

### Resources for school counsellors

A school counsellor was asked to describe how she would respond if she was asked to assist a student with an eating disorder who also experienced anxiety and depression. She responded by saying that:

*I did not receive any specific training in eating disorders in student welfare (or, for that matter, as a psychologist). Usually for a welfare person at a school, you would be expected to pass those cases on to the visiting psychologist. A support helpline would be useful, plus free one or half-day training. Brochures are always useful to have.*

In Victoria, Eating Disorders Foundation of Victoria provides secondary consultation and training for school staff. Training is on the

identification, early intervention, support and prevention of eating disorders. There is also an accompanying resource called “An Eating Disorders Resource for School staff”. The resource is available on line and can be downloaded for free or purchased for \$20. Recovery is Possible for Everyone provides support/guidance/information where appropriate. In rural Victoria, Goulburn Valley Child and Adolescent Mental Health Service provides secondary consultation, professional meetings, and access to school nurses.

MonashLink Community Health Service has given talks to school counsellors regarding risks, treatment options, prevention etc. They indicated that they are (somewhat) available to do further talks, if required. Royal Brisbane Hospital Eating Disorders Outreach Service said that school counsellors are welcome to attend training. They indicated that they have done training for University of Queensland student counselors and would be keen to organise structured training at any school with enough interested counselors. Oak House provides educational talks to school counselors about body image, detecting eating disorder etc.

### Resources for sports coaches

A sports coach was asked about resources for athletes who have an eating disorder and anxiety and depression. He responded by stating:

*I train a runner who has an eating disorder and it is troubling. Generally coaching courses touch on eating disorders (it certainly does in the gym instructors' course). But the advice is that we refer people onto their GP. We are made aware of conditions such as bulimia and anorexia nervosa but additional resources are not given out.*

Eating Disorders Foundation of Victoria provides secondary consultation and training for sports coaches and health and fitness workers, such as personal trainers. Training is on the identification, early intervention, support and prevention of eating disorders. There are accompanying resources called “An Eating Disorders Resource for Coaches” and “An Eating Disorders Resource for Health & Fitness Professionals. The resource can be purchased for

\$20. The coach interviewed for this study will be given a copy of both publications.

Goulburn Valley Child & Adolescent Mental Health Service described the ‘Coach the Coach’ initiative which delivers mental health first aid training to sports coaches in Goulburn Valley Football League.

Royal Brisbane Hospital Eating Disorders Outreach Service stated that sports coaches are welcome to attend training workshop. In addition, they have a training package and information on how to develop policy support, if gyms require the information. They indicated that “uptake hasn't been great but we are doing a large drive at the moment to encourage gyms to think more seriously about their role in identification and support of their customers who might have eating issues”.

### Resources for volunteers

Eating Disorders Foundation of Victoria volunteers are provided with comprehensive training and knowledge of all appropriate referral services and a thorough understanding of other mental illnesses especially anxiety and depression. Volunteers participate in the direct provision of some core services including the Eating Disorders Foundation of Victoria Helpline and email service, drop in service, chat room, support groups and message board.

A volunteer for the Eating Disorder Foundation of Victoria was asked to describe the resources that she used.

*I have been with Eating Disorders Foundation of Victoria for about 3 years. I am trained as a group convener and as a public speaker. The public speaking training was conducted over about 6 sessions one night a week. The group convening training was over a similar period of time with a two day workshop at the end. Group conveners are then required to observe 6 groups before becoming an active convener*

*The Eating Disorders Foundation of Victoria also has a help line and although the training for group convener and help line are the same I have never been available during the day to be a phone counsellor.*

*Training sessions accompanied by training notes that are most helpful.*

*Professionals speaking on various aspects of eating disorders to obtain an understanding of the presenting situ-*

ation are very helpful. A basic requirement of volunteers is to ensure they are up to date on treatments and information about eating disorders.

The training comes with a manual and accreditation certificate and is followed up by ongoing refresher training on various relevant topics and supervision. Volunteers are very well supported and phoned after each session to ensure they are OK and that there aren't any issues. The Eating Disorders Foundation of Victoria is constantly available for debriefing.

Oak House delivers training programs to assist volunteers to manage issues such as low mood and secretive eating disorder behaviour. Recovery is Possible for Everyone has an intern program and volunteers are provided with supervision, information and support. South West Area Eating Disorder and Royal Brisbane Hospital Eating Disorders Outreach Services also have a volunteer program. Royal Brisbane Hospital Eating Disorders Outreach Service states that although they do not have specific resources, volunteers are welcome to attend training venues if they are interested

Joondalup Mental health Unit does not have resources for volunteers. However hospital volunteers are briefed before making contact with clients.

Also, the following website 'Eating Disorder Activists and Eating Disorder Volunteers Meet-ups' includes many Australian cities: <http://edvolunteer.meetup.com/cities/au/?all=1>

## Treatments that participants described as effective

Participants were asked to describe treatments/programs that they considered to be the most effective for people with an eating disorder who experience anxiety and depression. This question elicited a range of treatments that were considered to be effective (A summary of responses is reported in Table 3).

Many participants suggested that this question needs to be asked to people with an eating disorder rather than organisations who provide those resources. Some participants stated that the type of treatments depends on the stage of eating disorder, type of eating disorder, along with the severity of the symptoms of depression and anxiety.

**Table 3: Treatments that participants described as effective**

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Medical services
• In-patient services
• Medication (e.g. anti-depressant and anti-anxiety medication)
• Outpatient cognitive behavior therapy for eating disorders
Psychological
• Acceptance and Commitment Therapy
• Motivational Enhancement Therapy
• Dialectical Behavioral Therapy
• Cognitive behaviour therapy
• Cognitive behaviour therapy and combined medication (if an adult)
• Family-Based Treatment (Maudsely) - combined with medication if adolescent
• Family counselling
• Narrative therapy
• Mindfulness
• Individually-based and designed therapy for adults
• Psychotherapy
• Interpersonal Psychotherapy (if co-morbid depression)
Nutritional
• Dietetic support
• Nutritional rehabilitation - weight restoration is key to treating depression in low weight anorexia nervosa
Psychosocial
• Day programs
• Education and awareness of the mental illnesses
• Attendance at support groups
• Self help
• Self Esteem programs and other relevant psychoeducation programs
• Alternative stress management techniques e.g. yoga, meditation, creative therapies (e.g. creative arts therapy)
• Reading/watching recovery stories

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Recovery is Possible for Everyone, stated that "each person is very different and requires assessment to comprehensively answer this question". Recovery is Possible for Everyone is currently using their own treatment protocol which combines the following:

- Acceptance and Commitment Therapy;
- Psychoeducation, Dietetics;
- Cognitive Behavioural Therapy; and
- Relapse Prevention.

Participants stated that they were not aware of research on treatment effectiveness when co-morbidity is a feature. Their comments were frequently couched in terms of "my best guess" or "it seems to be worthwhile". For example, a psychologist at Oak House stated that "it seems to

be worthwhile to give guided self-help a go”, as it empowers and informs clients “who are, after all, the people who have to do most of the hard work”.

Centre of Excellence in Eating Disorders suggests that it is important to consider the possible contribution of underweight and under-nutrition to the clients’ experience of lowered mood and anxiety as well as depression and anxiety existing as co-morbid conditions. Additional treatment may need to be used as co-morbid nature of symptoms becomes clearer, or as health improves and medication (if warranted) is likely to be more effective.

Royal Brisbane Hospital Eating Disorders Outreach Service state that starvation-malnutrition must be managed first and symptoms of anxiety (i.e. social anxiety, food fears, perfectionism and obsessive compulsive disorder) and depression may alleviate secondary to nutritional rehabilitation.

