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The Social Self in Bulimia Nervosa: Public Self-Consciousness, Social Anxiety, and Perceived Fraudulence

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Bulimic women appear preoccupied not only with their physical presentation but also with their "social self"—how others perceive them in general. This study examined the relationship of the social self to body esteem and to bulimia nervosa. In Phase 1, in which 222 nonclinical women (aged 16 to 50) participated, the social-self measures of Perceived Fraudulence, Social Anxiety, and Public Self-Consciousness were negatively associated with body esteem. In Phase 2, 34 bulimic women were compared with 33 Ss scoring high on the Eating Attitudes Test (EAT) and 67 matched control. Bulimic Ss, high-EAT Ss, and control Ss all differed on Perceived Fraudulence, and bulimic Ss and high-EAT Ss scored higher than control Ss on Public Self-Consciousness and Social Anxiety. The findings strongly support the hypothesized link of social-self concerns to body dissatisfaction and bulimia nervosa.

A central symptom of eating disorders is preoccupation with appearance—a constant concern with how the physical self is viewed by others. Beneath this manifest symptom seems to lie a pervasive concern with how others view the self in general. Eating disordered patients appear preoccupied with self-presentation and with how others perceive and evaluate them, a facet of the self first designated the "social self" by William James (1890/1983).1

Research suggests that women with bulimia nervosa and anorexia nervosa experience significant difficulties in the area of social adjustment, characterized by social anxiety, impoverished relationships, and social isolation (Fairburn et al., 1990; Grissett & Norvell, 1992; Herzog, Pepose, Norman, & Rigotti, 1985; Johnson & Berndt, 1983; Mizes, 1988; Norman & Herzog, 1984; Rybicki, Lepkowsky, & Arndt, 1989; Tobin, Johnson, Steinberg, Staats, & Enright, 1991; Yager, Landsverk, & Edelstein, 1987). The social disturbances do not seem to relate simply to eating pathology: Even after the behavioral symptoms of eating disorders remit, social maladjustment has been found to persist for many patients (Casper, 1990; Herzog, Keller, Lavori, Bradburn, & Ott, 1990; Malik, Whipple, & Huerta, 1987; Norman & Herzog, 1986; Norman, Herzog, & Chauncey, 1986; Stonehill & Crisp, 1977; Yager et al., 1987). Related research suggests that disordered eating is linked to deficits in social self-confidence and to preoccupation with self-presentation (Blanchard & Frost, 1983; Gross & Rosen, 1988; McCoulay, Mintz, & Glenn, 1988; Mintz & Betz, 1986).

How might these difficulties in the social self be related to body dissatisfaction and eating disorder? The body is a "social object," constantly accessible to the gaze of others, and women's bodies are scrutinized by men and women alike with an attentiveness far surpassing that given to men's bodies (Silberstein, Striegel-Moore, & Rodin, 1987). If a woman feels inadequate in her physical appearance, then social anxiety seems a probable result. Alternatively, if she feels insecure about herself in general, her worries about how others perceive her are likely to include, and perhaps become focused on, their evaluations of her body. Hence, we would predict a relationship between body image dissatisfaction and social anxiety.

Clinically, we have observed that eating disordered women, through their amplified attention to physical appearance, often seem to be struggling to construct an adequate social self. They seem exquisitely tuned to the evaluations others make of them and the expectations others hold for them, both in terms of physical appearance and at a far broader behavioral and psychological level. As Johnson and Connors (1987) and Jones (1985) have summarized, these women seem to suffer from an overdeveloped "false self" (Winnicott, 1965). In the absence of a "true self," they become hypervigilant about public face and social attitude. Although bulimic women may be successful at creating an acceptable facade for the world, their concerns with fulfilling others' expectations at the expense of acknowledging their own needs prevent them from developing a stable self-definition and leave them feeling fraudulent. According to clinical theorists, the false self originates in the early failure of significant others to provide adequately an accurate, empathic re-

