Eating Disorders and Pregnancy

Twenty Important Things to Know

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The ANAD Approach

The National Association of Anorexia Nervosa and Associated Disorders
About the Author
Patricia Santucci, MD, FAED, FAPA is a board-certified psychiatrist who has had over 40 years of private clinical experience working in the field of eating disorders. Her involvement in ANAD began in 1975 where she has both served on the board as well as serving as President for many years. Presently, she is ANAD’s Medical Director and chair of ANAD’s Educational Committee. Her focus has always been to bring eating disorder awareness and education to professionals and the community. During her career she became a founding member of the Academy for Eating Disorders, Associate Professor of Psychiatry at the Stritch School of Medicine, Director of Eating Disorder Services at Mercy Hospital and Linden Oaks in the Chicago suburbs, and eventually Medical Director of Linden Oaks Hospital in Naperville, Illinois. She has received numerous awards for her work in the field and lectured nationally and internationally on the topics of eating disorders, women’s mental health issues, and mental health responses to trauma and disasters.

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Disclaimer
While every effort has been made to ensure the information contained in this resource is accurate, no legal responsibility is accepted by the authors or the educational committee of ANAD for any errors or omissions. This information resource should not substitute medical advice and is not a comprehensive clinical guide. It is intended as a resource to promote recognition and prevention of medical issues during pregnancy associated with eating disorders. ANAD does not endorse any third party and is not liable for any actions taken on the base on information we provide.

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Eating Disorders and Pregnancy
Twenty Important Things to Know
Healing the eating disorder community through compassionate action.

At ANAD, we believe in a comprehensive Approach to eating disorder treatment and recovery:

**Acceptance of everyBODY**
Accept yourself, accept others. Every individual is unique and beautiful, yourself included.

**Prioritize self-care**
Learning to engage in self-care is not selfish. It is self-preservation, an act of love towards your body and mind. Give yourself permission to engage in self-care.

**Parents, spouse, loved ones**
Don’t go it alone. Support dramatically improves recovery, buffers stress, and enhances quality of life and well-being. Accept love and support, as well as give love and support.

**Recovery**
Full recovery from an eating disorder is possible, but it takes time. Have patience with yourself.

**Options**
Effective treatment often requires a spectrum of treatment options. ANAD provides an array of free services, consistently explores new ideas and innovative approaches, and provides opportunities for people to share and learn from others who have recovered.

**Aftercare**
We believe posttreatment support is crucial. Strengthen your eating disorder recovery by participating in ANAD’s many programs.

**Compassionate care**
Having an eating disorder is not a choice. Eating disorders are complex, serious, biologically-based illnesses. Let’s move away from the shame and blame. You are not a diagnosis, a disease, or a disorder, but rather a human being that deserves respect and understanding.

**Hope, help, healing**
Walking alongside you in your journey, ANAD can help you transform your life. It is our honor to support you throughout your recovery.
Introduction

Becoming a mother can be an exciting and joyful time, but if you have an eating disorder pregnancy can be both physically and emotionally challenging. Approximately 10 million American women experience an eating disorder which often peaks during childbearing years. Eating disorders during pregnancy are more common than expected. One out of every 21 pregnant women met the criteria for an eating disorder— anorexia nervosa, bulimia nervosa, binge eating disorder, or an atypical eating disorder.

Women with eating disorders are concerned whether they have done damage to their reproductive organs or have destroyed the ability to have children. Most will seek fertility treatment, but unfortunately, may keep their eating disorder a secret. Since screening does not routinely occur in the obstetrician's office, eating disorders often go undetected. As a result, appropriate support, education, and treatment do not occur. For the most part, when an eating disorder is resolved, and restoration of weight and resumption of menses occurs, fertility usually resumes with rates that are often similar to the general population.

Once a woman becomes pregnant, she struggles with the anxiety of how pregnancy might affect her eating disorder. Pregnancy can change the course of an eating disorder, but not all eating disorders are alike. For some, pregnancy can be a window of opportunity for wellness, and for others, a window of vulnerability. There is the added concern of how an eating disorder may affect the pregnancy, delivery, and well-being of the baby. Research is shedding some light on outcomes, and we are learning that different types of eating disorders may present with various risks and complications. While there are certainly greater risks, there appears to be more optimism that women can have a healthy pregnancy and baby. Once the baby is born, postpartum issues can be challenging. A high risk of relapse of an eating disorder along with postpartum depression can complicate recovery and interfere with the ability of a mother to care for herself and her new baby.

