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"You're Just Looking at One Piece of the Puzzle… My Weight": A Phenomenological Examination of Diagnostic Crossover in Eating Disorders

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ABSTRACT
This paper examines the phenomenology of diagnostic crossover in eating disorders, the movement within or between feeding and eating disorder subtypes or diagnoses over time, in two young women who experienced multiple changes in eating disorder diagnosis over 5 years. Using interpretative phenomenological analysis, this study found that transitioning between different diagnostic labels, specifically between bulimia nervosa and anorexia nervosa binge/purge subtype, was experienced as disempowering, stigmatizing, and unhelpful. The findings in this study offer novel evidence that, from the perspective of individuals diagnosed with EDs, using BMI as an indicator of the presence, severity, or change of an ED may have adverse consequences for well-being and recovery and may lead to mischaracterization or misclassification of health status. The narratives discussed in this paper highlight the need for more person-centered practices in the context of diagnostic crossover. Including the perspectives of those with lived experience can help care providers working with individuals with eating disorders gain an in-depth understanding of the potential personal impact of diagnosis changing and inform discussions around developing person-focused diagnostic practices.

KEYWORDS: feeding and eating disorders, bulimia nervosa, diagnostic labels, diagnostic crossover, illness narrative.

Diagnosis and Diagnostic Crossover

The Diagnostic and Statistical Manual for Mental Disorders (DSM-5) is a handbook used as a guide to diagnose different mental disorders (American Psychiatric Association, 2022). Diagnosis aims to provide healthcare professionals with a common language, establish consistency in appropriate treatment provision, and allow researchers to standardize conclusions about the clinical course, outcomes, and treatments for a particular diagnosis.

The DSM-5 and DSM-5-TR (American Psychiatric Association, 2022) categorize eight unique feeding and eating disorders (FEDs). FEDs are psychological disorders that are characterized by abnormal eating, dysfunctional relationships with food, and a preoccupation with one's weight and shape. This paper limits its discussion of FEDs to three eating disorders (ED) anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED). There are three essential features of AN: persistent energy intake restriction; intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain; and a disturbance in self-perceived weight or shape. AN can be classified into two subtypes: anorexia-

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restrictive type (ANR) and anorexia binge-purge type (ANBP). BN is categorized by recurrent episodes of binge eating (an episode of eating an unusually large amount of food in a short period of time accompanied by a sense of loss of control); recurrent inappropriate compensatory behaviors (e.g., self-induced vomiting, misuse of laxatives, diuretics, excessive exercising and dietary restriction) to prevent weight gain; and self-evaluation that is unduly influenced by body shape and weight. The essential feature of BED is recurrent episodes binge eating.

The DSM-5 uses a mutually exclusive classification system for FED diagnoses so that an individual may only be diagnosed with one FED at a time, despite multiple similarities between FED diagnostic categories. For example, self-evaluation that is unduly influenced by body shape and weight is present in both AN and BN diagnoses. The presence of binge eating is the hallmark diagnostic criterion for ANBP, BN, and BED. Inappropriate compensatory behaviors are present in both ANBP and BN. According to DSM-5 diagnostic criteria, the difference between an ANBP and BN diagnosis is the body mass index (BMI): "unlike individuals with anorexia nervosa binge-eating/purging type, individuals with bulimia nervosa maintain a body weight at or above a minimally normal level" (American Psychiatric Association, 2022, p. 387). It is important to note that AN, including both subtypes, is the only FED with a BMI diagnostic criterion.

The term diagnostic crossover is used to describe movement within FED subtypes (e.g., ANR and ANBP) or between FED diagnoses (e.g., (AN and BN) over time (Plessow & Eddy, 2015). For example, an individual diagnosed with BN would transition to ANBP if their BMI is 18.5 or lower, and vice versa. Research indicates diagnostic crossover is common among individuals diagnosed with AN, with approximately 50% of individuals crossing between the subtypes (i.e., from ANR to ANBP), and approximately 20-35% crossover to BN (Breithaupt et al., 2022; Fichter et al., 2017). Diagnostic crossover is less common among individuals with BN, with about 10-15% crossover to AN (American Psychiatric Association, 2022; Glazer et al., 2019).

Eating Disorders and Diagnostic Hierarchy

EDs are highly stigmatized and ED diagnoses often are imbued with moral implications in both the minds of the individuals diagnosed and within society (Baffsky, 2020; Stanghellini et al., 2021; Whiskin, 2023). Stigma against EDs remains relatively understudied compared to other psychopathologies but existing research indicates that hierarchies and stigma exist among ED diagnoses whereby certain ED diagnoses are associated with higher levels of shame, guilt, and self-disgust (Brelet et al., 2021; Ellis et al., 2020). Research has shown diagnostic labelling and language can shape treatment expectations, inform behavior and future planning, and have significant psychological impacts (Sims et al., 2021). Of particular concern are the implications of a diagnostic label for people who are diagnosed with types or subtypes of disorders that are highly stigmatized and/or marginalized.

