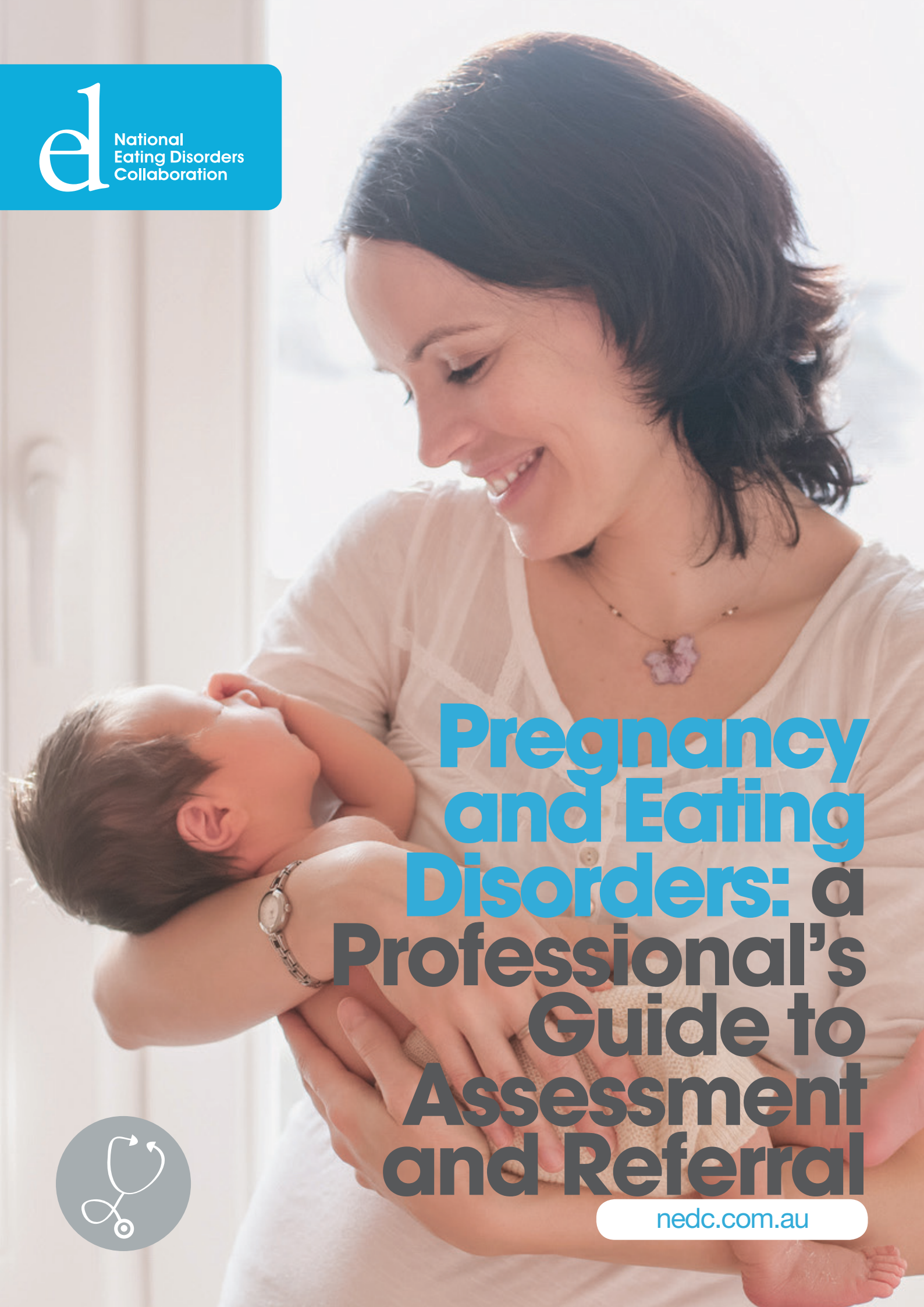




National
Eating Disorders
Collaboration



**Pregnancy
and Eating
Disorders: a
Professional's
Guide to
Assessment
and Referral**



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General Information for Professionals

About Eating Disorders

Eating Disorders are serious mental illnesses with severe physical and psychological impacts. They occur in people of all ages, genders and cultural backgrounds.