There was also some disagreement about treatments. For example, Bendigo Eating Disorders Support Group suggested in-patient services and psychiatric modalities and family counselling were effective. However, Gold Coast Anorexia & Bulimia Support Resource Centre is “not a fan of psychiatrists” - they prefer support groups and counselling. Southern Primary Health - Southern Women’s agree that a person should not be treated as an inpatient “unless client is physically compromised.”

Participants suggested that people recover best from an eating disorder when they have a ‘team’ of professionals working with them such as a psychologist, dietician, family therapist etc. South West Area Eating Disorder Service also suggested a range of services are necessary, including outpatient, inpatient, and carer support by practitioners working in collaboration with other practitioners. For those who can afford them - day programs that provide access to all of the above treatments “are known to be very effective”.

MonashLink Community Health Service described Centre for Clinical Interventions Self Help Program which is available free on the internet as being “based on current evidence-based best practice”. Lismore Eating Disorders and Women’s Health described group therapy as helpful

“because not only did we look at ways of dealing with the difficulties, but there was a reduction in feelings of isolation, or being the only one, and then a building of community and connection between the women which has been very sustaining”. A representative said that women also loved doing art therapy, or creative ways of expressing things. Other interventions included mindfulness/ breathing are very practical and easy techniques for people to use immediately.

Psychoeducation was also described as helpful “in terms of identifying the interplay of feelings, thoughts, and behaviours, and how the underlying genesis of the eating disorder may be linked to these feelings and thoughts”. It was also stated that medication “has proven beneficial in ‘taking the edge’ off the mood difficulties, which allows for more open exploration of background issues.”

A representative from Oak House referred to “screening tools”. She stated that “screening is helpful because it ensures that the treatment plan incorporates strategies and plans to deal with co-morbidities”. Joondalup Mental health Unit recommends a “consistent approach based on the management plan devised by the multidisciplinary team”.

Counselling was also described as effective. “We can follow changes as they occur and tailor the assistance to the individual”. To assist the implementation of counselling, the Medicare rebate for psychologists, social workers, and occupational therapists was described “very helpful” as an alternate to public mental health, especially when the eating disorder is reduced and mood difficulties remain.

ATAPS enables GPs under the Better Outcomes in Mental Health Care program to refer consumers to allied health professionals who deliver focused psychological strategies. Allied health professionals, include psychologists, social workers, mental health nurses, and occupational therapists. ATAPS aims to provide patients with assistance for short-term intervention. Patients are eligible for a maximum of 12 sessions per calendar year - six time-limited sessions with an option for a further six sessions following a mental health review by the referring GP. Sessions can be individual and/or group therapy sessions.

## Effective strategies/lifestyle

Many participants stated that eating disorders and co-existing anxiety and depression can not be resolved without appropriate support from family, friends, community and professionals.

Participants were reluctant to generalise and stated that effective strategies depend on a client's interests and the degree of impact of their disorders on the individual. They said that people need to find what works best for them, and that this is different for different people.

The list of effective strategies/lifestyle was collected (A summary of responses is reported in Table 4).

## Reported difficulties in the provision of services

Participants were asked to describe issues that they currently experience in delivering services. They referred to issues such as:

- Difficulties accessing affordable services
- Lack of specific expertise in eating disorders, particularly in rural areas
- Clients' resistance to taking medication
- Not able to dedicate the resources and time needed to work with women who often require long term support (e.g. counselling and medical monitoring).

It was also stated that the management of clients with high psychiatric and physical risk is complex and requires specialist training.

Butterfly Foundation stated that chief difficulties in this area are often related to medication treatments. For example, some medications are very effective for depression but not for anorexia nervosa. "So when someone is experiencing both illnesses it can be hard to know what to treat first". There can also be difficulties in working with people who are highly anxious and afraid of hospitalisation, even though this may be necessary due to them being physically compromised.

According to Eating Disorders Foundation of Victoria, there is a lack of:

- Knowledge amongst professionals of eating disorders and its common link to anxiety and depression.

**Table 4: List of strategies/lifestyle that were described as effective**

- 
- Receiving professional treatment from health practitioners, programs and organisations that have experience in these areas.
  - Specialist assessment and Management Plan facilitation - then devolve care to GP
  - On-going outpatient support with a multi-disciplinary team approach.
  - Holistic approach Person centred approach that treats the mind and body
  - Non-punitive approach
  - Systematic approach
  - Involve family (as much as possible)
  - Separating the person from the illness
  - Addressing nutrition & eating behaviour;
  - Psychological support during this phase as indicated by symptoms & evidence base in treatment
  - Developing broad support networks - health professionals, community friends and relatives.
  - Being connected with friends and family.
  - Remaining connected with your communities. (work, hobbies etc)
  - Education and awareness of the mental illnesses that you have.
  - Reading/watching recovery stories
  - Support groups
  - Non-judgmental, strengths-focused treatment programs
  - Keeping a journal
  - Reading self help books particularly at points that you feel yourself lapsing.
  - Self awareness (e.g. Triggers)
  - Dietary allocations
  - Relaxation techniques (with regular follow up by treating team)
  - CBT techniques (coached by clinical psychologist)
  - Reported difficulties in the provision of services
  - Participants were asked to describe issues that they currently experience in delivering services. They referred to issues such as
  - Difficulties accessing affordable services
  - Lack of specific expertise in eating disorders, particularly in rural areas
  - Clients' resistance to taking medication
  - Not able to dedicate the resources and time needed to work with women who often require long term support (e.g. counselling and medical monitoring).
- 

- Continuity in professional treatment and support in the public health system.
- Awareness within the community that anxiety and depression is a contributing factor for some people developing and eating disorder at any stage of their life.

South West Area Eating Disorder Service said that there was a lack of basic training for nurses, dietitians and GPs.

The Centre for Adolescent Health stated that treatment has to be integrated - “you can’t have one health professional treating the eating disorder and another (treating) the depression or anxiety”. However, other organisations stated that some practitioners focus on the anxiety and depression without also incorporating the impact of starvation and/or binge/purges on mood. Then there are also those that focus more on the weight, without taking in the psychological aspects.

Oak House stated that anxiety and depression are often symptoms of being significantly under weight and therefore it is difficult to ascertain whether it is depression/anxiety or more eating disorder related symptoms. Mooroolbark Dietetic Services stated that it was difficult to know which to treat first. They acknowledged that lack of eating contributes to anxiety/depression: “But which comes first?”

One participant hypothesised that eating disorder behaviours are often a strategy to manage underlying depression and anxiety. So often when the client’s eating disorder improves the underlying problems of anxiety and depression resurface.

According to Illawarra Eating Disorders Service, clients often deny the severity of anxiety/depression symptoms, interaction of the eating disorders with depression or anxiety (i.e. one perpetuating the other). ISIS- Centre for Women’s Action on Eating Issues stated that these clients are less likely to utilise groups due to higher levels of social anxiety and risks for possible suicidality, self harm. This can also impact on face to face work.

Some participants suggested that antidepressants and atypical antipsychotics have a role in the treatment of co-morbidities of eating disorders and anxiety and depression, but a number of patients are resistant to taking medication.

Royal Brisbane Hospital Eating Disorders Outreach Service identified a lack of specialist clinicians, especially in rural and regional areas. This was also the case for South Australia, where there are limited public programs that specialize in eating disorders (there is one inpatient program; no day programs). Joondalup mental health unit stated that not only were patient services limited, but there was also limited knowledge and education.