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1 William James (1890/1983) proposed two additional components of the self: the spiritual self, reflecting the private, internal aspects of one's experience, and the material self, involving material property and body and family (Baumgardner, Kaufman, & Cranford, 1990; Lamphere & Leary, 1990).
spouse that would enable development of a secure sense of self (Bruch, 1985; Geist, 1989; Strober, 1990). The eating disordered woman's extreme efforts to achieve a socially desirable appearance represent her attempt to be accepted in the face of this social invalidation (Button, 1983; Chiodo, 1987). Hence, heightened public self-consciousness both results from and serves to perpetuate the sense of false self.

A small amount of research provides initial support for the hypothesized associations between these developmentally based deficits in the social self and disturbed eating, although research has not yet used a clinical population. Utilizing the Bell Object Relations Inventory, two studies of college women found relationships between disordered eating and the Insecure Attachment subscale, which purportedly reflects ambivalent and painful interpersonal relationships and fear of object loss (Becker, Bell, Billington, 1987; Heesacker & Neimeyer, 1990). Also in a college sample, Friedlander and Siegel (1990) found a relationship between a measure of perceived self-other differentiation and disordered eating. However, research has not yet examined the basic clinical assumption that eating disordered women are aware, to a heightened degree, of their self-presentation or the specific hypothesis that they experience a sense of false self. We selected two measures that could enable us to examine the relationship of eating disorders to these two dimensions of the social self. The Self-Consciousness Scale (Fenigstein, Scheier, & Buss, 1975) assesses the concern with self-presentation and with others' view of the self. The Perceived Fraudulence Scale (Kolligan & Sternberg, 1991) measures the degree to which the individual experiences the self as false, as competent on the exterior but inadequate on the interior.

An initial question, addressed in Phase 1 of our research, is how perceived fraudulence and public self-consciousness are related to body dissatisfaction in a nonclinical population. Although there is an extensive clinical literature concerning the role of the social self in bulimia nervosa, the empirical literature on this issue has largely relied on nonclinical populations. Therefore, for Phase 2 we recruited a sample of bulimic patients and compared them with control subjects and to a nonpatient sample of women scoring high on the EAT-26, a measure of eating disorder symptoms (Garner, Olmsted, Bohr, & Garfinkel, 1982). Inclusion of these groups enabled us to examine the extent to which social self-difficulties are evident in the clinical syndrome of bulimia nervosa, as compared with a nonclinical level of disregulated eating.

Phase 1

Method

Subjects

For Phase 1, a sample of 222 women between the ages of 16 and 50 (M = 22.53, SD = 6.0) was recruited from two sources. Female students enrolled in introductory psychology courses at two private universities were recruited to participate in the study to fulfill a course requirement. To overcome the pervasive problem in the body image and eating disorders research field of limiting research efforts to college undergraduates, an additional group of women (n = 83) was recruited from the local community through a newspaper advertisement for paid research subjects for studies on women's health. The majority of subjects were Caucasian (84%). All subjects provided their height and weight, from which a body mass index (BMI) was computed. The mean BMI for Phase 1 subjects was 22.22 (SD = 3.87).

Procedure

All subjects completed the measures in the order listed below.

Perceived Fraudulence Scale. To assess the experience of a false self, the Perceived Fraudulence Scale (PFS; Kolligan & Sternberg, 1991) was administered. The PFS purports to assess the degree to which one perceives oneself as an impostor or a phony. Subjects rated each of the 51 items (e.g., "I sometimes feel there's something false or misleading about me that others don't notice"); "My private feelings about, and perception of, myself sometimes conflict with the impressions I give others through my public actions or behaviors"; and "In some situations I feel like an impostor") on a 7-point scale ranging from 1 (strongly disagree) to 7 (strongly agree). The developers of the scale reported internal reliability of .90 and found perceived fraudulence to be substantially discriminable from depression, social-evaluative anxiety, and self-monitoring.