Contrary to popular belief, eating disorders are not a 'diet gone too far' or a 'lifestyle choice.' A person with an eating disorder is very ill and requires serious medical and psychological treatment in order to recover.

In Australia, eating disorders affect approximately 9% of the population and around 15% of women will experience an eating disorder at some point in their lives. The mortality rate for people with eating disorders is the highest of all psychiatric illnesses; this is over 12 times higher than the mortality rate for people without eating disorders.

Eating disorders occur in a significant number of **pregnant women** and **post natal women**, and the outcomes can be dangerous for both mother and baby. An eating disorder can develop as a result of a pregnancy (and subsequent changes in body shape and weight during pregnancy) or it can develop/exist prior to the pregnancy, with the pregnancy further complicating eating disorder symptoms and impacting health.

These symptoms and body dissatisfaction can remain once the baby is born. A mother's expectations of her post natal body and of the time it 'should take' to return to her pre-pregnancy size and shape may be unrealistic. When it comes to pregnancy and childbirth, there is no 'normal' in terms of expectations to 'return to' or 'become' a particular size or shape before, during or after the pregnancy and early motherhood period. The health and nutrition of the mother and her baby is paramount and women should be encouraged to embrace any changes to their body as natural and healthy. Women who place emphasis on avoiding weight gain or a changing body shape during pregnancy and/or focus on intensive exercise in the early months following childbirth place themselves and their babies at additional health risks.

These risks include:

- Antenatal and postnatal depression and anxiety,
- Impaired foetal development and antenatal complications,
- Premature births,
- Lower birth weights and birth defects,
- Hyperemesis (excessive vomiting),
- Gestational diabetes,
- Unplanned caesareans,
- Increased risk of miscarriages
- Breast milk supply complications due to nutritional deficiencies in the mother
- Increased risks of nutritional deficiency for the baby when transitioning from breast or bottle feeding to introducing solids.

As a **midwife, obstetrician, gynaecologist, psychologist, dietitian, paediatrician, or early childhood nurse** you possess the existing skill set, and the opportunities to screen for risk behaviours and to identify, monitor and refer any patient who may have or is at risk of developing an eating disorder. Help and close monitoring should be provided prior to conception, throughout the pregnancy and during the postpartum period. There is probably no other time in a woman's life where she and her baby are so actively engaged in a broad and systematic health program as pregnancy and early motherhood. Therefore, risks of eating disorders can be more easily screened for, identified and assessed throughout this period of healthcare.

Types of Eating Disorders

There are 4 specified eating disorders outlined by the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders), released in 2013: Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder and Other Specified Feeding or Eating Disorder.

Anorexia Nervosa: Anorexia Nervosa occurs in individuals that severely restrict their food and energy intake and maintain a significantly low weight (less than BMI 17kg/m²) due to an intense fear of gaining weight. Body weight, shape and appearance are consistently associated with self-evaluation and worth.

Bulimia Nervosa: Bulimia Nervosa involves recurrent episodes of binge eating, i.e. eating an unusually large amount of food in a short period of time and/or experiencing a loss of control when eating. In addition, compensatory behaviours to prevent weight gain also characterise Bulimia, and can include purging, misuse of laxatives or similar medications, fasting or excessive exercise. Body weight and shape are consistently associated with self-evaluation and worth.

Binge Eating Disorder: An individual with BED will eat, in a discrete period of time, an unusually large amount of food and will often have no sense of control during the eating episode. Those with BED will often eat rapidly, eat until they are uncomfortably full or eat significant amounts of food even when they are not hungry. People with BED will often feel shame or guilt over their behaviour and may frequently eat alone. Unlike Bulimia Nervosa, BED is not associated with purging or weight maintenance behaviours.

Other Specified Feeding and Eating Disorders: The OSFED category is used to classify diagnoses of feeding and eating disorders that cause significant distress or impairment within an individual, but that do not meet the exact or specified criteria for the above eating disorder. Individuals with OSFED can be just as ill as those with a specified eating disorders and require the same amount of help and treatment to recover.