AN and BN are often described via binary oppositions - success and failure, control and out-of-control, strength and weakness - despite sharing many of the same diagnostic features and having relative high rates of diagnostic crossover (Castellini et al., 2022; Eli, 2018; Kearns, 2020). Previous research point to the moral associations of certain ED behavioral symptomology and cultural attitudes towards different body sizes (e.g., anti-fat bias), as part of the underpinning for why certain EDs are understood as 'better' or 'worse' (Burns, 2004; Counihan, 1992). Behaviors associated with AN, such as extreme dieting/self-starvation, the hallmark behavior of AN, have long been referred to as a form of ultimate control where an individual defies, conquers, and transcends their corporeal needs and desires (Bordo, 1993; Marks et al., 2020). Individuals with BN do not 'conquer' their body via the same kind of disembodied will (i.e., self-starvation) like in AN. Instead, behaviors associated with BN (e.g., binge eating and purging) are described in terms of bodily desires overcoming the individual,

> *Whereas anorexic patients are capable of starving themselves, bulimic patients can only resist eating for so long before succumbing to a bout of overeating. Bulimic patients may be said to exemplify the worst fears (i.e., eating and/or overeating) of the anorexic patients come true.* (Russell, 1979, p. 444)

Similar sentiments are re-iterated in more current literature describing the etiology of patients with AN as individuals who "are often high achievers who have an intense need to be accepted by others" while the etiology of patients with BN include "childhood and parental obesity, early menarche, and parental alcoholism" (Turner & Peveler, 2023, p. 384).

Research has shown that in the minds of individuals diagnosed with EDs, AN is frequently described as a more desirable and acceptable diagnosis than BN (Mond & Arrighi, 2012) (e.g., "a bulimic is an anorexic who failed, and I had no intention of failing" (Eli, 2018, p. 164); "with eating disorders everybody kind of wants to be anorexic" (Frey, 2020, p. 143). Insight provided by individuals who have experienced ED diagnostic crossover is valuable to understanding the ways diagnostic crossover may impact the overall treatment and recovery process. Currently, only one study has examined patients' experiences with diagnostic crossover. In a sample of five women who had received ED inpatient treatment service in the south east of England and had experienced crossover from AN to BN and/or BED, it was found that being diagnosed with BN (after AN) stimulated feelings of shame and a sense of moral failure (Mortimer, 2019). Shame and stigma have been consistently identified as key barriers to treatment-seeking and are a risk factor for continued eating disorder behaviors, and thereby may influence the likelihood of ED recovery (Ali et al., 2017; Foran et al., 2020; Hamilton et al., 2022). The current research focuses on the personal accounts of two individuals and seeks to articulate their perspectives and make sense of the meanings they ascribe to diagnostic crossover.

Methods

Data were collected through virtual semi-structured interviews with seven women who currently engaged or had engaged in binge eating and purging behaviors between September and November 2020. Seven women expressed interest in participation and all seven were interviewed. Participants had to be 18 years of age or older at time of interview and be currently engaging in or have had previously engaged in binge eating and purging behaviors per self-report. In this paper, I focus on the accounts of two participants who experienced diagnostic crossover from ANBP to BN and/or BN to ANBP in an inpatient treatment setting. The remaining five interviews are not included in this paper as diagnostic crossover was not experienced by the five women interviewed. Diagnostic crossover was not explicitly asked about, however, a question on history of eating disorder diagnoses was. Although the study had been initially designed to explore accounts of identity, the theme of diagnostic crossover arose during the interviews and was identified as important by the two participants who experienced diagnostic crossover. The lack of existing literature on this topic further warranted additional research on patient perspectives on and experiences with diagnostic crossover. Description of the participants can be found in Table 1.

Participants were solicited through online posts on the social media platform Reddit. The website is composed of an interlinked community of subforums, called ''subreddits,'' that are dedicated to a specific topic. For this research, the subreddits used to recruit participants include r/eating_disorders, r/bulimia, and r/EatingDisorders (*Connecting Food, Eating, Body and Mind*, 2012; *Eating Disorders*, 2008; *Eating Disorders, Uncensored*, 2014). Using these spaces allowed access to populations that include individuals with an established identity within the context of eating disorders. Other similar studies have used Reddit to recruit research

participants (Shatz, 2017; Zapcic et al., 2023). In the recruitment post, I represented myself as [identifying author information] interested in articulating the lived experiences of individuals who participate in binge eating and purging behaviors. Participants were not financially compensated for their participation.

Interpretive Phenomenological Analysis

The two interviews that are the focus of this paper were analyzed using interpretative phenomenological analysis (IPA). IPA is a qualitative research method that aims to provide detailed examination of a personal lived experience (J. A. Smith, 1996). The aim of IPA is not to produce an objective statement or generalizable account of an event or state, but rather is concerned with trying to understand what it is like from the point of view of the participants (J. A. Smith and Osborn, 2003). IPA is well-suited for the current study since, given the small and homogenous sample, the aim was not to produce generalizable conclusions from participants' narratives or to make general claims about the validity of diagnostic crossover (J. A. Smith & Osborn, 2015). Notably, a distinctive feature of IPA is its idiographic commitment to producing an interpretative analysis which is tied closely to the account coming from the participant (J. Smith et al., 2009). The results therefore are largely collated using longer quotations from participants so that the experience of each individual has a presence and there is an articulation of both convergence and divergence within the study sample.