Self-Consciousness Scale. The Self-Consciousness Scale (SCS; Fenigstein et al., 1975) was administered to measure how the subjects experienced and reflected on the self. The SCS contains 23 items that are rated on a scale ranging from 0 (extremely uncharacteristic of self) to 4 (extremely characteristic of self). The scale yields three factors: Public Self-Consciousness pertains to an awareness of the reaction of others to the self (e.g., "I'm concerned about what other people think of me"); Social Anxiety is defined as a discomfort in the presence of others (e.g., "It takes me time to overcome my shyness in public situations"); and Private Self-Consciousness concerns attending to one's inner thoughts and feelings (e.g., "I reflect about myself a lot"). Test-retest reliability at 2 weeks ranged from .73 to .84 (Fenigstein et al., 1975). More recent research has confirmed that the SCS is reliable (e.g., Mittal & Balsabramanian, 1987) and valid (e.g., Nasby, 1989; Schlenker & Weigold, 1990).

Body Esteem Scale. Body dissatisfaction was assessed with the Body Esteem Scale (BES; Franzoi & Herzog, 1986; Franzoi & Shields, 1984). The BES lists 35 aspects of physical appearance and physical functioning. The BES has been found to correlate significantly with a measure of body shape dissatisfaction and with self-esteem (Silberstein, Striegel-Moore, Timko, & Rodin, 1988). Subjects rated satisfaction with each item on a 5-point scale ranging from 1 (very dissatisfied) to 5 (very satisfied). An overall body esteem score was calculated by summing across all items, with higher scores indicating greater body satisfaction.

Eating Attitudes Test. The 26-item Eating Attitudes Test (EAT-26; Garner et al., 1982) measures thoughts, feelings, and behaviors associated with eating disorders such as anorexia nervosa and bulimia nervosa. Subjects rated each item on a 6-point scale ranging from never to always. The three least pathological ratings receive a score of 0, and the three responses indicating more disturbance are scored from 1 to 3. An overall score was obtained by summing across items, with higher scores suggesting more disordered eating. The scale developers report high internal consistency (r = .90; Garner et al., 1982), and subsequent research has found the EAT-26 highly accurate in classifying eating disordered and non-eating disordered individuals (Gross, Rosen, Leitenberg, & Willimuch, 1986; Williams, Schaefer, Shisslak, Gronwald, & Comerci, 1986).

Symptom Distress Checklist-90R. The Symptom Checklist-90, Revised (SCL-90R; Derogatis, 1983) is a 90-item self-report inventory designed to measure a wide range of psychological symptoms. Extensive reliability and validity data have been published (Derogatis, 1983). On a 5-point scale ranging from 0 (not at all) to 4 (extremely), subjects...
rated the degree of discomfort they experienced during the past week on each symptom. A Global Severity Index was derived by summing across all items and dividing the sum by the total number of items.

Results

Phase 1 data analyses examined the relationship between the social-self variables and body dissatisfaction. Comparisons of the student sample and the community sample on all measures of inquiry yielded no statistically significant differences, using the Bonferroni correction for multiple t tests. In our analyses, therefore, we considered the sample as a whole. Table 1 displays mean scores for all measures utilized for Phase 1 analyses.2

We predicted an association of the social-self variables to body dissatisfaction. As shown in Table 2, Perceived Fraudulence, Social Anxiety, and Public Self-Consciousness were negatively associated with body esteem, whereas Private Self-Consciousness was not significantly related to body esteem. To examine the relationships between the social-self variables and body esteem further, we calculated a stepwise regression. Because of the significant negative association between BMI and body esteem (r = -.27, p < .001), BMI was forced into the regression before entering the social-self variables as predictors of the body esteem score. Controlling for BMI (b = -1.27, SE = .31, F = 16.42, p < .001, R² = .07), Perceived Fraudulence (b = -.016, SE = .03, F = 61.72, p < .001, partial R² = .21) and Social Anxiety (b = -.64, SE = .22, F = 11.37, p < .01, partial R² = .04) emerged as significant predictors of body esteem (Final model: F = 32.75, p < .001, R² = .33).