There is an increasing awareness of eating disorders, but information is limited on pregnancy and eating disorders. This booklet aims to provide some basic information to help you become aware of the issues that you will be facing. As a starting point, you are encouraged to take the self-assessment questionnaire. If you are concerned, bring it to the attention of your healthcare provider. It can be the beginning of a meaningful dialogue that can lead to better care for you and your baby.

ANAD is here to help and support you during this journey. For more information on pregnancy and eating disorders, contact ANAD at www.anad.org, and request our most recent publication:

Eating Disorder Self-Assessment

Screening for eating disorders should be routine during pregnancy and postpartum period

Overall, the screening questions will address:

(1) Do you think you have an eating problem? (2) Do you worry about your weight?

If you answer yes to either of these questions, continue with the following screening questions:

The Scoff Questionnaire developed by Morgan and Lacey is a useful screening tool

S- Do you make yourself sick because you feel full? Y/N
C- Do you worry about loss of control over your eating? Y/N
O- Have you recently lost one stone (about 14 pounds) in 3 months? Y/N
F- Do you believe you are fat although others say you are thin? Y/N
F- Would you say food predominates your life? Y/N

Scoring: the 1 point for YES. A score >2 is suggestive of an eating disorder

You may continue by asking yourself the additional questions:

1- Are you concerned about your weight or shape?
2- How do you feel about being weighed at every office visit?
3- How do you feel about weight gain during pregnancy?
4- Do you consciously restrict what you eat?
5- Do you use laxatives or vomit to control your weight? Other means?
6- What are your exercise habits?
7- Do you go on binges or feel that you have lost control of your eating?
8- Do you feel guilty about your eating habits?
9- Do you eat in secret?
10- Have you ever had or currently have an eating disorder?
11- Are you concerned you may have an eating disorder?

After completion of the self-assessment, please bring your answers to the attention of your health care provider.
Twenty Important Things to Know About Pregnancy and Eating Disorders

1. FREQUENCY:
Eating disorders commonly occur during pregnancy and affect one out of every 21 pregnant women.¹ Over 60 percent of women did not disclose their history to their doctor, resulting in undetected cases, thereby increasing the risks for mother and child.² Advocate that all your healthcare professionals learn about eating disorders, ask pertinent questions, and continue to screen routinely for eating disorders during prenatal and postnatal visits.

2. FERTILITY:
Having an eating disorder may make it more challenging to get pregnant, although not impossible. Women with a past or current eating disorder usually have undergone fertility treatment, and most women do become mothers.³ Before investing time and money in expensive fertility treatments, make sure your weight is fully restored and your eating disorder symptoms are well controlled. Your chances of becoming pregnant or responding to fertility treatment will be greatly enhanced as a result of treating an eating disorder before pregnancy.

3. UNPLANNED PREGNANCIES:
Don’t risk an unplanned pregnancy. Women with eating disorders have an increased rate of unplanned pregnancies and induced abortions.⁴ Often, women with an eating disorder may not have a period or have irregular periods and many times assume they cannot conceive. Ovulation (release of an egg) can occur in the absence of menses. Always protect yourself with adequate contraception.

4. PRE-PREGNANCY COUNSELING:
The best time to plan and prepare for your pregnancy is BEFORE you conceive.⁵ Use this time to make sure your eating disorder and other significant issues are well controlled. Learn what to expect regarding the upcoming physical and emotional changes, how pregnancy can affect your eating disorder, what risks are involved for both mother and baby, etc. Now is the time to examine what has worked in the past. It is also the time to anticipate future triggers. Anticipating potential problems and developing a plan of action can help maximize your success.
5. RECOVERY FIRST:
Although you may be impatient to have a baby, postpone your pregnancy until you have recovered. You will want to start strong and stay strong for this journey. It is important to be in remission for at least a year, start your pregnancy at a healthy weight, aim to acknowledge and accept the changes that are about to occur, and be sure that any medical complications are stabilized. If pregnancy occurs at a positive time, when you and your relationships are more stable, there appears to be a better prognosis.

