Recovery is developmental: An exploration of Eriksonian psychosocial theory adapted to eating disorder recovery

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Recovery is developmental: An exploration of Eriksonian psychosocial theory adapted to eating disorder recovery

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Abstract

This qualitative study investigated women’s experiences of recovery from an eating disorder using an adaptation of Erikson’s stage theory of recovery from mental illness. Five female participants, ages 20-40 years old and who identified as having an eating disorder and going through some form of treatment, were interviewed regarding their development, experience, and recovery from an eating disorder after completing the EAT-26 survey. Participants’ responses were analyzed using open, axial, and selective coding. Three influences within the recovery process emerged through the analysis: personal (self), transitional, and interpersonal (social). The analysis suggests that an adaptation of Erikson’s developmental theory is useful in understanding the processes of eating disorder recovery.

Keywords: Eriskson, developmental, psychosocial, qualitative, recovery

Introduction

Causes of eating disorders are well known to be multi-factorial. Women who have engaged in eating disorders have explained that a felt sense of lack of control in their lives was one of the main contributing factors to the development of their eating disorders (Patching, 2009). They believed that if a sense of control over their food intake could be achieved, then that control would carry over into their lives and contribute to a stronger sense of individualized self (Noordenbos, 2011, Patching, 2009). Perfectionist tendencies may also lead to eating disorders (Johnson, 2002). Some have expressed a strong sense of not belonging or feeling misunderstood or devalued as a factor affecting their development of an eating disorder (Patching, 2009; Bardon-Cone, 2010; Johnson, 2002). Perhaps even more difficult than identifying the causes of eating disorders, is defining recovery from eating disorders. Inconsistent definitions of recovery among research studies cause results to be incomparable (Noordenbos, 2011; Courturier, 2006; Barton-Cone, 2010; Stice, 2009). It is important for the definition of recovery to contain physical, psychological, and behavioral criteria (Barton-Cone, 2010; Courturier, 2006; Noordenbos, 2011; Johnson, 2002). Women in recovery support this notion. They defined full recovery by whether or not they had regained control of their lives, reconnected with life, and achieved self-acceptance (Patching, 2009).

Psychological recovery encompasses a wide range of features depending on the specific eating disorder. One common marker of recovery is a new-found lack of intense fear of weight gain (Noordenbos, 2011); another marker is regaining control of eating habits, especially in patients with bulimia nervosa (Noordenbos, 2011; Patching, 2009). Positive self-concept is another marker of recovery in patients who
are fully recovered from an eating disorder, rather than partially (only physically and/or behaviorally) recovered (Bardone-Cone, 2010). Patients have described recovery in very positive terms and associate it with a happier life style (Malson, 2011; Patching, 2009), and they included psychological, emotional, and social well-being in their descriptions (Malson, 2011). Patients are more likely to successfully recover when they and their caregivers agree that recovery includes physical, behavioral, and psychological functioning (Bardon-Cone, 2010; Malson, 2011; Fitzsimmons, 2010).

Rather than attempting to define recovery, maybe it is more productive to attempt to describe the stages that those in recovery from eating disorders have experienced. Recovery is a non-linear and individual process that is unique to the patient’s personal strengths and resiliencies (Vogel-Scibilia, et al., 2009). But it can nonetheless be seen as a developmental process that occurs in a stage-like fashion. Rigid or prescribed stages cannot be expected and are not even desirable. However, it is possible to describe recovery using a flexible stage model. Vogel-Scibilia, et al. (2009) adapted Erik Erikson’s theory of psychosocial development to fit with the stages of recovery from any mental illness. These adapted stages can be applied to recovery from eating disorders. Vogel-Scibilia, et al.’s (2009) stages are as follows:

**Trust vs. Doubt**

The first stage forms the essential basis for recovery. The patient must accept his or her disability and establish at least some trust in the concept of recovery (Vogel-Scibilia, et al., 2009). This process of acceptance and acknowledgement form a foundation for the recovery work to follow (Vogel-Scibilia, et al., 2009; Barton-Cone, 2010; Courturier, 2006; Noordenbos, 2011).