Screening and Assessment

Early intervention of eating disorders in pregnant and post natal women is dependent on careful screening and assessment and early detection of symptoms. During her pregnancy and early motherhood years, a woman is heavily engaged in systematic healthcare and screening programs, and therefore the chances of identifying eating disorder risks are enhanced by the increase access to this cohort of patients.

It is important to note that the onset of an eating disorder can occur at any stage of the prenatal and postnatal periods. A patient may have already had an existing (yet unrecognised or untreated) eating disorder before falling pregnant or they may have developed disordered eating behaviours due to their pregnancy and associated physical, mental and emotional changes. These behaviours may carry over to the postnatal period, or they could develop in the postnatal period.

It is also important to remember that a female with an eating disorder may be ashamed of her behaviour and may harbour feelings of guilt about how the eating disorder is affecting her baby.

Alternatively, other patients may not even realise they have an eating disorder problem and may not suspect their behaviour is harmful. Some may even deny they have a problem and can show reluctance or resistance to accepting treatment and help.

Eating disorders screening opportunities can exist as part of the broader screening program involved in pregnancy such as:

- Confirmation of the pregnancy and/or initial pregnancy consultation (GP, Obstetrician, Gynaecologist, Midwife)
- 12- and 20- week foetal ultrasounds, and subsequent or additional ultrasounds as deemed necessary by health care professionals (Sonographer, Radiologist, GP, Obstetrician, Midwife)
- Prenatal hospital admission interview (Midwife, Obstetrician)
- Third Trimester check-ups where attended.

Each State in Australia has its own systematic early child health program, whether delivery has occurred in the public or private hospital setting. These could include:

- Midwife home visit programs (usually conducted within 7-14 days after delivery)



- The early childhood nurse visit programs that are conducted in some area health services throughout the first 1 to 6 weeks post delivery and can occur either in the home or at Early Childhood Health Centres (EHC)
- Additional EHC education programs such as mothers' group introductory sessions, breastfeeding clinics and information sessions on introducing solids, and clinics set up to assist with early childhood behaviours (such as sleep issues),
- The early childhood and infant immunisation program (starting at 6 weeks, then at 6 months, 12 months and 18 months)
- GP, Obstetrician and Gynaecologists follow-up health and wellbeing appointments

In all of these settings, opportunities to identify risks, distorted views and disordered behaviours associated with body dissatisfaction, body image, eating, exercise and anxiety about feeding the baby may be present. For both pregnant and postnatal women, the following signs and symptoms should be considered and investigated

Step 1: Recognising Signs and Symptoms

In expectant mothers, eating disorder signs and symptoms can manifest as normal symptoms of the pregnancy (e.g. tiredness) or they can be disguised by other expected ailments associated with pregnancy (e.g. signs of vomiting may be mistaken for morning sickness rather than self-induced purging). Health professionals assessing a pregnant or postnatal woman should be aware of signs and symptoms in the context of eating disorders where they could be seen as not in the usual range associated with pregnancy or postnatal periods or are particularly severe.

In general, common eating disorder presentations can be psychological, physical and behavioural:

Psychological

- Concern, distress or preoccupation with weight gain, even when weight is within the expected range
- Dissatisfaction with body shape, even despite your discussions with them about expecting normal body shape changes with stages of pregnancy
- Negative or unusual attitudes towards food and/or eating (see below)
- Negative attitudes towards the unborn baby
- Depression, anxiety about pregnancy and anxiety about caring for their baby.

Physical & Medical

- Severe weight loss or low weight in relation to stage of pregnancy
- Severe weight gain or excessive weight in relation to stage of pregnancy
- Fainting, dizziness, headaches
- Shortness of breath, fatigue
- History of menstrual disturbances
- Previous infertility or related problems
- Gastrointestinal problems
- Low bone density

Behavioural

- Indications of food intake restriction
- Signs of repeated, self-induced vomiting
- Restriction of certain foods not advised by a clinician
- Avoidance of meals or changes in eating behaviour (e.g. refusing to eat with others)
- Evidence of substance/medication abuse in order to maintain body weight
- Insomnia or disturbed sleeping patterns
- Self-harming or suicidal behaviour (in which case emergency treatment will be vital)
- Excessive or distorted exercise patterns or signs of distress when exercising is not possible