Southern Health referred to difficulties in knowing how to access a specialist. Lismore Eating Disorders and Women’s Health stated that the difficulty in their region is that they have no specialist ‘eating disorders treatment’ professionals. They are all generalists - either as private practitioners, or working in the health department. Murray Plains Division of GP stated that remoteness from larger centres where specialist services exist, cost, travel etc. There was also a lack of expertise among GPs in diagnosing and dealing with these patients in small rural areas.

Shoalhaven body image & eating behaviour service stated that many people who experience eating disorders find it difficult to present for support and information due to the stigma associate with the illness.

Participants referred to the length of time it takes for treatment to be effective. This has implications regarding the Medicare rebate for counselling. Although this rebate was described as helpful, it is not considered enough for the people who need access to weekly or fortnightly counselling for an extended period, sometimes years, especially if the “gap” is sizeable. In addition, people recovering from an eating disorder are often ambivalent about their recovery, so programs need to be flexible.

Oak House stated that anxiety levels may increase early on in treatment. It is therefore difficult to keep clients engaged in treatment because symptoms typically worsen before any major improvement. MonashLink Community Health Service noted that people who do not have a lot of money and are not “at death’s door” often have great difficulty accessing treatment.

## Research priorities

The final question asked participants to suggest priorities for research. One participant stated: “Anything! Unfortunately there is a great lack of research in the eating disorders field and we need to learn much more about what treatments work for the benefit of all sufferers, carers and professionals”. However, according to Baigent (2008), “It is important not to be misled by the call for more research. In fact there has been a

lot of research done in the area but little with any real relevance to clinical work. Fairburn and Janet Treasure are two who have done a lot of good research in eating disorders” (personal communication).

Participants made the following suggestions for future research projects:

1. Some longitudinal studies around age of onset and prognosis.
2. Geographical and cultural variables and treatment outcomes.
3. Nature versus nurture of eating disorders.
4. Best practice for patients that are unable to access specialised metropolitan services (e.g. in rural areas).
5. Difficulty of treating patients with AN when they have marked obsessive compulsive features, especially when it related to over-exercising.
6. Comparing different systems approaches to care (e.g. individual vs. systems therapy).
7. Long term support for adults with eating disorders.
8. Involving carers in supporting individuals with eating disorders.
9. Prevention.
10. Effectiveness of treatment programs.
11. The most supportive, effective and lasting approaches by the way of treatment methods/styles.
12. Treatment that have been identified as overlapping or similar in benefit across these three illnesses.
13. The most effective treatment approach (combined treatment), sequential or simultaneous psychological treatment for both conditions.
14. Co-morbidity.
15. Research with people who have recovered from eating disorder who have also had anxiety and depression to explore which interventions were most useful in their recovery.
16. Non medication interventions.
17. Retrospective qualitative research can be helpful - with people who have

‘recovered’ from these difficulties, as well as their families.

18. Factors associated with good treatment outcomes, especially client factors and social factors.
19. The effectiveness of acceptance and commitment therapy in managing rigid thoughts about body image and food.
20. Effective ways to treat all conditions concurrently.
21. Acceptance and Commitment Therapy - Randomised Control Trial.
22. Multi-disciplinary teams.
23. Prevalence, identification and/or treatment of disordered eating, anxiety and depression in overweight and obese adolescents and adults.
24. Effectiveness of various treatments on pre-morbid depression and anxiety.
25. Effectiveness and risks of anti-depressants at low weights.
26. Social health & gender analysis.
27. Prevention and early detection initiatives.
28. Family based treatments for adolescents with co-morbidities.
29. Evaluation of existing services for outcomes including symptom relief and quality of life.

## Incidental findings

The incidental findings are both around the issue of diagnosis.

### 1. Diagnostic criteria

Several participants expressed difficulties with the diagnostic criteria of co-morbidity of eating disorder with anxiety and depression. One participant said:

*When you refer to people with “an eating disorder who experience anxiety and depression”, do you mean people with an actual clinically diagnosable, co-morbid mood or anxiety disorder? (In which case we don’t know of research or treatment initiatives which specifically target this group). Or do you mean people with an eating disorder who are also experiencing anxiety and depression - which in our view, would be all of them, as anxi-*

ety and depression are inherent in the experience of an eating disorder.

## 2. Obesity

One participant described people with obesity who experience anxiety and depression. However, unlike anorexia nervosa and bulimia nervosa, obesity is not categorised as a mental illness/eating disorder.

*While obesity is not an eating disorder, obese patients are at increased risk of binge eating disorder, and other disordered eating. Obesity also increases the risk of anxiety and depression. There are few treatment options available for overweight and obese adolescents and adults. Most people attempt to lose weight independently, or via commercial weight loss programs. The few non commercial treatment options available to overweight/obese individuals are typically medically based. Despite high prevalence, and often high severity, disordered eating, anxiety and depression are often not identified, and are rarely treated in obesity interventions.*

## Some concluding remarks

At the beginning of this project, the authors of this research report knew little about eating disorders with co-morbid anxiety and depression. This short research project, undertaken over a ten week period, gave us some insight into the problems that people with an eating disorder who experience anxiety and depression may experience. It also highlighted problems that people who support those with an eating disorder (professionals, family and friends) may experience. Clearly research into co-morbidity of eating disorders with anxiety and depression is an area that requires urgent, and rigorous, attention. In particular, evidence-based research is needed to determine what treatments are effective. The findings of this research needs to be disseminated in ways that enable people working in the area to easily access and understand. This may help to close the theory-practice gap. ❖

# 7

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# 8 Appendices

**Appendix 1: Questionnaire**

**Appendix 2: Available resources**

**Appendix 3: Inpatient services in Australia**

**Appendix 4: Summary of eating disorder organisations**

## Appendix 1: Questionnaire

### Questionnaire

#### Eating disorder/anxiety and depression: What resources are available?

**Organisation Name:**.....

**Contact Name:** .....

**Phone:**.....

**Email:**.....

Thank you for taking the time to complete this brief questionnaire. Please complete the questions either by typing in your responses and returning the form as an email attachment to <mailto:ewendy57@optusnet.com.au>, faxing it to 03 9489 0504 or mailing it to PO Box 1235, Fitzroy North, VIC 3068. You are welcome to print a copy and fill it in by hand if you prefer.

1 What resources does your organisation have available for people with an eating disorder who experience anxiety and depression?

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2 In your view, which of these resources are the most useful? Please describe why these resources are helpful.

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Research Matters  
<http://www.researchmatters.net/>

3 What resources does your organisation have available for non-professional carers (e.g. family members, friends) of people with an eating disorder who experience anxiety and depression?

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4 Does your organisation provide information about eating disorders/anxiety and depression for any of the following professionals? If so, please describe the resources that are currently available.

GPs

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Dieticians

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Psychologists

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Research Matters  
<http://www.researchmatters.net/>

**Psychiatrists**

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**Social workers**

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**Complementary  
therapists (e.g.  
naturopaths,  
acupuncturists,  
homeopaths)**

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**School counselors**

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**Research Matters**  
<http://www.researchmatters.net/>

Sports coaches

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Volunteers

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**5** What treatments/programs do you consider to be the most effective for people with an eating disorder who experience anxiety and depression?

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**6** What strategy/lifestyle do you consider to be the most effective for people with an eating disorder who experience anxiety and depression?

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Research Matters  
<http://www.researchmatters.net/>

**7** Describe any difficulties in the provision of services for people with an eating disorder who experience anxiety and depression?

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**8** Which area of research on eating disorders/anxiety and depression should be a priority?