**Hope vs. Shame**

The second stage involves acceptance of a personal recovery, and moves from a dependent to a much more independent posture in relationships (Vogel-Scibilia, et al., 2009). Anger is a strong feature in this stage.

**Empowerment vs. Guilt**

The third stage of recovery includes the hope for recovery to continue and for the acquisition of new coping skills (Vogel-Scibilia, et al., 2009). Coping skills have a valuable impact on whether or not a person may recover from their specific mental illness (Vogel-Scibilia, et al., 2009; Barton-Cone, 2010). Guilt may arise in this stage and can be used to urge further recovery.

**Action vs. Inaction**

The fourth stage of recovery is known as the “energy stage” (Vogel-Scibilia, et al., 2009). This is when the patient begins discovering greater purposes in life and engaging in behavioral recovery, which is a key component in the recovery process (Vogel-Scibilia, et al., 2009; Barton-Cone, 2010; Courturier, 2006; Noordenbos, 2011).

**New Self vs. Sick Self**

The fifth stage of recovery is when a patient begins to separate her identity from the disorde (Vogel-Scibilia, et al., 2009). This stage is consistent with what eating disorder researchers have labeled as psychological recovery, which they have found is evident in fully recovered patients (Noordenbos, 2011; Patching, 2009).
**Intimacy vs. Isolation**

This sixth stage of recovery describes a social aspect of recovery. Patients begin to develop mentoring relationships within the realm of peer-support contacts (Vogel-Scibilia, et al., 2009).

**Purpose vs. Passivity**

The seventh stage of recovery describes patients’ ability to resolve conflicts and accept advice from others when necessary (Vogel-Scibilia, et al., 2009). It is during this stage when patients begin to fear relapse.

**Integrity vs. Despair**

During the final stage of recovery, patients reach closure, especially from any grief they might have experienced, and they affirm their recovered lives (Vogel-Scibilia, et al., 2009).

There is a growing field of scholarly work investigating recovery from eating disorders from both qualitative and quantitative perspectives. Qualitative studies tend to employ individual, in-depth interviews (Cockell, 2004; Reid, 2008; Patching, 2008) and to focus on the narratives and experiences of the patient rather than diagnostic therapeutic models (Patching, 2008). Qualitative studies focus on analyzing and interpreting these narratives (Cockell, 2004; Reid, 2008; Patching, 2008; Bardone-Cone, 2010; Malson, 2011; Noordenbos, 2011; Colton, 2004) and do not focus on numbers or use statistical analyses that would be expected in quantitative studies (Johnson, 2002; Striegel-Moore, 2002; Couturier, 2006; Stice, 2009; Bulik, 2000; Root, 1990; Carter, 2004). The current research study investigated women’s experiences of recovery from a qualitative standpoint. It examined women’s reports of their recovery from eating disorders in light of Vogel-Scibilia, et al.’s (2009) adaptation of Erikson’s stage theory to recovery from mental illness.

**Method**

**Participants**

Participants for this qualitative research study were five women over the age of 18 and under the age of 40 years, who had been diagnosed or identified having an eating disorder and who self-identified as being in recovery or recovered. Participants responded to flyers and verbal announcements in college classes regarding the study.

Participants were aware that this was a research study and that their responses could be submitted for publication and/or presentation. Participants’ real names were not used: pseudonyms were employed. In order to establish the greatest possible sense of confidentiality no demographic data were collected on participants other than to verify that they were over 18 years of age.

**Data Collection**

Participants first completed the EAT-26 survey, which provides data regarding participants’ current personal attitudes and behaviors towards food (Garner, et al., 1982). Individual semi-structured interviews then took place immediately following completion of the EAT-26 instrument between the two researchers and one participant at a time. Each interview lasted less than 45 minutes and took place in a private faculty office. One researcher

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1 The study was IRB Approved.
reviewed the purpose of the study with the participant, as well as the voluntary nature of participation and the participant was able to ask any questions regarding the experiment. There were 8 interview and 6 task questions that covered the initial diagnosis of the participant's eating disorder, their past and/or current treatment, and their experience with and views on recovery.

The participants' responses were both immediately transcribed by the researcher, who was not asking the questions, and also video recorded for future reference. Participants talked through their placement of the terms in each column and explained to the researchers why they had placed each term under their chosen column header.

