JOHN PRESCOTT RAISES THE ISSUE OF EATING DISORDERS IN MEN

The former deputy prime minister’s disclosure that he suffered from bulimia emphasises that nurses must be alert to signs of such conditions in men. Nerys Hairon reports

Former deputy prime minister John Prescott’s surprising revelation that he suffered from bulimia nervosa has highlighted the importance of awareness that eating disorders affect both men and women (Oakeshott, 2008). Nurses need to be aware of risk factors and warning signs for these conditions in both sexes.

In the same week as Mr Prescott’s revelation, the British Medical Journal published a personal account by a male medical student of his experience of anorexia nervosa (Samuel, 2008). In addition, beat (the working name of the Eating Disorders Association) has publicised a request from a production company asking for men with eating disorders to contribute information for a documentary (beat, 2008).

To improve identification of the conditions, NICE (2004) guidance on core interventions for eating disorders outlined the target groups for screening and the care patients should receive.

PRESCOTT’S REVELATION
The former deputy prime minister’s admission is all the more surprising because of his public persona as a former boxer who once punched a protester in the face. He says he suffered in misery and silence for many years because of the shame of being a high-profile man with the disorder.

Writing in The Sunday Times, he explains that people normally associate eating disorders with young women, such as anorexic girls, models trying to keep their weight down or women in stressful situations, such as Princess Diana (Oakeshott, 2008).

Mr Prescott says one of the causes of his disorder was stress, brought on by overwork in the 1980s. He battled with the condition for several years, and finally managed to recover from his bulimia a few years ago. The politician says he hopes making his condition public will help others to disclose such problems rather than suffer in silence.

OTHER MEN’S EXPERIENCES
In the same week as Mr Prescott’s revelation, the British Medical Journal featured a first-person account of anorexia by a male medical student (Samuel, 2008). He explains how a diet and health regimen in his teenage years slowly turned into a battle against food and eating, as well as a battle with self-image and body. The desire to lose weight during adolescence was prompted by a feeling of being different, as he had been overweight as a child and was born with a congenital deformity in one leg.

Samuel’s constant fear of weight gain turned his life into an existence ‘dominated by exercise (excessive and obsessive), calorie counting and work’. When undertaking the psychiatry attachment at the local hospital he was asked to attend an eating disorders clinic. This was when he admitted he had a problem, after entering ‘a room full of human mirrors of my bony form’.

SERVICES FOR MEN
A review of specialist healthcare provision for men with eating disorders in the UK, commissioned by beat, revealed that lack of awareness of the conditions in men makes it more difficult for them to access services (Copperman, 2000).

Incidence
The review found that approximately 10% of people with eating disorders are men, and that around 20% of men with eating disorders identify themselves as gay. It is estimated that 60,000–90,000 people with
eating disorders are known to clinics at any one time in the UK. According to the review, this suggests that 6,000–9,000 men should be known to eating disorder services at any one time. Since community studies identify a much higher prevalence, this is likely to be an underestimate.

Copperman (2000) highlighted that there is considerable overlap between the risk factors and age of onset in men and women, typically in the late teens. However, she also identified some significant differences. As there is less cultural endorsement for dieting among men, the onset of eating disorders usually has a specific trigger. These include:

- Avoiding childhood bullying for being overweight;
- Those with gastrointestinal symptoms;
- Patients with physical signs of starvation or repeated vomiting;
- Children with poor growth.

Mr Prescott’s recent revelation indicates that it is also important to bear in mind possible risk factors in men, such as stress and overwork, and issues in adolescent boys such as bullying or involvement in athletics.

NICE recommended that when screening for eating disorders one or two simple questions should be considered for use with specific target groups. For example: ‘Do you think you have an eating problem?’ and ‘Do you worry excessively about your weight?’

In addition, young people with type 1 diabetes and poor treatment adherence should be screened and assessed for the presence of an eating disorder.

### CARE AND TREATMENT

NICE (2004) outlined the care that should be provided across all eating disorders, and specific treatment for anorexia, bulimia and atypical eating disorders.

Across all conditions, NICE gives advice on assessment and coordination of care, providing good information and support, getting help early, management of physical aspects, and specific considerations for children and adolescents.

Patient assessment should be comprehensive and include physical, psychological and social needs, and a comprehensive assessment of risk. Patients and, where appropriate, carers should be provided with education and information on eating disorders and their treatment. For key priorities in bulimia management identified by NICE, see box below left. For full details on assessment and management of eating disorders, see www.nice.org.uk.

### CONCLUSION

Eating disorders clearly affect men as well as women, and it is hoped the disclosure from a high-profile politician will make it easier for men to recognise and admit when they have a problem. It is imperative that healthcare professionals are alert to the risk factors for onset and the signs that a patient has already developed an eating disorder.

### REFERENCES


### PRIORITIES IN THE MANAGEMENT OF BULIMIA

- As a possible first step in addressing their condition, patients with bulimia should be encouraged to follow an evidence-based self-help programme
- As an alternative or extra first step, adults with bulimia may be offered a trial of an antidepressant
- Cognitive behavioural therapy for bulimia nervosa (CBT-BN – a form of CBT specifically adapted for people with the eating disorder) should be offered to adults with bulimia, for 16–20 sessions over 4–5 months
- Adolescents with bulimia may be treated with CBT-BN, which should be adapted as necessary to suit their age, circumstances and level of development, and should include the patient’s family as appropriate

**Source:** NICE (2004)