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**Any additional comments:**



Research Matters  
<http://www.researchmatters.net/>

## Appendix 2: Available resources

### Books recommended by participants

1. “Bulimia Nervosa and Binge Eating: A self help guide to recovery using cognitive behavioural strategies” by Peter J. Cooper.
2. Skills-based Learning for Caring for a Loved One with an Eating Disorder, 2007, Treasure, Smith and Crane. Published by Routledge
3. Talking to Eating Disorders: simple ways to support someone with anorexia, bulimia, binge eating or body image issues, 2005, Heaton & Strauss. Published by New American Library
4. The Secret Language of Eating Disorders, 1997, Claude-Pierre. Published by Vintage Books

A new book “Interventions for Body Image and Eating Disorders: Evidence and Practice” edited by Susan Paxton and Phillipa Hay will be published in February, 2009

Co-edited book by Pr. Susan Paxton about treatments for eating disorders, dealing with various forms of treatment (e.g. family-based, cognitive-behavioural, interpersonal) and treatment delivery modes (e.g. face to face; internet delivery; guided self-help)

Eating Disorders Foundation of Victoria (EDFV) publishes a range of resources that can be ordered on-line. These include:

1. An Eating Disorders Resource for Schools  
Produced by the EDFV and CEED, this 92 page resource focuses on information for school staff about health promotion, identification, early intervention and restoring student well-being. Includes case studies, interviews and observations from school teachers, parents and those suffering or recovered from an eating disorder.
2. Information on Eating Disorders for Families, Partners & Friends  
Produced by the EDFV this 76-page booklet provides information for carers about the disorders, and ideas about how to help.
3. Information on Eating Disorders for Health Professionals (1999)  
40-page booklet, produced by the EDFV, providing information useful to a range of health practitioners and community workers.
4. Understanding Eating Disorders (2002)  
35 page Australian booklet providing detailed information about eating disorders and personal experiences. This booklet was first printed in 1992, and has since had three revisions. It contains seven easy to read sections including: Description of an eating disorder; What causes eating disorders; Seeking help; Different types of treatment and therapy; How are family and friends affected; hat can family and friends do; Recovery stories.
5. When all food tastes yuck  
Produced by the EDFV, When All Food Tastes Yuk was written as a response to the increase in eating disorders such as anorexia nervosa and bulimia in children aged from 8 to 15. It is aimed at helping carers and families understand what an eating disorder is and how they can relate to a child who has an eating disorder. The booklet provides information on eating disorders and features contributions from children, including a front cover depicting an 11-year-old boy’s “eating disorder monster”. Written in simple to read language with quotes, illustrations and case studies, chapters include: Warning Signs; Choosing Appropriate Help; Helping Siblings; Prevention and Approaching Someone.
6. An eating disorders resource for coaches  
This resource covers identification, intervention, support and prevention for coaches and sports professionals.

7. An eating disorders resource for health and fitness professionals

A 50 page resource, also covering identification, intervention, support and prevention.

### **Clinical practice guidelines**

1. Anorexia nervosa: Australian treatment guide for consumers and carers, Royal Australian and New Zealand College of Psychiatrists, 2005

This treatment clinical practice guideline is for adolescents and adults who have anorexia nervosa or who believe they are at risk of developing it. The guide contains the latest research available on anorexia nervosa and recommendations from recovered consumers to assist people to choose the best kind of treatment.

2. Australia and New Zealand clinical practice guidelines for the treatment of anorexia nervosa, Royal Australian and New Zealand College of Psychiatrists, 2004

These guidelines rely largely upon expert opinion and uncontrolled trials. These guidelines acknowledge that it is not possible to draw general conclusions about the efficacy of specific treatment options for anorexia nervosa because there are few controlled clinical trials. It is also acknowledged that the quality of trials that have been done is generally poor.

## Appendix 3: Inpatient services in Australia

In 2007, the number of in-patient beds in each state and territory of Australia were collected by Australian and New Zealand Assembly of Eating Disorders (ANZAED). This data has been checked and up-dated for this report. As a result, Austin Health, Royal Children's Hospital, Frankston Hospital, Geelong Clinic and Southern Health have been added to the list of hospitals in Victoria; and Sydney Children's Hospital Randwick and Redbank House have been added to the list of hospitals in NSW.

While many patients with an eating disorder can be treated effectively as outpatients, an ANZAED position paper states that "there is a continued need for specialist inpatient services for those with severe illness" (2008). ANZAED endorses the RANZCP guidelines for specialist inpatient care and indications for admission.❖

STATE	HOSPITAL	NUMBER OF BEDS
ACT		0
NSW	Westmead	<ul style="list-style-type: none"> <li>• 4 Children (12 - 16 years)</li> <li>• 8 Adolescent (14 - 18 years),</li> <li>• 3 - 4 Adult</li> </ul>
	Redbank House	1
	Royal Prince Alfred	4
	Sydney Children's Hospital Randwick	3-4 Not designated (6-17 years)
	Wesley (private)	10
	Northside Clinic (private)	15 - 18
Northern Territory		0
Queensland	Royal Brisbane	5
	Mater	10
	New Farm Clinic (private)	10
South Australia	Flinders Medical Centre	6
	Women's & Children's	3
Tasmania		0
Victoria	Royal Melbourne	8
	Austin Health	9 (mood and eating disorder beds)
	Royal Children's adolescent unit	Not designated (approx 6 people admitted with an eating disorder at any one time)
	Southern Health (Monash Medical Centre)	2 adult 6 adolescent medical unit 2 Not designated (stepping stones)
	Frankston Hospital	1
	Melbourne Clinic (private)	7
	Geelong Clinic (private)	6
Western Australia	Princess Margaret Children's	6-8 general medical wards
	Hollywood (private)	6-8

## Appendix 4: Summary of eating disorder organisations

The following table provides a short description of each eating disorder organisation, including whether or not the organisation provides an eating disorder specific service. Organisations were identified using the following methods: Internet search; white/yellow pages; snowball method and information provided by beyondblue's clinical advisor.

Not all organisations or individual services/practitioners providing specific services for people with eating disorders were identified using this methodology. So this table does not provide a complete listing of all services available in Australia, but rather provides a snapshot of the kinds of services available. ❖

### Eating disorder organisations in Australia

National/ State	Service Type	Name of Organisation	ED specific Y/N	Description
National	Peak Body	Australia and New Zealand Assembly of Eating Disorders (ANZAED)	Y	ANZAED is a multidisciplinary organisation that represents and supports the activities of all professionals working in the field of eating disorders and related issues.
National	Sports Institute	Australian Institute of Sport	N	The Australian Institute of Sport has regularly requested input from the Flinders Medical Centre's Weight Disorders Unit Director to provide education, consultation and advice as well as to present at their conferences.
National	Peak body	Australian Women's Health Network	N	AWHN is a not-for-profit network run primarily by volunteers to maintain and advance a national voice on women's health through advocacy and information sharing.
National	Association	Dieticians Association of Australia	N	DAA provides a range of publications to keep members informed about the profession and current issues in nutrition and dietetics.
National	Foundation	The Butterfly Foundation	Y	Community based charitable organisation that supports people with eating disorder and their carers through direct financial relief, advocacy and lobbying, awareness campaigns, health promotion and early intervention work.
National	Private company	Mandometer Pty Ltd	Y	A program for the treatment of eating disorders developed at the Karolinska Institute in Sweden.