Data Analysis

The EAT-26 surveys were scored according to the instructions by Garner, et al. (1982). The interview transcripts and video recordings were re-read and re-viewed prior to analysis. The interview transcripts were analyzed by both researchers in light of Vogel-Scibilia, et al.'s (2009) adaptation of Erik Erikson's psychosocial stages of development. Through this lens, the categorization strategies of coding and thematic analysis were used to draw connections between the recovery stages and the responses given by the participants (Maxwell, 2013). Three different coding processes took place during the analysis of the data received from participants: open coding, axial coding, and selective coding (Corbin & Strauss, 1990).

The open coding process involved initial categorization from the interview and task responses. The audio and written responses from the individual interview were revisited and reviewed. Specific phrases pertaining to participants' definition of recovery were categorized. Axial coding deepened the analysis by relating the categories created in the open coding process into subcategories and tested the new emerging relationships against the data. This paradigm considered conditions, context, strategies, and consequences that related the categories and subcategories (Corbin & Strauss, 1990). The final step in the analysis involved selective coding in which all categories were collectively centered on a unifying analytical idea and further explication was given to categories where needed.

Results and Discussion

Preliminary participant data are presented in Table 1. An EAT-26 survey score of over 20 indicates sufficient concern for a referral to a professional to determine whether there is an appropriate criterion for an eating disorder (Garner, et al., 1982). Three of the five participants scored over 20 and referral resources were provided.

Open coding of the participants' interview and task data provided support for Vogel-Scibilia, et al.'s (2009) recovery stages with women in recovery from an eating disorder. Table 2 shows the interviewees' developmental stages of recovery, as categorized by researchers after analyzing the interview data. Positive and negative comments towards each stage were noted, and if they had no comment regarding any stage, that was also noted. Axial coding was used to create over-arching categories that described common themes, which turned out to fit a range of recovery stages. The three overarching categories that strongly emerged during axial coding were Internal, Transitional, and External Influences. These overarching categories encompassed ranges of recovery stages as follows: Internal influences covered the first
three recovery stages, transitional influences covered the middle two stages, and external influences included the final three recovery stages. Selective coding demonstrated that Erikson’s psychosocial stages, as adapted by Vogel-Scibilia, et al. (2009) accurately depict the developmental process that participants experienced in their recovery from eating disorders.

Interviewees’ responses paralleled the stages adapted from Erikson by Vogel-Scibilia, et al. (2009) (See Table 2). All participants started their recovery process at the Trust v. Doubt stage, and then with treatment and recovery, returned to the Eriksonian stage where they were prior to the onset of the eating disorder. Only one participant, Alex, had so far progressed beyond the stage where she had been prior to the onset of the eating disorder.

First overarching category: Personal Influences

Recovery stages: Trust vs. Doubt, Hope vs. Shame, Guilt vs. Empowerment

All participants spoke about personal influences involving in the three initial stages of Trust vs. Doubt, Hope vs. Shame, and Guilt vs. Empowerment. Each reported initial recovery experiences and feelings that were consistent with the Hope vs. Doubt stage. Participants then moved through the stages in a more or less step-wise progression until they progressed to the stage where they were before the onset of the eating disorder.

Trust vs. doubt. This was the starting place for all the participants in the recovery process. Trust in the process of continued growth and optimistic outlook on recovery also aided Alex to continue through the subsequent stages of recovery after she had returned to where she was before the onset of her eating disorder. Four of the five participants stated that they either did not think that full recovery from the eating disorder was possible or they were already as recovered as they could be. They were stalled, at least temporarily. The one exception was Alex who stated that she would, “like to become more active in awareness…” Alex’s EAT-26 score was the lowest of the group. Qualitative analyses also indicated that she was the participant in the study who was the farthest along in the recovery stages. Her trust in the process of growth may have contributed to her progress through the stages and her low EAT-26 score.