6. BE OPEN AND HONEST:
Once you discover you are pregnant, have an open and honest discussion with your doctor and your significant others. Don’t let the stigma of having an eating disorder rob you and your baby of good care. If you have a past history or current eating disorder, your pregnancy may be viewed as high-risk. Close prenatal and postnatal monitoring are often recommended with the hope of preventing complications. Appointments with your ob/gyn may need to be longer and more frequent to allow sufficient time to review your symptoms and discuss your concerns.

7. USE OF THE MULTIDISCIPLINARY TREATMENT TEAM:
Eating disorders are best managed by a multidisciplinary team that consists of professionals who are trained and experienced in eating disorders and communicate regularly. A medical doctor, mental health professional, and dietician make up the core team. When you become pregnant, your ob/gyn, as well as your baby’s pediatrician, will also become part of your team. Other specialists or consultants, such as psychiatrists, endocrinologists, or lactation experts can be added as needed.

Women with eating disorders need additional emotional support, so don’t go it alone. In addition to professional help, develop a support network of family and friends. Support groups are also excellent ways to expand your support network.

8. INCREASED RISK FOR ANXIETY AND DEPRESSION:
Be watchful for depression and anxiety. An eating disorder places you at an increased risk for these disorders before, during, and after pregnancy. For depression that is not severe, talk therapy is often helpful. For those with severe depression, antidepressant medication may be recommended. If you are fearful of taking medication during your pregnancy, discuss the options with your psychiatrist. Many antidepressants are considered relatively safe to take during pregnancy or while breastfeeding. Depression can be a serious illness with consequences for both mother and child. Often the risk of untreated depression far outweighs the risk of taking medication.
9. WINDOW OF OPPORTUNITY:
Pregnancy can have a positive impact on your eating disorder. It can be a window of opportunity to experience wellness. Some women have viewed pregnancy as a pathway to recovery where new, healthy, and lasting behaviors are experienced. For new mothers, motivation to change runs high, and there is often a willingness to focus on concerns for the baby’s welfare rather than an eating disorder. Pregnancy can be an excellent time to engage in treatment and experience success.

Pregnancy may have a persistent and positive long-term effect. In women with a history of anorexia nervosa, the mortality rate for those who had given birth was decreased by 65% in comparison to those who did remained childless. Whether pregnancy changes the course of an illness that has one of the highest mortality rates of any disorder is unknown. Pregnancy may represent a marker that for some women, they have achieved a certain level of emotional and physical recovery.

10. REDUCTION OF SYMPTOMS:
Every woman is different, and pregnancy can affect eating disorders in different ways. There may be a continuation of the pre-existing eating disorder, various levels of improvement, a crossover to another form of an eating disorder, or a resurgence of symptoms, even in those who have experienced recovery. However, most women with anorexia nervosa and bulimia nervosa experience a reduction of symptoms, with bulimia nervosa symptoms often being significantly decreased during pregnancy.

During the early months of pregnancy, depression and concerns about weight and body image often increased, but as time goes on, many are able to adapt. Most women with anorexia nervosa, are able to attain the recommended guidelines for weight gain during pregnancy, relax the rigid rules centered around certain foods, and put aside their eating disorder in order to nurture their unborn baby.

For many women with bulimia nervosa, pregnancy appears to be a powerful stimulus to decrease bulimic behavior. A common pattern is to experience a reduction in both binging and purging, or at least an elimination of purging. As pregnancy progresses, women appear to improve, and some are able to stop binging and purging entirely during their pregnancy.¹

This dramatic improvement can mislead women into believing that their eating disorder has been resolved. Pregnancy does not guarantee a discontinuation of symptoms. As part of your self-care program, make sure you routinely monitor your eating disorder symptoms during pregnancy and well into the postpartum time. To make sure you are getting the best possible care, share this information with your treatment team.
11. WINDOW OF VULNERABILITY - BINGE EATING DISORDER:
Binge eating disorder (BED) appears to take on a different course, and instead of remission of symptoms as seen in anorexia nervosa or bulimia nervosa, there is often a persistence of symptoms. Rather than a window of opportunity for wellness, pregnancy appears to be a window of vulnerability. New onsets of binge eating disorder were much more common than in other eating disorders, even in women without a history of an eating disorder. For some women, pregnancy can be seen as a time when it is permissible to break free from restrictive eating, but also restrictive eating can lead to a binge.

BED is the most common eating disorder occurring during pregnancy. BED, being a fairly new diagnosis, may not be easily recognized or differentiated from overeating or appetite changes associated with pregnancy. Identification of this disorder is important since BED influences birth outcome. Effective treatments are available. ANAD’s website offers additional information, including their self-help program, Binge Eating - Breaking the Cycle.