Signs & Complications Specific to Pregnancy

Eating disorders can also lead to a range of serious medical complications in pregnant women. For this reason, women who are expecting or who have delivered may also present to clinicians with related issues or complications that can indicate the presence of an eating disorder, such as:

- Little or no weight loss (in the case of binge-eating disorder for example) or weight gain (in the case of anorexia nervosa for example) over the course of the pregnancy, despite a growing foetus.
- Problems with foetal growth and development
- Gestational diabetes
- Respiratory problems
- Miscarriage

- Premature labour / preterm delivery
- Complications during labour
- Unplanned caesarean
- Low birth weight
- Stillbirth or fetal death
- Postnatal depression
- Measureable health indicators as outlined in Step 3.

Signs & Complications Specific to Postnatal/New Mothers

In addition to a range of serious health complications for postnatal women with eating disorders, there are also present risks to infants that need to be considered in the eating disorders context.

Postnatal and early childhood specific signs include:

- A history of eating disorders prior to pregnancy or during pregnancy
- Postnatal depression
- Rapid, otherwise unexplained postnatal weight loss or weight gain
- Negative feelings towards the baby or to becoming a mother
- Anxiety about baby's appearance – e.g. overly referring to the baby as 'chubby'
- A strong focus on pre-baby shape and/or returning to body shape-inspired exercise soon after childbirth
- Compulsive/obsessive breast-feeding (can be associated with a desire to lose weight quickly)
- Difficulty maintaining or loss of milk supply
- Signs associated with purge activities such as signs of excessive vomiting (bad breath, eroding teeth), laxative abuse, calluses on knuckles (from forced purging)
- Irregular weight gain in the infant
- Signs of under or over feeding in the infant
- Signs of malnutrition or under-nutrition in the mother and infant
- Measureable health indicators as outlined in Step 3 (physical assessment)

Clinicians should assess and investigate any of the above signs, symptoms and complications in conjunction with the following additional approaches.

- Does your weight affect the way you feel about yourself?
- Are you satisfied with your eating patterns?



Step 2. SCOFF Discussion & Additional Screening Assessments

Since eating disorder signs and symptoms can be masked by other symptoms of pregnancy, the SCOFF questionnaire (which has been designed specifically for eating disorders) can be used to elicit a discussion about a potential disordered eating problem in pregnancy and postnatal check ups.

These SCOFF questions can be flexible in delivery (e.g. rephrase, combine questions) to suit the patient's mental/emotional state.

Patients who provide a 'yes' response to 2 or more questions require further questioning and investigation.

SCOFF Questions

S – Do you forcibly make yourself Sick because you feel uncomfortably full?

Are there any signs of frequent, deliberate vomiting, as opposed to expected levels of morning sickness during pregnancy? Have signs of vomiting continued despite regression of morning sickness or nausea?

C – Do you feel like you lose Control when you are eating?

Binge eating and other disorders will characteristically involve episodes of uncontrollable eating or a sense of loss of control while eating. Is the patient consuming large amounts of food rapidly or are they eating an unusually excessive amount of food, even when they are full or not hungry? Are they eating with others or frequently eating alone?

O – Have you recently lost more than One stone (6.35kgs) in a 3-month period?

Is the individual's weight in the healthy range relative to their stage of pregnancy? Check for signs that their weight may be staying the same, despite the additional weight of the baby.

F – Do you believe yourself to be Fat when others say you are too thin?

Is there distortion in the way the female feels about her body weight or shape? Do they feel uncomfortable with the way their body is changing due to the pregnancy (e.g. "I'm too fat")? Do others (friends, family) make remarks about their shape or weight (e.g. "You don't seem to be showing much")?

F – Would you say Food dominates your life?

Is the patient's attitude towards food within the expected responses for pregnancy? Are they distressed about food or eating? Have they become overly sensitive or irritable when asked about food or eating?



As a clinician, your assessment does not need to diagnose. However, it should detect the possible presence of an eating disorder. Your evaluation should take into account responses to the SCOFF questions, as well as other psychological, physical and behavioural signs or complications.