Hope vs. shame. Hope and shame were discussed by participants as both past and present experiences. Two participants who talked of shame as an aspect of eating disorders continued to evidence shame throughout the interview. They had begun to deal with shame, and spoke of it as something that they were done with, but they were still struggling with it. During the brief task at the end of the interview, Natalie placed the word “shame” in between the categories “Where I was” and “Where I am,” yet placed the word hope under the column “Where I am.” She explained that she had “been thinking differently around food” and saw it as a “need for sustenance” and was focusing on “maintaining a healthy lifestyle.” However, later in the interview, she discussed the effects of treatments and stated, “Since then it did not change anything but the way I thought...it did not change the way I felt or my behaviors...I’ve only lost 20lbs.” Although Natalie was confident in her hope to change, she still had aspects of shame with which she was grappling. Maria also spoke about how she felt both shame and hope simultaneously, “I feel like a big fat woman after I eat...I try to
do different things and to stop my eating habits.” This burdening overlap of both hope and shame in the recovery stage was expressed only by the two participants who reported binge symptoms.

Guilt vs. empowerment. All of the participants in the study placed themselves higher on Vogel-Scibilia, et al.’s (2009) recovery stages during the brief activity compared to their stage the researchers placed them in after analyzing their interview data. This suggests that all of the participants experienced at least some sense empowerment and were not living with extreme guilt, self-loathing, or a damaging sense of self. However, a few participants reported the guilt that occasionally overcame them from time to time. Alex stated, “I have moments where I wish maybe I was skinner or I get frustrated with myself...but I don’t have an unhealthy relationship with food now.” Alice, when speaking about placing empowerment in the “Where I hope to be” column, said, “I’m getting there but I think there’s a way to go.” However, Alice did place guilt in the “Where I use to be.” Maria also said, “Of course it is our fault. Nobody puts the food in our mouths. It’s just a feeling. An ugly feeling.” Recurring guilt may be one of those things that need to be revisited and reprocessed from time to time. Possibly there is need for occasional re-cycling of many or all of the recovery stages (see Figure 1). This reoccurrence of negative feelings may occur at any stage in recovery, suggesting that by revisiting the previous stages, the individual can then continue with recovery.


Positive self-concept is one of the defining features of recovery from an eating disorder as explained by Bardone-Cone (2010). These personal influences stages of recovery help individuals secure a basis for this self-concept. Transitional influences further solidify positive self concept.

Second Overarching Category: Transitional Influences

Recovery stages: Action vs. Inaction, Sick-Self vs. New-Self

Transitional influences include the call to personal action during recovery and the establishment of an identity separate from the eating disorder (or not).

Action vs. inaction. Alice, Natalie, and Maria each described their struggles within the Action v. Inaction stage. Alice reported, “I’ve made a good start, but it’ll go beyond that. Psychologically, you know how to cope with it, but I’m still forcing myself to be more comfortable.” She is continuing to take action, but is still aware of the strides she needs to make. Natalie said, “I didn’t know what action to take before but now I’ve taken some action yet I still have more to take. I’ve compartmentalized now,” and, “You teach yourself new habits...I don’t know, but you have to learn to ignore it and overcome it.” Maria took independent action and used a form of distraction to avoid binge behaviors. She said, “I try to clean the house, but I still need something (food) in my hand. I do a lot of exercise the next day because I don’t want to gain weight.”

Nutrient balance is a common type of action plan often introduced early in the recovery process, especially in individuals with anorexia nervosa (Noordenbos, 2011). The ability to balance nutrients and create an
eating schedule is another form of gaining back control for individuals with eating disorder that is another fundamental characteristic of recovery (Patching, 2009). Two of the five participants spoke about consulting a dietitian or nutritionist during the initial stages of their recovery, and stated this was helpful but not the only form of treatment they received. Although the physical health of the individual should be addressed first during treatment, the routine of balancing nutrition on a daily basis is a characteristic of the transitional influence one goes through during recovery from an eating disorder.

**Sick self vs. new self.** Once an individual has begun to seek purposeful work and become productive in their recovery, it is important to re-evaluate, once again, their identity. The phase of finding a “new-self” rather than a “sick-self” involves having a separate personal identity from the eating disorder. Maria spoke to the challenge of finding a new-self, “when you don’t even know where you are [in recovery] or what you have.” Cathy also noted the initial challenge of separating from the sick-self, “I was sick and I didn’t think of myself as sick for a long time.” Alex extended this idea by stating, “I was my eating disorder…I felt empowered by it and that’s why recovery is so hard. You feel like ‘I’ve got this’ to let yourself not care anymore is hard. I still struggle with this.” A separate identity from the eating disorder appears to be necessary before moving on to the overarching category of interpersonal influences. Without being able to define oneself independent of the eating disorder, it is difficult to find where social relationships could fit into one’s life.