These findings provide strong support for the predicted association of social-self concerns and body esteem in a nonclinical population. Phase 2 was then undertaken to ascertain how the social-self variables relate to the clinical syndrome of bulimia nervosa.

Phase 2

Method

Thirty-four patients were recruited as they presented for treatment at two eating disorder clinics. Diagnosis of bulimia nervosa according to Diagnostic and Statistical Manual of Mental Disorders (rev. 3rd ed., or DSM-III-R; American Psychiatric Association, 1987) criteria was established by a trained clinician on the basis of an intake interview. By definition, all patients engaged in binge eating on average at least twice a week during the past 3 months. Mean frequency of binge eating episodes per week was 7.46 (SD = 5.57). A majority of patients (76%) reported purging by means of vomiting, and an additional 12% indicated regular use of laxatives as a means of controlling their weight. Only 12% of the patients relied solely on dieting to counteract the effects of binge eating. Of patients who vomited, 65% vomited at least once daily, and an additional 32% vomited at least twice a week. Laxative abuse occurred less regularly: Only 15% of laxative abusers reported taking laxatives on a daily basis, and an additional 15% used laxatives at least twice a week. Mean duration of bulimia nervosa was 6.80 years (SD = 4.15).

To compare the patient group with women evidencing elevated levels of disturbed eating, a group of Phase 1 subjects was identified who scored above the clinical cutoff of 20 on the EAT (n = 38; “high-EAT” subjects). A group of matched control subjects was generated by selecting Phase 1 subjects who scored below 20 on the EAT and who matched the bulimic patients or the high-EAT subjects on the criteria of race, age, and BMI. Thirty-four matched controls were found for the patients. We were unable to find matches for 5 of the 38 high-EAT subjects owing to these 5 women’s high body weights. These 5 women were therefore dropped from the high-EAT sample. The final Phase 2 sample thus included 134 women: 34 bulimic patients, 33 high-EAT subjects, and 67 matched controls. The majority of subjects (93%) were Caucasian. The mean age of Phase 2 subjects was 23.36 years (SD = 5.80 years).

Results

Mean scores on all measures for Phase 2 subjects are displayed in Table 3. A multivariate analysis of variance comparing the three groups of subjects on the subscales pertaining to Self-Consciousness found a significant overall group difference, F(2, 131) = 5.71, p < .001.

For between-group comparisons, the Bonferroni correction (p = .05/12) was applied, resulting in a significance level of .004. Planned contrasts comparing patients and controls were significant for Public Self-Consciousness, F(1, 93) = 15.35, p < .001, and for Social Anxiety, F(1, 99) = 12.58, p < .001, but not for Private Self-Consciousness, F(1, 99) = 0.39, p = .39. Similarly, planned contrasts comparing high-EAT subjects and control subjects found significant group differences on Public Self-Consciousness, F(1, 99) = 19.91, p < .001, and on Social Anxiety, F(1, 98) = 9.43, p < .001, but not on Private Self-Consciousness, F(1, 98) = 5.28, p = .05. None of the planned contrasts comparing patients and high-EAT subjects on the Self-Consciousness subscales was significant. An analysis of variance (ANOVA) yielded significant group differences on Perceived Fraudulence, F(2, 131) = 24.1, p < .001. Planned post hoc comparisons found all three groups differed significantly, whereby patients had significantly higher Perceived

Table 1

Mean Scores for Phase 1 Subjects on Measures of Social Self, Body Esteem, and Eating Concern

<table>
<thead>
<tr>
<th>Measure</th>
<th>M (n = 222)</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraudulence</td>
<td>187.35</td>
<td>42.43</td>
</tr>
<tr>
<td>Public Self-Consciousness</td>
<td>26.18</td>
<td>5.30</td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>17.53</td>
<td>5.28</td>
</tr>
<tr>
<td>Private Self-Consciousness</td>
<td>37.41</td>
<td>6.74</td>
</tr>
<tr>
<td>Body Esteem Scale</td>
<td>114.28</td>
<td>18.30</td>
</tr>
<tr>
<td>Eating Attitudes Test-26</td>
<td>10.61</td>
<td>9.60</td>
</tr>
</tbody>
</table>