12. BODY IMAGE:
Changes in body shape and weight during pregnancy are often more distressing for women with eating disorders. Many women feel they are experiencing a “tug of war” between their eating disorder and unborn child which can lead to a feeling of disgust, dissatisfaction, or loss of control over their body. Yet, despite these intense feelings, many are able to modify their eating disorder behaviors. Some women are able to view these changes positive and necessary and even begin to love their new body — seeing themselves as pregnant, not “fat”.

Knowing what to expect and why these changes occur can help you accept them as an indication of a healthy pregnancy. Embrace these changes and celebrate what your body is doing, not just what it looks like. Your body may never be the same, but neither will you.

13. RISKS FOR MOTHER AND CHILD:
When a woman with an eating disorder or history of an eating disorder becomes pregnant, everyone becomes concerned about the outcome and the risks to both mother and baby. Research based on small clinical studies often focused on women with a greater severity of illness. Serious findings, which often are conflicting and inconsistent, included an increased risk for: premature labor, birth defects, intrauterine growth retardation (unusually small baby at birth), babies with higher/lower birth weight, low Apgar scores (measures the color, heart rate, reflexes, muscle tone, and respiratory effort), complications during delivery (breech, higher risk for Cesarean section, multiple births), miscarriages, stillbirths, pregnancy-induced diabetes, preeclampsia, etc.
In contrast, recent, larger studies, focused on women in the general population, were much more optimistic. They concluded that “women with eating disorders have an increased risk for complications associated with pregnancy, delivery, and birth outcomes, but they were not as negative as initially reported.” Some experts have even expressed their opinion that overall, the majority of women with eating disorders had normal pregnancies, resulting in healthy babies.\(^9\)

This, of course, is good news, but women should not minimize the risks. If an eating disorder is undetected, persists, or worsens during pregnancy, there is an increased risk for complications. Anorexia nervosa is a serious biologically driven disorder and has the highest mortality of any psychiatric illness. Women who have bulimia nervosa also have a higher risk for hyperemesis gravidarum, a condition characterized by severe nausea, vomiting, weight loss, and electrolyte disturbance. If combined with purging behaviors related to the eating disorder, there can be serious medical concerns. There are times when two lives are at risk, and the need for specialized care in a hospital-based unit that can manage both the medical and obstetrical complications will be necessary.

All eating disorders are not alike, and each type can present different risks for mother and baby. Women need to know the risks, what behaviors impact their pregnancy and unborn babies, and what they can do to reduce them.

14. RISKS ASSOCIATED WITH ANOREXIA NERVOSA:
In general, women who have recovered from anorexia nervosa tend to have uncomplicated pregnancies. Researchers have reported that there is “an excessive small risk to mother and the fetus.”\(^17\) If a woman is healthy enough to naturally conceive, continues good nutrition, and achieves the recommended weight gains, she may well be healthy enough to sustain her pregnancy and have a healthy baby.

However, women with a history or active anorexia nervosa are at risk to have lower weight babies.\(^10\) A baby with a low birth weight may have problems with lower oxygen levels at birth, breathing, difficulty feeding and gaining weight, infection, or even surviving. Your doctor may carefully monitor your weight and do serial ultrasounds to monitor fetal size. Lower weight babies may be due to premature birth or intrauterine growth restriction, which occurs because of the mother’s health.

Having a lower weight baby can be associated with poor maternal nutrition and not gaining enough weight during the pregnancy. According to the recommended guidelines for weight gain during pregnancy, about 20% of women with anorexia nervosa gained an “inadequate” amount of weight. The remainder actually gained “adequate” or “excessive” weight. “Excessive” weight gain may be seen as a negative for women with bulimia nervosa or binge eating disorder. However, in women with anorexia nervosa, an “excessive” weight gain is viewed as positive and even appropriate could possibly provide some protection against low birth weight and even buffer the new mother against relapse postpartum.
Starting pregnancy at a lower weight may be another explanation why women with a history or active anorexia nervosa gave birth to lower weight babies. More weight gain than “recommended” may be needed to assure a healthy baby. Modern fertility treatment has also made it possible for underweight women who do not have a menses or ovulate to become pregnant. It is highly recommended that fertility treatment be postponed until weight is fully restored.