National/ State	Service Type	Name of Organisation	ED specific Y/N	Description
Victoria	Public Hospital	Austin Health, acute psychiatric unit	N	The acute psychiatric unit is a general psychiatric unit containing 9 beds allocated for eating disorders.
Victoria	Public Hospital	Frankston Hospital	N	Frankston Hospital has one eating disorder inpatient bed available for people on the Mornington Peninsular.
Victoria	Public Hospital	Royal Melbourne Hospital, Eating Disorder Program	Y	Patients of the program may attend an outpatient clinic or day program or become an inpatient of the service.
Victoria	Public Hospital	Royal Children's Hospital Healthy Eating Program at the Adolescent Unit	Y	The Healthy Eating Program at the Centre for Adolescent Health is a state-wide service that offers assessment, consultation and treatment services to young people (11 – 17 years old) with a variety of eating concerns.
Victoria	Public Hospital	Southern Health (Monash Medical Centre, Eating Disorders Program)	N	There are 3 distinct services <ul style="list-style-type: none"> <li>• 2 beds in a specialist adult mental health inpatient service</li> <li>• 6 acute beds on adolescent medical unit for young people with an eating disorder who require management of the physical complications of the illness.</li> <li>• 2 beds in the Adolescent Psychiatry Inpatient Unit (Stepping Stone) for those patients with an Eating Disorder who have an additional psychiatric co-morbidity.</li> </ul>
Victoria	Community based specialised service	Butterfly/ Southern Health Day Program	Y	The day program provides support and intervention to individuals and their families who are suffering from eating disorders.
Victoria	Private Hospital	Melbourne Clinic, eating disorders unit	Y	The Eating Disorders Unit has 7 in patient beds.
Victoria	Outpatient facility	Oak House	Y	Recovery programs for all types of eating disorders.
Victoria	Institute	The Bouverie Centre	N	Bouverie Centre provides family therapy for Mental Health issues including eating disorders
Victoria	Health service	Geelong DES	Y	The service is run by Barwon Health.
Victoria	Health service	Recovery is Possible for Everyone – RIPE	Y	RIPE has a counsellor and dietitian to offer a coordinated, multidisciplinary approach for people who are struggling with eating disorders and body image issues.
Victoria	Private health service	Mooroolbark Dietetic Services	N	Specialist dietitians assist clients to becoming as healthy as possible and maintain a weight that is right for them.
Victoria	Community Health Service	MonashLink	N	MonashLink provides treatment for people with mild to moderate eating disorders (including binge eating disorder, bulimia, and anorexia) and disordered eating.
Victoria	Division of GPs	Rich River Health Group	N	An amalgamation The Murray River Medical Centre, Moama Medical Centre, Heygarth Street Medical Clinic and Percy Street Medical Centre.
Victoria	Mental Health Service	Goulburn Valley CAMHS	N	Specialist child and adolescent mental health service.
Victoria	Division of GPs	Murray-Plains	N	CBT counselling services in general practices.
Victoria	Community Health Service	Sunraysia	N	Listed on the CEEDs web page as providing rural services for people with an eating disorder.

National/ State	Service Type	Name of Organisation	ED specific Y/N	Description
Victoria	Mental Health Services	Peninsula Health	N	Produced a video "Eating disorders: anorexia/bulimia nervosa" which is available in several hospital libraries.
Victoria	Foundation	Eating Disorders Foundation of Victoria	Y	The foundation provides information, knowledge, support and resources in order to encourage resilience and recovery and lessen the impact of the eating disorder on the quality of life of individuals and families.
Victoria	Centre	The Bronte Centre at St. Vincent's Health	Y	The centre offers intensive outpatient treatment for people with body image and eating disorders including psychological counselling, dietetic management, behavioural challenges, medical management
Victoria	Centre	Centre for Adolescent Health	N	The Centre responds to the health problems that affect young people between the ages of 10 and 24 years.
Victoria	Research group	La Trobe University School of Psychological Science, Eating Disorder and Body Image Research Group	Y	Eating Disorder and Body Image Research Group runs groups for mid-life women with body image problems.
Victoria	Psychology Clinic	Swinburne University of Technology, Psychology Clinic	N	Provides a range of low-cost psychological services to the Melbourne community, including to people with eating disorders.
Victoria	Centre	Victorian Centre of Excellence in Eating Disorders	Y	CEED aims to undertake strategies to build quality, sustainable eating disorder treatment responses delivered by public specialist mental health services.
Victoria	Health program	RMIT Choose Health Program	Y	A cognitive behaviourally based lifestyle interventions for overweight and obese adolescents and adults.
Victoria	Support groups	EDFV	Y	EDFV runs three distinct support groups in Melbourne and rural Victoria: (1) For people with an eating disorder; (2) Support group for families and friends of people with an eating disorder; (3) Combined support group.
New South Wales	Public hospital	Central Coast Eating Disorders Early Intervention Outpatient Service	Y	Outpatient service with dietitian, clinical psychologist, and social worker.
New South Wales	Public hospital	Children's Hospital Institute of Sports Medicine	Y	Individual outpatient treatment for anorexia nervosa, bulimia nervosa, eating disorder not otherwise specified, disordered eating, overweight, binge eating disorder and obesity.
New South Wales	Public hospital	Macarthur Mental Health Service	N	Eating Disorders Clinic outpatient clinic provides assessment and treatment.
NSW New South Wales	Public hospital	Nepean Hospital	Y	Patients requiring admission are admitted to a general ward. There is also an outpatient Eating Disorder Clinic.
New South Wales	Public hospital	Redbank House child, adolescent and family psychiatry	N	Adolescent mental health inpatient unit with one bed available for young people with an eating disorder.
New South Wales	Public hospital	Royal Prince Alfred Hospital	Y	Four beds are allocated for people with eating disorders in the Missenden Unit.

National/ State	Service Type	Name of Organisation	ED specific Y/N	Description
New South Wales	Public hospital	Royal Prince Alfred Hospital, Eating Disorder Outpatient Clinic	Y	Adult outpatient assessment clinic with limited dietetic and psychological treatment capacity.
New South Wales	Public hospital	South West Area Health Services, Adult Eating Disorder Day Treatment Program	Y	A structured recovery program with supervised meals for re-feeding/weight restoration and normalisation of eating, psychological group program, individual psychiatric management and individual psychotherapy.
New South Wales	Public hospital	Sydney Children's Hospital Randwick, child and adolescent mental health service	N	Provides a broad range of mental health services, including 3-4 inpatient beds for young people (6-17 years) with an eating disorder.
New South Wales	Public hospital	Tamworth Base Hospital, Nutrition and Dietetics Department	N	Outpatient dietetic counselling for people with an eating disorder.
New South Wales	Public hospital	Westmead Hospital	Y	The Children's Hospital at Westmead has a 4 inpatient beds for children aged 12 – 16 on a children's medical unit with a medical treatment and re-feeding program. For adolescents aged between 14 -18, there are 4-6 beds on an adolescent medical unit and 2 beds on the adult acute psychiatric unit. The Adult Inpatient Program has 3 beds on general psychiatric ward.
New South Wales	Public hospital	Westmead Hospital Outpatient Eating Disorder Clinic	Y	Individual and Group programs for Bulimia and Binge Eating.
New South Wales	Private Hospital	Peter Beumont Centre for Eating Disorders Wesley Private Hospital	Y	Wesley Private Hospital has 10 inpatient beds for people with an eating disorder. It also has a day program.
New South Wales	Private Hospital	Northside Clinic	Y	Northside Clinic has 15 – 18 beds for people with an eating disorder.
New South Wales	Health service	Centre for Psychotherapy, Eating Disorders Service, Newcastle	Y	Eating Disorder Assessment, Treatment and Information Service.
New South Wales	Health service	Hunter Mental Health Services Community Adolescent Team	N	Eating disorder outpatient service for 12-18 years olds.
New South Wales	Health centre	Lismore Eating Disorders and Women's Health Centre	Y	Women's Health Centre provides assessment and treatment for women with eating disorders.