2 Our community sample’s mean score on Perceived Fraudulence is slightly lower than the mean for a college sample reported by Kolligan and Sternberg (1991; M = 199.5, SD = 52.30). A recent study of adult patients and controls by Belfer and Glass (1992) reported mean scores comparable to ours for Public: Self-Consciousness (M = 24.97, SD = 3.80), Social Anxiety (M = 16.27, SD = 4.17), and Private Self-Consciousness (M = 34.48, SD = 5.93). Our sample’s mean scores on the EAT-26 and the BES are also similar to those reported by Silverstein and her colleagues, based on a college student sample (EAT: M = 8.24, SD = 7.44; BES: M = 111.58, SD = 14.32; Silverstein et al., 1988).
Fraudulence scores than high-EAT subjects who in turn scored significantly higher than control subjects.

Table 3 also points to strong group differences on measures of disordered eating (EAT-26), F(2, 132) = 170.85, p < .0001, body esteem (BES), F(2, 132) = 22.67, p < .0001, and general psychiatric distress (GSI), F(2, 132) = 33.70, p < .0001. On each of these measures, patients appeared significantly more distressed than high-EAT women, who in turn obtained significantly higher scores than control subjects.

It seemed possible that the social-self variables differentiated among the groups in Phase 2 and were predictive of body esteem in Phase 1 because they represent some basic level of psychiatric distress. Because all subjects had completed the SCL-90R, we were able to consider whether the social-self variables made a specific contribution to body dissatisfaction above and beyond the extent to which social-self dysfunction reflects general psychological difficulty. To explore this question, we used all subjects from both phases. To represent group membership, two dummy variables were constructed (bulimia and high-eat) and contrasted against control subjects as the reference group. A hierarchical regression analysis was performed, entering the following variables (in order) to predict body esteem: bulimia, high-eat, body mass index, global symptom index (SCL-90R), perceived fraudulence, and social anxiety, and interaction terms of Diagnostic Group × Perceived Fraudulence and Social Anxiety, respectively. None of the interactions was significant (data not shown).

After controlling for diagnostic group, BMI, and global symptom index, perceived fraudulence remained significant predictors of body esteem (final model: F = 33.17, p < .001, R² = .45). Adding perceived fraudulence and social anxiety to the regression model increased the amount of variance explained from 31% to 45% (p < .01).

**Discussion**

The findings of this study strongly support the hypothesis that social-self concerns are intimately linked to body dissatisfaction and eating disorder. In the nonclinical sample used in Phase 1, body dissatisfaction was related to Public Self-Consciousness, Social Anxiety, and Perceived Fraudulence, all of which are dimensions of the social self. In contrast, body esteem was not associated with Private Self-Consciousness, which is not a component of the social self. Similarly, Blanchard and Frost (1983) found that Public Self-Consciousness and Social Anxiety, but not Private Self-Consciousness, were associated with restrained eating in an undergraduate sample.

Phase 2 results offer empirical support for the clinical theory postulating that social-self dysfunction plays an important role in bulimia nervosa. Bulimic patients differed from normal control women on Public Self-Consciousness, Social Anxiety, and Perceived Fraudulence but not on Private Self-Consciousness. High-EAT women also differed from normal controls on Public Self-Consciousness and Social Anxiety, and on Perceived Fraudulence but not on Private Self-Consciousness. Our findings support Heatherton and Baumeister’s (1992) assertion that binge eaters possess heightened self-awareness of how they are perceived and evaluated by others, but not of their intrapsychic experiences.