Having an active eating disorder during pregnancy is associated with unfavorable obstetric outcomes but not every pregnancy conceived in the midst of an eating disorder will end in tragedy. Being at a healthy weight prior to pregnancy, gaining an adequate amount of weight each trimester, maintaining good nutrition, and having sufficient support can play a crucial role in determining the health of your new baby.

15. RISKS ASSOCIATED WITH BULIMIA NERVOSA AND BINGE EATING DISORDER: Women with current or past history of bulimia nervosa or binge eating disorder had a significant increased risk for miscarriages. For women with active bulimia nervosa, there was a two to three-fold increase in risk of miscarriage, and a higher than expected number of fetal complications. The highest rate of miscarriage occurred in women with binge eating disorder- 47% compared to 17% in women without eating disorders.

Staying within the limits of recommended guidelines for weight gain during pregnancy is important, especially for women with eating disorders. Women struggling with both bulimia nervosa and binge eating disorder often gained “excessive” weight during pregnancy which could place them at risk for pregnancy-induced diabetes, hypertension, early delivery, and other obstetrical complications such as giving birth to larger babies or requiring a Cesarean section.

Gaining those excess pounds during pregnancy may push the panic button, but remember dieting during pregnancy is dangerous. You will need to increase your caloric intake during the 2nd and 3rd trimester. If you are gaining too fast or too much, your dietician can give you tips about meal planning to help you stay fit while choosing foods that pack a big nutritional punch without tons of calories. Allow your weight to be monitored. If the scale makes you anxious, you can always request that you be weighed backwards and not told the number.

16. POSTPARTUM RISKS:
Two major risks during the postpartum period are the onset of postpartum depression and risk of relapse of an eating disorder. Not all eating disorders are alike clinically nor do they have the same course or outcome. Some women will remain in remission, and even recover, while others will experience various levels of relapse, or even a crossover to another type of eating disorder.
A large study, done on pregnant women in the general population who were diagnosed with an active eating disorder at least 6 months prior to conception, revealed the following percentages of remission (defined as symptom-free) at 18 and 36 months after delivery: 12

### Postpartum (PP) Remission Statistics

<table>
<thead>
<tr>
<th>Eating Disorder</th>
<th>PP: 18 months</th>
<th>PP: 36 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia Nervosa</td>
<td>50% in remission</td>
<td>59% in remission</td>
</tr>
<tr>
<td>Bulimia Nervosa</td>
<td>40% in remission</td>
<td>30% in remission</td>
</tr>
<tr>
<td>Binge Eating Disorder</td>
<td>45% in remission</td>
<td>42% in remission</td>
</tr>
</tbody>
</table>

Those that remained symptom-free after delivery often reported they had no time for their eating disorder, nor did they want their children to imitate their behaviors. For these women, there was a new meaning to their life that reduced the focus on weight and shape.

Although the remission statistics are encouraging, it is important to note that the relapse rate is very high. Three years after delivery, 41% of women with anorexia relapsed, 58% of women with binge eating disorder relapsed, and approximately 70% of women with bulimia nervosa relapsed.

Ongoing eating disorders can interfere with adjustment and increase the risk for postpartum depression. Screening for both eating disorders and depression are needed well into the postpartum period. Hopefully, early detection and intervention will decrease the cycle of risk.

17. **REASONS FOR RELAPSE:**

Women identify a major reason for relapse is their desire to rapidly lose weight after giving birth. Delivery does not immediately bring back a woman’s pre-pregnancy body. It took nine months to get to this weight, give yourself time to return to a healthy weight. Don’t risk relapse by getting caught up in the triumphant stories of slimming down at supernatural rates. These behaviors are unrealistic, unhealthy, and dangerous. One of the most important adjustments you can make after delivering a baby is to accept yourself for the new person you are.

There are, of course, other factors: a rapid hormonal shift, lack of sleep, the stress of coping with a fussy infant, or coping with the new identity of motherhood. Eating disorders often serve as a way of regulating negative mood and emotions, and an underlying depressive or anxiety disorder can impair the recovery process.
18. POSTPARTUM DEPRESSION AND ANXIETY:
Having a baby is probably one of the most stressful times in a woman’s life. Depression and anxiety can be signs of baby blues or something more serious, like postpartum depression. Women with eating disorders often have a co-morbid depression or anxiety disorder. If you have a history of an eating disorder, you have a 35% chance of having a postpartum depression—almost three times the rate of the general population. If you have an active eating disorder, your risk increases.