National/ State	Service Type	Name of Organisation	ED specific Y/N	Description
New South Wales	Health centre	Shoalhaven Body Image and Eating Behaviour Service	Y	The service provides assessment, personal nutritional feedback and guidance, individual counselling, group treatment, information resources, family support, and cross-referral liaison.
New South Wales	Health centre	Illawarra Eating Disorders Service	Y	Type of Service: Assessments, Ongoing individual counselling, Nutrition counselling, Support for sufferers and carers, Group programs, Information and community activities
New South Wales	Centre	NSW Centre for Eating & Dieting Disorders	Y	CEDD is an academic and support centre with a number of key functions.
New South Wales	Foundation	Eating Disorders Foundation	Y	Provides programs to assist in recovery and provide links between hospitals, patients, family, schools and community.
Queensland	Public hospital	Royal Brisbane and Women's Hospital	Y	5 in-patient beds are available for the treatment eating disorders.
Queensland	Public hospital	Brisbane Hospital Eating Disorders Outreach Service	Y	The outreach service provides consultation and support services.
Queensland	Public hospital	Mater Hospital	N	There are 10 beds in the child youth mental health service for adolescents with a range of mental illnesses, including eating disorders.
Queensland	Private hospital	New Farm Clinic, Eating Disorders	Y	The Eating Disorders unit is a 10 bed facility that provides treatment to patients suffering from anorexia nervosa, bulimia nervosa and other disordered eating behaviours.
Queensland	Private health service	Eating Disorder Nutrition Services	Y	Services offered include: one on one, family support, supportive meal education, workshops, consultation, and research.
Queensland	Association	The Eating Disorders Association	Y	EDA has developed a resource kit to assist health professionals, groups or individuals in establishing and maintaining a healthy support group for people affected by eating disorders.
Queensland	Support group	Anorexia & Bulimia Support Resource Gold Coast	Y	A small self funded support group.
Queensland	Centre	ISIS Centre for Women's Action on Eating Issues	Y	ISIS developed a model of woman-centred or feminist group work practice with women who identify as having serious eating issues such as bulimia, anorexia, and compulsive eating.
Northern Territory	Association	Northern Territory Association for Mental Health	N	
ACT	Program	ACT Eating Disorders Program	Y	A specialist, community-based, multi-disciplinary team providing a comprehensive assessment and treatment program for all eating disorders.
ACT	Centre	Women's Centre for Health matters	N	Women's Centre for Health matters works to improve the health and well-being in the ACT and region.
Tasmania	Health service	Community Nutrition Unit	N	The Community Nutrition Unit works with communities to improve nutritional and food related health.

National/ State	Service Type	Name of Organisation	ED specific Y/N	Description
Tasmania	Support group	Support Group for Family and Friends of People with Eating Disorders	Y	
South Australia	Public hospital	Flinders Medical Centre Weight Disorder Unit	Y	An academic unit which has 6 beds and provides a comprehensive service managing co-occurring depression and anxiety.
South Australia	Public hospital	Women's & Children's Hospital	Y	WCH adolescent ward has 3 inpatient beds for people with eating disorders.
South Australia	Private Hospital	Blackwood Private Hospital	N	Provides treatment for patients by a GP and counsellor. Admissions are possible.
South Australia	Health service	Southern Primary Health – Southern Women's	N	Provides referral information for women with an eating disorder.
South Australia	Health service	Flinders University Services for Eating Disorders	Y	Provides outpatient psychotherapy programs, treatments, training and conducts research.
South Australia	Association	Eating Disorders Association of South Australia	Y	The Eating Disorders Association of South Australia (EDA <sub>SA</sub> ) is a not for profit community organisation established in 1983 with the aim of providing information and support to people with eating disorders, their friends and families as well as to better inform the community of the effects of these conditions.
South Australia	Sports Institute	South Australian Sports Institute	N	Provides information about eating disorders.
South Australia	Network	Private practitioner network	N	An unofficial group of clinicians in South Australia who treat patients with an eating disorder.
Western Australia	Public hospital	Princess Margaret Hospital for Children	Y	The Princess Margaret Hospital for Children has 6 – 8 beds for eating disorders.
Western Australia	Private hospital	Hollywood Private Hospital	Y	Hollywood Private Hospital has 6 – 8 beds for people with eating disorders and an outpatient eating disorder program.
Western Australia	Health service	Joondalup Mental health Unit	N	A therapy team including a clinical psychologist, psychiatric (consultants and registrars), nursing staff trained in mental health and dietician review.
Western Australia	Private practice	Eating Disorders Centre	Y	The Eating Disorders Centre is a psychology-based private practice.
Western Australia	Centre	Centre for Clinical Interventions	N	CCI conduct clinically applied psychosocial research and provide training and supervision for various psychological interventions.
Western Australia	Association	Bridges Association Incorporated	Y	Bridges Association was established to promote understanding and to provide support services for all people affected by eating disorders in Western Australia.



# 9

# Contact List

## National

### Australian Institute of Sport

**Address:** PO Box 176  
Belconnen ACT 2616  
**Ph:** (02) 6214 1111  
**Fax:** (02) 6251 2680  
**Web:** <http://www.ausport.gov.au/ais/>

### Australia and New Zealand Academy of Eating Disorders

**Contact:** Phillipa Hay  
**Address:** School of Medicine  
Locked Bag 1797  
Penrith South DC NSW 1797  
**Email:** P.Hay@uws.edu.au

### Dietitians Association of Australia

**Address:** 1/8 Phipps Close  
Deakin ACT 2600  
**Ph:** (02) 6163 5200  
**Fax:** (02) 6282 9888  
**Email:** nationaloffice@daa.asn.au

### The Butterfly Foundation

**Contact:** Julie Thomson  
Volunteer Services Co-ordinator &  
Information Officer  
**Address:** PO Box 453,  
Malvern VIC 3144  
**Ph:** (03) 9822 5771  
**Fax:** (03) 9822 5776  
**Email:** julie@thebutterflyfoundation.org.au  
**Web:** <http://www.thebutterflyfoundation.org.au/>

## Victoria

### Acute Psychiatric Unit, Austin Health

**Contact:** Mary Apostolidis (NUM)  
**Address:** 4797 Banksia St  
Heidelberg VIC 3084  
**Ph:** (03) 9496 6407  
**Fax:** (03) 9496 2091  
**Email:** Mary.apostolidis@austin.org.au

### Bendigo Eating Disorders Support Network

**Contact:** Mark McHugh  
**Address:** 8 Olinda Street VIC Bendigo  
**Ph:** 0417 523 583  
**Email:** mmchugh@mpdgp.com.au

### Bouverie Centre

**Contact:** Dr Colin Riess  
**Address:** 8 Gardiner St  
Brunswick VIC 3086  
**Ph:** (03) 9385 5100  
**Fax:** (03) 9376 9890  
**Email:** c.riess@latrobe.edu.au  
**Web:** [www.latrobe.edu.au/bouverie](http://www.latrobe.edu.au/bouverie)

### Bronte Centre at St. Vincent's Health

**Contact:** Jan Clarke  
**Address:** 33 Wakefield St  
Hawthorn VIC 3122  
**Ph:** (03) 9854 1700  
**Fax:** (03) 9854 1701  
**Email:** Jan.clarke@svhm.org.au  
**Web:** [www.thebrontefoundation.com.au](http://www.thebrontefoundation.com.au)

## Centre for Adolescent Health

**Contact:** Professor Susan Sawyer  
Director, Centre for Adolescent Health  
**Address:** 2 Gatehouse St  
Parkville VIC 3052  
**Ph:** (03) 9345 6457  
**Fax:** (03) 9345 6502  
**Email:** susan.sawyer@rch.org.au  
**Web:** www.rch.org.au/cah