**Third and final overarching category: Interpersonal Influences**

**Recovery stages: Intimacy vs. Isolation, Purpose vs. Passivity, Integrity vs. Despair**

Participants who scored higher on the EAT-26 survey, those who qualified to receive referrals to an eating disorders specialist, either had more “no comment” or more negative responses regarding categories referring to interpersonal influences. Natalie, who scored the highest on her EAT-26, did not have any comments regarding purpose, passivity, integrity or despair. She was not this far along in her recovery stages; she was still in the transitional influences stages. Most likely she will need to resolve her transitional issues before she is able to move forward to the social influences stages.

**Intimacy vs. isolation.** Intimacy in the study was defined as seeking out peer relationships to share recovery life and/or integrating intimate relationships with recovery (Vogel-Scibilia, et al., 2009). Isolation was defined as remaining alone in the recovery process and not involving others. Many of the participants identified involving others as one of the most fulfilling aspects of their treatments. Alice said, “Therapy was great because she [counselor] told me all the science behind it…but talking to my brother in law [who also was recovering] was a lot more helpful because he’s been through it.” Sharing her recovery story with another individual with an eating disorder appeared to be a strong drive for recovery for Alice. Cathy also found comfort in telling some of her close friends; however she also confessed, “I never told my family about it.” Telling a select few individuals seemed to help the participants’ drive towards recovery and also strengthen
their ability to trust in recovery. This is a reflection of the power of connections brought about through personal and interpersonal influences. By trusting in recovery, stronger intimate relationships formed during recovery and these relationships in return strengthened their trust in recovery. Participants selective chose certain individuals in whom to confide. Natalie said her boyfriend was really “encouraging and helpful” by reminding her of what she needed to accomplish. She also said, “I’m getting encouragement from others.”

**Purpose vs. passivity.** Only three of the five participants spoke about seeking purpose or a “life niche.” Alex remembered when she finished her treatment and met her husband she “clung to that relationship so much and did not take the time to figure out my own goals and what I wanted to do.” Her relationship may have assisted her in developing greater intimacy, but stalled her progress somewhat through the remaining recovery stages. Rather than continuing on, she latched onto her intimate relationship. She feels now she has grown and learned from that, however she still struggles to “separate my identity from the way that I look.” Alex may need to revisit the “newself” to re-strengthen her new identity. Cathy spoke about purpose as something she was currently trying to work on. She felt that the idea of trust, intimacy, action, and empowerment all worked towards her discovering the person she wants to be, “a healthy and happy and good person.” Maria only stated that regarding purpose there was “no time for that now” and that she needed to continue focusing on getting better. All three of these participants demonstrated that they were in different stages of recovery but were very self aware regarding their own need to address them in somewhat sequential, or at least prioritized, order.

**Integrity vs. despair.** Participants offered no comments during the interview process about integrity or the reflection of life lived in recovery (Vogel-Scibilia, et al., 2009). However, this should not come as too much of a surprise given that none of the participants in the current study were over 40 years old. Developmentally, none of them were at the stage of their life to begin looking back and creating closure.

The over-arching influence categories build upon one another (see Figures 2 and 3). The results from open coding analysis suggest a developmental progression consistent with Vogel-Scibilia, et al.’s (2009) adaptation of Erikson’s psychosocial stages. Recovery from eating disorders is developmental in a way that some may not have previously considered.

**Figure 2. Eating Disorder Recovery Process Mirrors Eriksonian Developmental Process**

**Figure 3. Overarching Categories in Recovery Process Stages**

**Strengths and Limitations**

Erikson’s theory of psychosocial development is a well-accepted, time-tested theory of human development. Vogel-Scibilia, et al. (2009) proposed a new, interesting use of Erikson’s theory and adapted it accordingly to the recovery of mental illness. This study explores Vogel-Scibilia, et al.’s proposal in the specific case of women in recovery from eating disorders. Participants’ were forthright and descriptive about their experiences of recovery and their experiences paralleled Vogel-Scibilia, et al.’s (2009) stages.