Postpartum depression can occur anywhere from a few weeks to a year after having a baby and can impact your recovery, your ability to care for yourself, interfere with your ability to care for or bond with your baby, create problems with breast feeding, stress interpersonal relationships, or lead to thoughts about harming yourself or your baby. Some women will experience anxiety as a symptom of postpartum depression. Anxiety often focuses on irrational fears regarding the health and safety of the baby and can center around food and weight issues.

Women experiencing postpartum depression often feel ashamed, embarrassed, and do not tell people how they feel. Serial screenings should be done well into the postpartum time could help detect these disorders. Postpartum depression can be an emergency. If there is concern, contact your physician immediately to determine the appropriate intervention.

19. DIFFICULTIES WITH FEEDING YOUR NEW BABY
Mothers want the best for their child and are often worried about transferring their eating disorder to their offspring. To date, there is no evidence that mothers cause an eating disorder, but they can have an influence. If your eating disorder sways your decisions, then feeding your baby can be distressing and lead to problems for both you and your baby. Babies born to mothers with eating disorders are often fussy. Mothers with eating disorders frequently expressed concerns about the interaction with their new baby and the ability to bond, difficulty with breastfeeding, uncertainty regarding the amount or type of food to feed your child, preoccupation with a child’s appearance or weight, mealtime conflicts, etc. Your pediatrician, as one of the team members, will be monitoring the growth and development of your new baby and is an excellent resource that you can turn to for support.
NEED FOR CONTINUED CARE FOR MOTHER AND BABY:

Pregnancy is a life-changing event, but the time after pregnancy is often experienced as a defining moment. Motherhood is a new identity and giving birth to this new identity may be as difficult as giving birth to your new baby. Caring for your newborn can be stressful and disrupt your eating and sleeping patterns as well as interpersonal relationships. It is easy to slip back into familiar and secretive eating disorder behaviors to deal with stress. Pregnancy is the time for additional support from both healthcare professionals and one's social network. Resources need to be made available so that continuity of care and close monitoring of mother and baby can continue.

The postpartum period, usually defined as 6-8 weeks after delivery, begins after the birth of the baby and ends when the mother’s body has nearly returned to its pre-pregnant state. In reality, the transition takes much longer. Postpartum visits for women with eating disorders need to be earlier and more frequent than the traditional 6-week follow-up visit, with routine screening for eating disorders and depression. Close monitoring of mother and baby well beyond the postpartum period is necessary to watch for emergence of symptoms.

Learning to engage in self-care is not selfish. To the contrary, it is self-preservation. The focus often shifts to the baby, but taking care of yourself is just as important. Be honest about where you are emotionally and physically. Self-evaluation can be difficult, especially if you are experiencing a re-emergence of your symptoms. Have patience and don’t expect perfection, knowing that you are doing the best you can for you and your family.

Move away from the shame and blame. Eating disorders are complex, biological-based illnesses, and while no one chooses to have an eating disorder, you can choose recovery. Practice self-compassion. Remind yourself to be gentle with you when you are struggling. You are worth it. Your baby is worth it. And you both deserve a healthy and happy life.

2. Bulik, CM, survey of women between ages 25-45 conducted by SELF magazine in partnership with University of North Carolina at Chapel Hill, news release, April 22, 2008.


About ANAD:
The National Association of Anorexia Nervosa and Associated Disorders, Inc. (ANAD) is a non-profit (501 c 3) organization working in the areas of support, awareness, advocacy, referral, education, and prevention. ANAD is the oldest eating disorder organization in the United States. Our mission is to alleviate suffering and provide support for those struggling with eating disorders and provide resources for families, schools, and the eating disorder community.

ANAD’s Free Support Services:

ANAD Eating Disorder Support Groups make it easy to get in-person support from your peers in recovery and can help prevent relapses.

ANAD Recovery Mentors help guide and support those in recovery by sharing their own recovery experiences. Recovery is real. Mentors are living proof.

The ANAD Helpline is staffed with trained volunteers who can help those in eating disorder crisis and recommend professional treatment options. Call the Helpline today: 630-577-1330

ANAD Grocery Buddies are coming in 2018. Volunteers will be trained in how to help relieve the fear and anxiety around grocery shopping for those in recovery.

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