Whereas both the bulimic and high-EAT subjects had elevated scores on Public Self-Consciousness and Social Anxiety compared with the normal control subjects, the only social-self measure that differentiated all three groups was the Perceived Fraudulence Scale. There may be ceiling effects on the Public Self-Consciousness and Social Anxiety scales that prevent detection of differences between the two groups with disregulated eating. Alternatively, the results may suggest that the Perceived Fraudulence Scale addresses more precisely and sensitively an issue linked to the clinical syndrome of bulimia nervosa.

High-EAT women fell between the other two groups on measures of body esteem, disordered eating, perceived fraudulence and psychiatric distress. These findings support the view that eating disorders lie on a continuum ranging from uncontrolled weight and eating at one end, to weight dissatisfaction and moderately disregulated eating in the middle, to the clinical syndromes of anorexia nervosa and bulimia nervosa at the other end (Rodin, Silberstein, & Striegel-Moore, 1985). High-EAT women may experience subclinical forms of eating disorders, or they may be at a preclinical stage of an eating disorder. Given certain precipitants (such as stressful life events), these women may develop a full clinical syndrome. The fact that high-EAT women share similarities with, yet also differ from, bulimic patients suggests that high-EAT women are an interesting group worthy of further research. Careful investigation of this population may offer a helpful look at what moves some women along the continuum of disordered eating to the extreme of a clinical syndrome.

Our analysis using SCL-90R scores of subjects from both phases enabled us to ascertain that the relationship between social-self deficits and body dissatisfaction is not simply a function of general psychiatric distress: Perceived Fraudulence and Social Anxiety remained significant predictors of body esteem when controlling for psychiatric symptoms. Initial research has

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*Note: BES = Body Esteem Scale; EAT-26 = Eating Attitudes Test; PFS = Perceived Fraudulence Scale; SCS = Self-Consciousness Scale.*

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3 Bulimia: b = -24.07, SE = 3.55, T = -6.77, p < .001, partial R² = 0.16; high-EAT: b = -4.43, SE = 3.80, T = -2.89, p = .01, partial R² = 0.02; BMI: b = -1.41, SE = 0.53, T = -3.89, p < .01, partial R² = 0.05; and global symptom index: b = -10.58, SE = 2.73, T = -5.13, p < .001, partial R² = 0.07.
found that social anxiety is elevated in a variety of psychiatric disorders suggesting that the Self-Consciousness Scale taps social disturbance common to a variety of psychiatric disorders. A recent study reported significant differences between anxiety disorder patients and nonpsychiatric controls on Social Anxiety (Belfer & Glass, 1992). Furthermore, comparing agoraphobic patients, patients with affective disorder (not further defined), anorexic patients, and bulimic patients, Belfer and colleagues (Belfer, Crump, & Bradach, 1991) found no significant differences between the four patient groups on Public Self-Consciousness and on Social Anxiety. Hence, anorexics appear to be as socially anxious and as concerned about how others' perceive them as do bulimic patients. Moreover, the Self-Consciousness Scale does not discriminate between clinical groups; rather, it appears to measure a nonspecific pathological feature (see also Ingram, 1990).

A limitation of our study is that it does not include other clinical populations to examine the extent to which perceived fraudulence plays a unique role in bulimia nervosa. Bruch's (1978, 1985) clinical writing has suggested that anorexic patients are characterized by self-deficits likely to result in perceived fraudulence, yet anorexic patients need to be studied to confirm Bruch's (1978, 1985) formulation. Interesting additional comparison groups would include patients with personality disorder suggestive of core social-self deficits, such as narcissistic personality disorder.

Our study does not permit us to identify the causal direction of the association between perceived fraudulence and bulimia nervosa. The experience of a false self may constitute an important risk factor for bulimia nervosa: On the one hand, as an individual struggles with a sense of fraudulence and inadequacy, she focuses on creating a facade for the world, which translates concretely into increased preoccupation with her body and her eating. On the other hand, the experience of false self may be a consequence of having an eating disorder, which may amplify perceived fraudulence. Binging and purging constitute a shameful secret hidden from others and provide a weight control method that feels fraudulent.

