While accepting as “usual”, the various changes in eating attitudes and habits that occur in pregnancy, the possibility of an association with eating disorder symptomatology and/or other psychiatric morbidity raises crucial questions as regards the management of these women. This study has set out to determine if such associations exist. The general objective was to assess the pattern of eating attitudes and habits among primigravid women and to determine any associated psychiatric morbidity.

Screening for eating disorder symptomatology was done using the *Eating Attitudes Test*-26 (EAT-26). This instrument, not having been locally validated, was also administered to a hundred (100) non-pregnant subjects who were matched with an equal number of pregnant subjects for age, sex, ethnicity and level of education, in order to obtain a normative reference value with which the index group could be compared. The *General Health Questionnaire*-12 (GHQ-12) was used to screen for psychiatric symptoms among the pregnant subjects employing a cut-off score of ≥ 3. The *Schedule for Clinical Assessment in Neuropsychiatry* (SCAN) was then administered on probable cases. Personality attributes of the pregnant subjects were assessed using the *Eysenck Personality Questionnaire* (EPQ).

The subjects were aged between 18 and 37 years. Mean age was 27.05 ±4.28 for the pregnant subjects while it was 27.10±4.32 for the non-pregnant reference group. Pattern of eating attitudes among the pregnant subjects include: aversion (70%), dietary craving (50%), nausea and/or vomiting (72%).
Using a reference value of ≥21 on the EAT-26 obtained in this study, 13% of the pregnant subjects compared with 3% of the non-pregnant reference group had possible eating related psychopathology. One percent of the pregnant subjects met *International Classification of Diseases* (ICD10) diagnostic criteria for Eating Disorder Unspecified and 3% met diagnostic criteria for depression. Fifty percent of the pregnant subjects scored ≥3 on the GHQ-12.

The loading of neuroticism in the subjects had a significant positive linear correlation with their total EAT-26 scores (p=0.01). This however was not the case with psychoticism and introversion-extroversion dimensions.

The total EAT-26 scores had significant association with the experience of aversion ($X^2=3.54$, df = 1, Fisher’s exact p= 0.05) as well as with nausea and vomiting ($X^2=4.05$, df = 1, Fisher’s p= 0.04). No significant association was observed between total EAT-26 scores and ethnicity ($X^2=0.77$, df = 2, Fisher’s exact p=0.67) and the experience of cravings ($X^2=0.00$, df = 1, p= 1.0).

The association of eating disorder symptomatology (assessed with EAT-26) with the loading of personality attribute, neuroticism; the experiences of aversion, nausea and vomiting; as well as the prevalence of psychiatric morbidity in the study sample is significant enough to warrant attention. Further studies of the eating attitudes and habits in pregnancy are therefore recommended.