## Disordered Eating Service Geelong

**Address:** C/- CAMHS  
15 Parkington Street  
Geelong West VIC 3218  
**Ph:** (03) 5226 7075  
**Fax:** (03) 5222 8387  
**Email:** disordereating@gpageelong.com.au  
**Web:** www.gpageelong.com.au

## Eating Disorders Foundation of Victoria (EDFV)

**Contact:** Marilyn Amendola  
Volunteer Services Co-ordinator &  
Information Officer  
**Address:** 1513 High Street,  
Glen Iris VIC 3146  
**Ph:** (03) 9885 6563  
**Email:** marilyn.amendola@eatingdisorders.  
org.au  
**Web:** www.eatingdisorders.org.au

## Frankston Hospital

**Contact:** Dr Simon Blair  
**Address:** Hastings Road  
Frankston VIC 3199  
**Ph:** (03) 9783 2064  
**Fax:** (03) 9783 9655  
**Email:** cranbournerd53@optusnet.com.au

## Geelong Clinic

**Address:** 98 Townsend Road,  
St Albans Park VIC 3219  
**Ph:** (03) 5248 1155  
**Fax:** (03) 5248 4852

## Geelong Anorexia and Bulimia Support Group

**Contact:** Dr Ross King  
**Address:** 1 McKillop St  
Geelong VIC 3220  
**Ph:** (03) 5227 8481  
**Fax:** (03) 5227 2021  
**Email:** rking@deakin.edu.au

## Goulburn Valley Child & Adolescent Mental Health Service

**Contact:** John Miksad  
**Address:** Graham St  
Shepparton VIC 3630  
**Ph:** (03) 5832 2200  
**Fax:** (03) 5832 2206  
**Email:** John.Miksad@gvhealth.org.au

## Karolinska Institute (Vic) (See Manodometer)

## La Trobe University School of Psychological Science

**Contact:** Beth Shelton  
**Address:** La Trobe University  
Bundoora VIC 3083  
**Ph:** (03) 9479 2949  
**Email:** b.shelton@latrobe.edu.au  
**Web:** <http://www.latrobe.edu.au/psy/projects/bodyfree/>

## Mandometer Pty Ltd

**Contact:** Melanie Ward  
**Address:** 412 Bay Street  
Brighton, Melbourne VIC 3186  
**Ph:** (03) 9596 5718  
**Email:** melanie.ward@mandometer.com.au

## MonashLink Community Health Service

**Contact:** Dr Beth Shelton and Sheree Smalley  
**Ph:** (03) 8540 6000  
**Email:** bshelton@monashlink.org.au

## Mooroolbark Dietetic Services

**Contact:** Julie Viney  
**Address:** 156 Manchester Rd  
Mooroolbark VIC 3138  
**Ph:** (03) 9726 0810  
**Fax:** (03) 9726 0810  
**Mob:** 0407 329 722 (BH)  
**Email:** julieaviney@optusnet.com.au

## Murray-Plains Division of General Practice

**Contact:** Angela Boal  
Program Services Team Leader

**Address:** P O Box 459  
Cohuna VIC 3568

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**Fax:** (03) 5456 4087

**Email:** aboal@mpdgp.com.au

**Web:** <http://www.mpdgp.com.au>

## Oak House

**Contact:** Natasha Hepworth

**Address:** PO Box 210  
Surrey Hills, VIC 3027

**Ph:** (03) 9888 4737

**Fax:** (03) 9888 4797

**Email:** team@theoakhouse.com.au

**Web:** <http://www.theoakhouse.com.au>

## Recovery is Possible for Everyone - RIPE

**Contact:** Sarah Harry

**Address:** The Abbotsford Convent  
C1.48, 1 St. Heliers Street,  
Abbotsford, VIC 3067

**Ph:** 0412 128 115 (BH)

**Email:** info@recoveryispossible.com.au

**Web:** <http://www.recoveryispossible.com.au>

## Rich River Health Group

**Contact:** Dr John Quayle

**Address:** 214 Ogilvie Ave  
Echuca VIC 3564

**Ph:** (03) 5480 6700

## Royal Melbourne Hospital - Eating Disorder Unit

**Contact:** Kerry Goddard (NUM)  
Dr Chia Huang (Director)  
Jani White (Coordinator, day program)

**Address:** 2nd Level, John Cade Unit, RMH  
Grattan St  
Parkville VIC 3052

**Ph:** (03) 9342 4033

**Email:** Jani.White@mh.org.au

## Southern Health (Monash Medical Centre)

**Contact:** Dr Paul Lee

**Address:** 246 Clayton Road  
Clayton VIC 3168

**Ph:** (03) 9594 1414

**Email:** Paul.Lee@southernhealth.org.au

**Web:** [www.southernhealth.org.au](http://www.southernhealth.org.au)

## Swinburne University of Technology, Psychology Clinic

**Contact:** Dr Roger Cook

**Address:** 33 Wakefield St  
Hawthorn VIC 3122

**Ph:** Reception: (03) 9214 8653

**Email:** psychclinic@swin.edu.au

**Web:** [www.swin.edu.au/pc](http://www.swin.edu.au/pc)

## Victorian Centre of Excellence in Eating Disorders

**Contact:** Michelle Robertson

**Ph:** (03) 8387 2669  
(03) 8387 2673

**Fax:** (03) 8387 2667

**Email:** Michelle.Robertson@mh.org.au  
ceed@mh.org.au

**Web:** [http://www.rch.org.au/ceed/index.cfm?doc\\_id=2783](http://www.rch.org.au/ceed/index.cfm?doc_id=2783)

## NSW

### Central Coast Eating Disorders Early Intervention Outpatient Service

**Contact:** Judith Leahy (Area Coordinator)  
**Address:** Level 2, Wyong Central Community Health Centre  
36a Pacific Highway  
Wyong, NSW, 2259  
C/- PO Box 361  
Gosford, NSW, 2250.  
**Ph:** (02) 4356 9418  
**Fax:** (02) 4356 9401  
**Email:** jleahy@nscchhs.health.nsw.gov.au

### Children's Hospital Institute of Sports Medicine (CHISM)

**Address:** Suite 13, Level 2 Medical Centre  
The Children's Hospital Westmead  
Crn Hawkesbury Rd & Hainsworth St  
Westmead 2145  
Postal: Locked Bag 4001  
Westmead NSW 2145

### Eating Disorders Foundation

**Address:** PO Box 532  
Willoughby NSW  
**Ph:** (02) 9412 4499  
**Fax:** (02) 9412 4499  
**Email:** edf@edf.org.au  
greta@edf.org.au  
**Web:** www.edf.org.au

### Eating Disorders Service Centre for Psychotherapy

**Address:** 72 Watt Street  
Newcastle NSW 2300  
**Ph:** (02) 4924 6820  
**Fax:** (02)4924 6801

### Hunter Mental Health Services Community Adolescent Team

**Address:** 36 Kenrick Street  
The Junction, NSW 2291  
**Ph:** (02) 49692477  
**Fax:** (02) 49610731

### Illawarra Adolescent Mental Health Service

**Address:** 1 Atchison St.,  
Wollongong, NSW, 2500  
**Ph:** (02) 4254 1500  
**Fax:** (02)4254 1555

### Illawarra Eating Disorders Service

**Contact:** Cathy Anderson  
**Address:** C/ - Bulli Community Health Centre  
322 Princess Highway  
Bulli NSW 2516  
**Ph:** (02) 4284 0355  
**Email:** Catherine.anderson@sesiahs.health.nsw.gov.au