Additional Assessment Questions:

- Are you dieting or trying to lose weight?
- Do you think you have an eating problem?
- Do you worry a lot about your weight?
- Do you worry a lot about your body shape? How do you feel about the changes happening to your body?
- Is there a history of eating disorders in your family?
- Do you have prior experience of an eating disorder?
- Is there a history of depression or anxiety in your family, or have you ever suffered from depression or anxiety?
- Do you have any other illnesses, such as Polycystic Ovarian Syndrome or Diabetes?
- (Postnatal) Are you satisfied with how your baby is gaining weight?

Step 3. Physical Assessment

If signs and complications are present, it is recommended that a thorough physical examination should be conducted as part of the eating disorders assessment process. Referral to an appropriate clinician should be given if necessary. Clinicians should check and evaluate:

- General physical state (well vs. unwell)
- Body temperature (<36°C)
- Pulse rate for resting and standing (<60bpm, regular or irregular)
- Blood pressure lying and standing (postural drop >20mmHg)
- Alertness vs. somnolence/sleepiness
- Height and weight history and weight/height proportion – preconception, during pregnancy and postnatal
- Menstruation pattern/history
- Hydration (tongue, lips, sunken eyes, skin)
- Signs of vomiting (ketones on breath, bad breath, eroded teeth)
- Fundal measurements according to individual's expected progression of foetal growth (in pregnancy)
- Deep irregular sighing; breathing seen in ketoacidosis
- Peripheral circulation (limbs, extremities) and cold peripheries
- Physical changes, such as swelling in cheeks, jaw, ankles; calluses on knuckles; abdomen scaphoid
- Electrolyte disturbances (thirst, dizziness, fluid retention, swelling, weakness/lethargy, muscle twitches)
- Alkaline urinary pH



Referral to Appropriate Services

Assessing whether to refer your pregnant or early motherhood patient should take into consideration the 'risk of significant harm' to the patient or child and the reporting guidelines in place within your state-based health framework.

1. Before Conception

If you are consulting with a patient prior to conception (i.e. while the female is trying to conceive) you should aim to:

- Treat the eating disorder prior to pregnancy and/or
- Refer to an eating disorder specialist and/or mental health professional
- Provide evidence-based nutritional advice
- Educate on the important of good nutrition and foetal development
- Make a professional recommendation that conception be postponed until recovery from the eating disorder is achieved
- Refer to a hospital or emergency room if symptoms are severe or life threatening

2. During Pregnancy

If an eating disorder is detected in a woman who is already pregnant, a high risk management approach will need to be adopted throughout the perinatal period. You should:

- Refer to an eating disorder specialist and/or mental health professional or mental health team
- Discuss notifying additional antenatal services of the eating disorder with the patient
- Work with the patient's additional medical team, such as an obstetrician regarding risks and encourage the patient to undertake regular monitoring of foetus and development
- Educate on the importance of good nutrition and foetal development
- With patient's permission where possible, engage family members or carer to provide support and help
- Refer to a hospital or emergency room if the mother's or baby's life may be at risk

3. After Pregnancy

During post-partum follow-ups, several signs or symptoms may present that can indicate the mother is developing disordered eating problems. This may be a continuing issue that developed before the pregnancy or during the pregnancy, or it may have only developed after the birth of the baby.

Clinicians involved in post-partum care should aim to:

- Assess parenting skills and the mother's relationship with infant in general
- Provide advice and guidance to improve coping strategies if the mother is stressed or struggling
- Increase self-esteem and confidence in mothers/parents
- Provide breastfeeding support
- Be aware of possible relapse if a prior eating disorder was present
- Assess whether attitudes towards food and/or eating have changed
- Assess whether the mother's attitude or feelings about her own body weight and shape have changed
- Look for signs of postnatal depression or anxiety
- Monitor infant growth, development and weight gain
- Be aware of any negative emotions towards the infant
- Be aware of anxious or avoidant attachment patterns

If you suspect the mother may be at risk of developing an eating disorder or if you feel she may already be engaging in disordered eating, you can:

- Refer to an eating disorder specialist and/or mental health professional
- Provide nutritional advice and emphasise the importance of nutrition for growing babies
- Notify the assigned paediatrician, obstetrician, nurse or anyone else involved in the child's care
- Refer to a hospital or emergency room if the mother's or baby's life may be at risk
- Communicate the issue to another family member or carer who can provide additional support and help (e.g. husband, parent, sister, friend)

Management, Monitoring & Care

Providing ongoing monitoring and management of women who have or may be at risk of an eating disorder is critical to ensure the eating disorder is treated and that good health is achieved for both mother and baby.