Prospective studies are needed to examine the etiological significance of Perceived Fraudulence, Public Self-Consciousness, and Social Anxiety in bulimia nervosa. Furthermore, treatment outcome research should assess the degree to which changes in Perceived Fraudulence, Public Self-Consciousness, and Social Anxiety occur in treatment and how such changes relate to prognosis. Recent treatment outcome studies have found interpersonal psychotherapy to be as effective as cognitive-behavioral therapy in reducing bulimic symptoms (Fairburn, Agras, & Wilson, in press; Fairburn et al., 1990; Willey et al., in press), lending support to the view that social-self concerns are central to the bulimic syndrome and are vital to address in treatment.

Our findings support clinical theory and observation pointing to the salience in eating disorders of preoccupation with self-presentation and an experience of the self as fraudulent. The impaired social self may contribute to the eating disorder in a variety of ways. A focus on weight and food may constitute an effort to confine the patient's anxiety to one sphere (Friedlander & Siegel, 1990), as well as to gain social approval (Button, 1983). Furthermore, the disorder often keeps the woman tied to her parents, thereby reducing her conflicts about dependency (Friedlander & Siegel, 1990). At a concrete level, patients often state that interpersonal incidents that focus them on their social-self inadequacy constitute specific precipitants to binging and purging. In a laboratory study of binge eaters, stress of interpersonal nature was found to be particularly likely to induce the desire to binge (Cattanach, Malley, & Rodin, 1988). Social self-deficits are also likely to be reinforced and amplified as a consequence of the eating disorder, as the eating disorder both increases the psychological sense of not fitting in and serves to isolate the woman further from the social world.

The findings bear important implications for clinical work with eating disorders. Typically, patients who feel like impostors have their feelings of insecurity and self-doubt discounted by significant others (Clance & Imes, 1978; Clance & O'Toole, 1988). This lack of validation of their feelings contributes further to the sense of isolation and perceived fraudulence. Therapists are challenged to simultaneously affirm the patient's experience of fraudulence and to increase her awareness of cognitive distortions (Clance & O'Toole, 1988). Furthermore, the bulimic patient's presentation of "pseudo self-sufficiency" (Goodstadt, 1985) and her hypervigilance about impression management may make it difficult to establish a satis-

<table>
<thead>
<tr>
<th>Variable</th>
<th>Patients (n = 34)</th>
<th>High-eat subjects (n = 33)</th>
<th>Controls (n = 67)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Fraudulence</td>
<td>235.94</td>
<td>44.86</td>
<td>194.21</td>
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<tr>
<td>Public SCS</td>
<td>29.00</td>
<td>5.60</td>
<td>29.61</td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>19.71</td>
<td>5.39</td>
<td>19.24</td>
</tr>
<tr>
<td>Private SCS</td>
<td>36.88</td>
<td>6.98</td>
<td>39.45</td>
</tr>
<tr>
<td>BES total</td>
<td>89.76</td>
<td>21.10</td>
<td>105.55</td>
</tr>
<tr>
<td>EAT-26 total</td>
<td>35.76</td>
<td>13.92</td>
<td>28.27</td>
</tr>
<tr>
<td>Global symptoms index</td>
<td>1.45</td>
<td>0.81</td>
<td>0.98</td>
</tr>
<tr>
<td>Body mass index</td>
<td>21.64</td>
<td>2.76</td>
<td>22.47</td>
</tr>
</tbody>
</table>

Note: Column means with different subscripts differ significantly (p < .001). SCS = Self-Consciousness Scale; BES = Body Esteem Scale; EAT-26 = Eating Attitudes Test.
factory therapeutic alliance. Last, the acute public self-consciousness of bulimic patients translates into an overriding concern with the therapist’s perception, and therapists must remain aware of the patients’ chameleonic abilities to decipher and then match the needs and expectations of others, including the therapist.

References