### Lismore Eating Disorders and Women's Health

**Contact:** Mim Weber  
**Address:** 25 Uralba Street  
Lismore NSW 2480  
**Ph:** (02) 6621 9800  
**Email:** mimweber@versa.com.au

### Macarthur Mental Health Service Eating Disorders Clinic

**Address:** 6 Browne St  
Campbelltown NSW 2560  
**Ph:** (02) 46295400  
**Fax:** (02)46286101

### Nepean Hospital, Eating Disorders Clinic

**Address:** Cnr. Somerset and Derby Sts,  
Kingswood, NSW 2747  
**Ph:** (02) 4734 2352

### NSW Centre for Eating & Dieting Disorders (CEDD)

**Contact:** Sarah Maguire or Jeremy Freeman  
Eating Disorder Co-ordinators NSW  
**Ph:** (02) 9515 5843  
(02) 9515 6442  
**Email:** jfree@email.cs.nsw.gov.au,  
servicedevelopmentofficer@gmail.com,  
Sarah.maguire@email.cs.nsw.gov.au

## Redbank House child, adolescent and family psychiatry

**Address:** Institute Road, Westmead  
**Ph:** (02) 9845 6577  
**Fax:** (02)9891 5690

## Royal Prince Alfred Hospital Missenden Psychiatric Unit

**Contact:** Associate Professor Janice Russell  
**Address:** Level 1 Building 92  
 Royal Prince Alfred Hospital  
 Missenden Road Camperdown, 2050.

## Royal Prince Alfred Hospital Eating Disorder Outpatient Clinic

**Contact:** Dr Robert Gertler  
**Address:** Level 2, Building 92,  
 Royal Prince Alfred Hospital,  
 Missenden Rd., Camperdown  
**Ph:** (02) 9515 6040  
**Fax:** (02) 9515 6442

## Shoalhaven Body Image and Eating Behaviour Service, Nowra Community Health Centre

**Contact:** Ruth Sykes  
**Address:** PO BOX 55  
 Nowra NSW 2541  
**Ph:** (02) 4422 8111  
**Email:** ruth.sykes@sesiahs.health.nsw.gov.au

## SWAHS Adult Eating Disorder Day Treatment Program

**Contact:** Ms Natalie Crino (Clin. Psych)  
**Address:** 2D Fennell St  
 North Parramatta, NSW 2151  
**Web:** www.wsahs.nsw.gov.au  
**Postal:** P.O. Box 533 Wentworthville,  
 NSW 2145  
**Ph:** (02) 9630 9423  
**Fax:** (02) 9630 6190

## Sydney Children's Hospital Randwick

**Contact:** Dr Patricia McVeagh,  
 Medical Coordinator  
**Address:** High Street  
 Randwick, NSW 2031  
**Ph:** (02) 93824347

## Tamworth Base Hospital Nutrition and Dietetics Department

**Address:** Locked Bag 9783  
 Tamworth, NSW, 2340  
**Ph:** (02) 6767 8440  
**Fax:** (02)6766 3463

## The Children's Hospital at Westmead

**Contact:** Dr Sloane Madden  
 Department of Psychological Medicine  
**Address:** Hawkesbury Road  
 Westmead, NSW 2145  
**Ph:** (02) 9845 2005

## Westmead Hospital

**Contact:** Dr Simon Clarke  
 Department of Adolescent Medicine  
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 Westmead NSW 2145  
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 Wentworthville NSW 2145  
**Ph:** (02) 9845 6788  
**Fax:** (02) 9893 9062  
**Web:** www.wsahs.nsw.gov.au

## QLD

### Anorexia & Bulimia Support Resource Gold Coast

**Contacts:** Monica & Gwen  
**Address:** PO Box 391, Pacific Fair  
Broadbeach QLD 4218  
**Ph:** (07) 5522 8865  
**Email:** gceda@hotmail.com

### Eating Disorder Nutrition Services

**Contact:** Shane Jeffrey  
**Address:** 4 Jade St  
Albany Creek QLD 4035  
**Ph:** 0412 777 430 (BH)  
**Email:** shane\_jeffrey@health.qld.gov.au

### ISIS - Centre for Women's Action on Eating Issues

**Contact:** Amanda Deardon  
**Address:** 58 Spring Street  
West End QLD 4104  
**Ph:** (07) 3848 3377  
(07) 3848 3377  
**Email:** info@isis.org.au  
**Web:** www.isis.org.au

### New Farm Clinic

**Contact:** Rebecca Smith  
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New Farm QLD 4005  
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(07) 3254 9100  
**Fax:** (07) 3358 4781  
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### Royal Brisbane Hospital Eating Disorders Outreach Service

**Contact:** Elaine Painter and Erin Anderson  
**Ph:** (07) 3636 5241  
**Emails:** elaine\_painter@health.qld.gov.au  
erin\_anderson@health.qld.gov.au

### The Eating Disorders Association Inc (Qld)

**Contact:** Leanne Chapman  
**Address:** 12 Chatsworth Road  
Greenslopes QLD 4120  
**Ph:** (07) 3394 3661  
**Fax:** (07) 3394 3663  
**Email:** admin@eda.org.au, leanne@eda.org.au  
**Web:** www.eda.org.au

## NT

### Northern Territory Association for Mental Health

**Contact:** James Henderson  
**Ph:** (08) 8981 4128  
**Email:** james.henderson@teamhealth.asn.au

## ACT

### Women's Centre for Health Matters

**Contact:** Robyn James  
**Address:** Building One, Pearce Centre  
Collet Place  
Pearce ACT 2607  
**Ph:** (02) 6290 2166  
**Fax:** (02) 6286 2043  
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### Community Nutrition Unit

**Contact:** Julie Williams  
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Hobart TAS 7000  
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**Emails:** julie.williams@dhhs.tas.gov.au  
community.nutrition@dhhs.tas.gov.au  
**Web:** http://www.tas.eatingdisorders.org.au

### Support Group for Family and Friends of People with Eating Disorders

**Contact:** Shirin Fernanadez, Psychologist  
**Address:** Royal Hobart Hospital  
**Ph:** (03) 6222 8188

## SA

**Blackwood Private Hospital**

**Address:** Laffers Road  
Belair SA 5052  
**Ph:** (08) 82780461

**Eating Disorders Association of South Australia**

**Contact:** Loraine House  
**Address:** Everard House  
589 South Road  
Everard Park SA 5035  
**Ph:** (08) 8332 3466  
**Fax:** (08) 8332 3430  
**Email:** loraine.house@edasa.org.au  
**Web:** <http://www.edasa.org.au>

**Flinders University Services for Eating Disorders (SA),**

**Ph:** (08) 8204 4603  
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**Web:** <http://som.flinders.edu.au/FUSA/Psych/>

**Independent Practitioner Network Limited (IPN) SA DIVISION**

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Prospect SA 5082  
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**Lifeshouse**

**Contact:** Hilery Keane  
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Melrose Park SA 5039  
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**Mob:** 0448 400 370 (BH)  
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**South Australian Sports Institute (SASI)**

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(Australia)  
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**Women and Children's Hospital Adolescent Ward**

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Adelaide, SA 5006  
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## WA

**Bridges Association Incorporated**

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**Carers WA - Mental Health Carers Representation & Advocacy program**

**Contact:** Leonie Walker  
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**Eating Disorders Calamunnda**

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Pauls Valley WA 6076  
**Ph:** (08) 9293 0876

**Eating Disorders Centre**

**Address:** 25 Ellen St  
Fremantle WA 6160  
**Ph:** (08) 9335 1440

**Centre for Clinical Interventions (WA)**

**Address:** 223 James Street,  
Northbridge, Western Australia 6003  
**Ph:** (08) 8204 5237