In addition to referring to an eating disorders specialist, you should aim to:

- Create a management plan and provide ongoing reviews of eating disorder issues
- Regularly review the health and condition of both mother and baby
- Communicate regularly with other specialists and clinicians who may be involved in treating the patient for the eating disorder or providing care for the pregnancy (e.g. obstetricians, midwives, psychologists, early childhood nurses)
- Become familiar with the specific risks and or complications associated with the particular health problem or eating disorder e.g. social isolation, family support, risks commonly associated with generalised postnatal depression.
- Update other treating clinicians with relevant information and details throughout the course of the pregnancy so that they are informed when the time comes to deliver the baby or provide other forms of treatment.



Eating Disorders Prevention

Clinicians in any role should aim to prevent the development of eating disorders and promote good health in all women they care for. The period prior to conception can be ideal for encouraging prevention since many new mothers can be enthused about making changes for the benefit of their baby.

During care and consultations, you can promote prevention by:

- Prompting high self-esteem and confidence (as a woman, mother-to-be)
- Encouraging positive body image and highlighting that physical changes during pregnancy are normal and natural
- Educating on healthy approaches to food and eating while pregnant
- Educating on the risks of dieting and providing relevant, practical information on how to achieve good health
- Instructing on the importance of good health and nutrition for mother and baby
- Helping to cope with or treat other concerns or problems that potentially could lead to or exacerbate an eating problem (e.g. depression, anxiety, nausea)
- Assisting to develop media literacy around unrealistic media images and messages if the patient is susceptible to being influenced by these (e.g. “That pregnant celebrity is not a healthy indicator of how a pregnant woman should look”); this can be particularly relevant for young females.
- Promote a steady, moderate and relaxed approach to activity or exercise and explain the risks of over-exercising including milk supply, pelvic floor weakness postpartum and the long term damage that can occur with exercise that is too rigorous, excessive or too soon after birth.



Child Protection Concerns

All clinicians working with children should be aware of legislation that regulates the reporting and disclosure of disordered eating problems if or when they are shown to impact the wellbeing or health (mental or physical) of a child. Disclosure may be necessary if the mother has relapsed, is not progressing well with recovery, is reluctant to accept treatment or is denying the problem.

If you are facing a Child Protection issue, it is imperative that you follow the guidelines appropriate to your state. Further information can be obtained from the organisations below.

ACT

Office for Children, Youth and Family Support - Care and Protection Services
24 hours: 1300 556 729 (public), 1300 556 728 (mandatory)

www.communityservices.act.gov.au/ocys/services/care_and_protection

NSW

Department of Family and Community Services

24 hours: 132 111 (public), 133 627 (mandatory)

www.community.nsw.gov.au/welcome_to_docs_website.html

NT

Department of Children and Families

24 hours: 1800 700 250

www.childrenandfamilies.nt.gov.au

QLD

Department of Communities, Child Safety and Disability Services

Office hours: Visit this link to find your local Child Safety Services Centre:

<http://www.communities.qld.gov.au/childsafety/about-us/contact-us>

Out of Hours: 07 3235-9999 or 1800 177 135

www.communities.qld.gov.au/childsafety

SA

Families South Australia

24 hours: 13 14 78

www.families.sa.gov.au

TAS

Department of Health and Human Services – Child Protection Services

24 hours: 1300 737 639

www.dhhs.tas.gov.au/children/child_protection_services

VIC

Department of Human Services – Child Protection

Office hours: Please visit website below to find contact details for your local government area

Out of hours: 131 278

<http://www.dhs.vic.gov.au/cpmanual/practice-context/statewide-specialist-child-protection-services>