There are also limitations of the study. Only five female participants were involved...
in the current study; each of the participants volunteered in response to flyers and class announcements, so they may represent a different group of those in recovery than women who did not volunteer. The women had very different experiences, both of their eating disorder and of their recovery, so a critical mass of similar recovery experiences was not able to be studied. As other researchers have found, there is not a commonly shared definition of recovery from a research perspective, and the women in the study also had different definitions and ideas about recovery.

Implications for counselors or other caregivers

When counselors or other caregivers are working with a client in recovery from an eating disorder, taking the client’s developmental recovery stage into account may contribute to a more successful recovery. The developmental stage that the client was in when the eating disorder occurred, the stage she was in when treatment began, and where the client is currently, can all assist to inform treatment. The results of this study imply that once each Eriksonian recovery stage has been revisited, then clients can pursue the remaining stages between where they were at the onset of their eating disorders and where their peers are (to an age-appropriate psychosocial stage).

Once clients have caught up with their peers, they are “recovered.” According to the responses to interview questions it appears that previous recovery stages occasionally need to be revisited, if only briefly. This idea, based on participants’ reports of their experiences, turns the process of recovery into a continuous circle (see Figure 1).

Relapse, another aspect of eating disorders, can also be considered within this stage theory of recovery. Following relapse, clients might need to revisit each recovery stage until they are back where they were before the relapse. Certain stages may require extra attention following a relapse, as perhaps a poor resolution of that stage the first or second time around contributed to the relapse. More research is needed in the areas of recovery stages, and how relapse might fit into them.

References


Waller, G. (2012). The myths of motivation: Time for a fresh look at some received wisdom in the eating disorders?. *International Journal of Eating Disorders, 45*(1), 1-16
Table 1
Preliminary Participant Data

<table>
<thead>
<tr>
<th>Participant</th>
<th>ED Symptoms</th>
<th>Eat-26 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cathy</td>
<td>Restricting</td>
<td>13</td>
</tr>
<tr>
<td>Natalie</td>
<td>Binge</td>
<td>30</td>
</tr>
<tr>
<td>Alex</td>
<td>Binge purge</td>
<td>7</td>
</tr>
<tr>
<td>Alice</td>
<td>Restricting</td>
<td>24</td>
</tr>
<tr>
<td>Maria</td>
<td>Binge</td>
<td>20</td>
</tr>
</tbody>
</table>
Table 2
(a) Responses illustrating recovery stage development of Cathy, Natalie, and Alex