WA

Department for Child Protection and Family Support

Office hours: 08 9222 2555 or 1800 622 258

Out of hours: 08 9223 1111 or 1800 199 008

www.dcp.wa.gov.au/Pages/Home.aspx

Where to find more information

For further information and resources on eating disorders visit www.nedc.com.au

Clinical resources for health professionals

To access clinical resources for health professionals working with eating disorders visit <http://ceed.org.au/clinical-resources/> and <http://cedd.org.au/health-professionals/resources-clinical-guidance/>

Mental Health First Aid

For professionals who do not have a background in working with people with eating disorders, the Mental Health First Aid guidelines may provide a useful starting place to support recognition and safe responses to people who are developing or experiencing an eating disorder. The guidelines provide an evidence based set of general recommendations about how you can help someone who is developing or experiencing an eating disorder: www.mhfa.com.au/cms/

Latest Research and Resources

NEDC provides a single gateway through which healthcare providers can access the latest evidence-based information and resources on the prevention, identification, early intervention and management of eating disorders here: www.nedc.com.au/research-resources

Professional Development

Within Australia there are opportunities for professionals to advance their knowledge and expertise in the field of eating disorders.

Professional development: www.nedc.com.au/proffesional-develop

Upcoming events: http://member.nedc.com.au/events/event_list.asp

Eating Disorders Awareness for Professionals

Appropriate messages can be combined with effective engagement strategies to help health service providers and other professionals educate the community about eating disorders. The NEDC website provides further information on how to communicate about eating disorders, breaking down barriers, preventing eating disorders and eating disorders and obesity: www.nedc.com.au/eating-disorders-awareness

National Support Line: 1800 ED HOPE (1800 33 4673)

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Further Reading / References

American Pregnancy Association, Pregnancy and Eating Disorders: <http://americanpregnancy.org/pregnancy-health/pregnancy-and-eating-disorders/>

Beyond Blue, Mental Health Conditions: <http://www.beyondblue.org.au/resources/for-me/pregnancy-and-early-parenthood/mental-health-conditions>

Eating Disorder Hope, Eating disorders and pregnancy. <http://www.eatingdisorderhope.com/treatment-for-eating-disorders/special-issues/pregnancy>
Eating Disorders Review, Infants with mother with Eating Disorders: http://eatingdisordersreview.com/nl/nl_edr_20_3_4.html

South Australian Government, SA Health: http://www.sahealth.sa.gov.au/wps/wcm/connect/a13c27004ee217a7b435bdd150ce4f37/Eating+disorders+and+pregnancy+PPG_June2014.pdf?MOD=AJPERES&CACHEID=a13c27004ee217a7b435bdd150ce4f37

The Royal Womens Hospital: Victoria, Australia: <https://www.thewomens.org.au/health-information/pregnancy-and-birth/mental-health-pregnancy/eating-disorders-in-after-pregnancy/>



nedc.com.au

The National Eating Disorders Collaboration is a collaboration of people and organisations with expertise in the field of eating disorders, individuals from a range of healthcare and research sectors and people with a lived experience of an eating disorder.

Through the contribution of its members, the NEDC has the resources to lead the way in addressing eating disorders in Australia.

nedc.com.au brings research, expertise and evidence from leaders in the field together in one place.

It's a one stop portal to make eating disorders information a lot more accessible for everyone.

Become a member

We welcome individuals and organisations to become members of the NEDC. As a member you can get involved in one of the working groups and contribute to project deliverables. You will also be informed on collaboration activities and receive access to the members only area of the website.

Join the collaboration: www.nedc.com.au/become-a-member

Sign up for the NEDC monthly e-Bulletin

If you would like to keep up to date with what is happening in the wider eating disorders sector including the latest evidence based research on eating disorders you can register to receive our monthly e-Bulletin.

Subscribe to the e-Bulletin: www.nedc.com.au/subscribe





The National Eating Disorders Collaboration
103 Alexander Street Crows Nest NSW 2065
Phone: +61 2 9412 4499 Fax: +61 2 8090 8196
Email: info@nedc.com.au

For a downloadable copy of this resource visit:
www.nedc.com.au/health-professionals

The National Eating Disorders Collaboration
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