<table>
<thead>
<tr>
<th></th>
<th>Cathy</th>
<th>Natalie</th>
<th>Alex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust vs. Doubt</td>
<td>“At some point during freshmen year it occurred to me that maybe that label applied to me” “Yes I consider myself to be recovered”</td>
<td>“I realized that eating disorders aren’t just for skinny people” “I don’t think you can ever really do it [recover]...you always have the danger of slipping back into it”</td>
<td>“I went to therapy in college when I had trouble concentrating” “I realized I had a problem when I would do it on my own in the school bathroom [rather than with my friends]”</td>
</tr>
<tr>
<td>Hope vs. Shame</td>
<td>“I felt heavier than I should be and uncomfortable with my body” “I don’t think about it as much as I used to...”</td>
<td>“I’ve been thinking differently around food- a need for sustenance” “I’ve been working...on maintaining a healthy lifestyle”</td>
<td>“I will keep figuring myself out...I struggled with a very long time...”</td>
</tr>
<tr>
<td>Empowerment vs. Guilt</td>
<td>“I feel good about myself. I don’t have those negative feelings anymore.”</td>
<td>“The counseling center was very important to make myself realize what was going on”</td>
<td>“I have moments where I wish maybe I was skinner or I get frustrated... but I don’t”</td>
</tr>
<tr>
<td>Action vs. Inaction</td>
<td>&quot;I’m actively trying not to skip meals&quot;</td>
<td>&quot;I didn’t know what action to take before but now I’ve taken some action yet I still have more to take&quot;</td>
<td>&quot;There was a year when I was going to a therapist, nutritionist, and doctor every week...I was also part of a 4 person support group...we were all starting to recover..&quot;</td>
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<tr>
<td>New Self vs. Sick Self</td>
<td>&quot;I have a healthier relationship with food and my self-image&quot;</td>
<td>&quot;I’ve divided myself from it, seeing it as a part of me but it’s not me [entirely]&quot;</td>
<td>&quot;It’s no longer who I am, although it helped define who I became. It took a long time to get to that&quot;</td>
</tr>
<tr>
<td>Intimacy vs. Isolation</td>
<td>&quot;Once I started telling some of my really close friends, they just really helped me through it&quot;</td>
<td>&quot;I’m getting encouragement from others who see me&quot;</td>
<td>&quot;Right when I was done recovering I met my now husband and clung to that relationship so much&quot;</td>
</tr>
<tr>
<td></td>
<td>Family about it”</td>
<td>Purpose vs. “All these events go together to help me who I want to be healthy and happy and a good person”</td>
<td>No comment regarding this stage</td>
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<tr>
<td>Integrity vs.</td>
<td>No comment regarding this stage</td>
<td>No comment regarding this stage</td>
<td>No comment regarding this stage</td>
</tr>
<tr>
<td>Despair</td>
<td>&quot;I understand what I have and what I am doing with therapy” &quot;I still have some doubt about whether I’ll ever be able to get better”</td>
<td>&quot;Of course I doubt whether I will recover. I don’t know where to go or what to do”</td>
<td></td>
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</tbody>
</table>

Table 2 (continued)
(b) Responses illustration recovery stage development of Alice and Maria

<table>
<thead>
<tr>
<th></th>
<th>Alice</th>
<th>Maria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust vs. Doubt</td>
<td>“I understand what I have and what I am doing with therapy” &quot;I still have some doubt about whether I’ll ever be able to get better”</td>
<td>“Of course I doubt whether I will recover. I don’t know where to go or what to do”</td>
</tr>
<tr>
<td>Stage 1</td>
<td>Stage 2</td>
<td>Stage 3</td>
</tr>
<tr>
<td>---------</td>
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<tr>
<td>Hope vs. Shame</td>
<td>“Psychologically I’m more content”</td>
<td>“I want to feel something in my mouth...it’s more like an anxiety” “I just want to try and stop that feeling”</td>
</tr>
<tr>
<td>Empowerment vs. Guilt</td>
<td>“There’s always going to be some kind of preoccupation with food”</td>
<td>“Of course it is our fault. Nobody else puts the food into our mouths”</td>
</tr>
<tr>
<td>Action vs. Inaction</td>
<td>“I’m still forcing myself to be more comfortable” “I’ve made a good start, but it’ll go beyond that”</td>
<td>“I try to do a lot of different activities” “I try; I can’t. It’s just a feeling that’s in me. That feeling is what makes me do it”</td>
</tr>
<tr>
<td>New-Self vs. Sick-self</td>
<td><em>No comment regarding this stage</em></td>
<td>“I feel like a big fat woman after I eat” “It’s hard to go to a new self when you don’t even know where you are and what you have”</td>
</tr>
<tr>
<td>Intimacy vs. Isolation</td>
<td>“But talking to him was a lot more helpful because he’s been through it”</td>
<td><em>No comment regarding this stage</em></td>
</tr>
<tr>
<td>Purpose vs.</td>
<td>No comment regarding this stage</td>
<td>“There is no time for that now...I have too many problems”</td>
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<tr>
<td>Passivity</td>
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<tr>
<td>Integrity vs.</td>
<td>No comment regarding this stage</td>
<td>No comment regarding this stage</td>
</tr>
<tr>
<td>Despair</td>
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</tbody>
</table>
Figure 1. Results of the Grounded Theory of the Recovery of Eating Disorders based off Theoretical Framework of Vogel-Scibilia, et al.'s (2009) Adaption of Erikson’s Recovery Process

Start here and proceed to wherever the individual was before treatment of the eating disorder
Figure 2. Eating Disorder Recovery Process Mirrors Eriksonian Developmental Process
Figure 3. Overarching Categories in Recovery Process Stages