Table 1
Participant details

Name	Residence	Age	Age of ED onset	ED diagnoses (most recent first)	Self-identified diagnosis
Madison	Canada	28	22	BN; ANBP; BN	ED
Sarah	United States	23	16	AN; BN; ANBP; BN	ED

Note. AN = Anorexia nervosa; ANBP = anorexia nervosa binge-/purge type; BN = bulimia nervosa; ED = eating disorder

Data Collection and Analysis

Virtual semi-structured interviews were conducted via Zoom videoconferencing and lasted approximately two hours. All interviews were recorded and transcribed verbatim. Interviews focused on the same core concepts (e.g., childhood experiences, experience with institutions, conceptions of eating disorders, lived experience with disordered eating, and proclaiming identities). However, interviews also followed the direction of each participant's narrative.

Data analysis followed an iterative and inductive approach. Using an analytic process as described in the Sort and Sift, Think and Shift approach, interview transcripts were read and reread a number of times to ensure a general understanding of each participant's account, (Maietta et al., 2021). This process included notetaking, creating an inventory of quotations, and deriving emergent themes between interviews to allow for comparison and revision.

Ethical Considerations

In advance of meetings, participants were informed that audio would be recorded for evaluation purposes. Verbal consent was obtained from participants prior to beginning interviews. To ensure participant confidentiality, interviews were conducted using headphones and in a locked room with no windows in view of the computer. Participants had the option to

either have their camera on or off; both participants in this study chose to have their camera on. All data were stored on password protected files. All names used in this paper are pseudonyms and any information that may be identifiable has been modified to protect anonymity.

Results

Two major themes emerged during participants' descriptions of diagnostic crossover between ANBP and BN (in both directions). In the first theme I explore how participants experienced diagnostic crossover in their ED diagnosis and responded to this transition internally and externally. In the second theme, I examine how participants experienced diagnostic crossover as impactful, stigmatizing, and ultimately unhelpful to their treatment and recovery.

Negotiating Diagnosis: Through BMI and Behavior

In their experience with diagnostic crossover, participants felt misunderstood and overlooked by their clinicians, who were either clinical psychologists or medical doctors. Participants described being diagnosed with different EDs solely based on BMI change, despite an absence of change in any other symptoms. Both women described having their ED diagnosis change enforced an undue focus and value on weight to determine ED type and severity. When Madison was initially diagnosed with BN, she recalled the doctor telling her that "once you hit a certain BMI, then it would be anorexia but with binge eating." Madison noted that the comment did not bother her at the time because her "weight or looks were never the focus, it was more about dealing with stress". A few years later, Madison returned to the hospital due to an electrolyte imbalance from frequent purging, and was admitted to an inpatient ED treatment program. Madison described her intake experience during her second hospitalization:

> *I have it ingrained in my mind, my assessment with this doctor. I was in his office, and getting all assessed and stuff. And at first, he was like 'oh, when were you diagnosed with bulimia?' and then quickly said 'but what is your weight now?' and he pulled out a stupid little BMI chart and said that I now have anorexia with binging and purging, but that is was only mild anorexia. And like anyone else, in my disordered eating head, I said 'well f--- you b----, I'll prove you wrong. I'll just lose more weight so I have severe anorexia.* (Madison)

Madison said her disordered eating behaviors stemmed from coping with stress rather than a desire to lose weight. However, after doctors told her (a) she would be diagnosed with AN if she lost weight, and (b) that her disorder was mild, *because of her BMI*, despite multiple hospitalizations, Madison reported her focus shifted to losing weight to prove to her providers that she was "sick enough." Madison described "I was in denial that I had a problem when I was not underweight" noting that she did not believe she was in any danger because "I don't look that bad. Like even the doctor said it's just mild anorexia." Madison mentioned that "even now I'm still going through a big loop of binging and purging or whatever, but I'm in the normal BMI range now so no one really cares."

Sarah, who originally was diagnosed with ANBP, recounted feeling confused and angered when her doctors changed her ED diagnosis:

> *My diagnosis switching a million times based on whether or not I'm underweight or not, even though nothing's really changed? It's not like a significant huge weight discrepancy that's happening every time.*

> *We're talking like little bits. My diagnosis just changing on a dime because of that. It's definitely something that's frustrating to deal with. Because it gives the perception that you're dealing with a different kind of animal, but it's the same.* (Sarah)

Sarah said her initial reaction to being diagnosed with BN after ANBP was "am I not thin enough for anorexia? Am I not skinny anymore?"

> *Having been diagnosed with anorexia first and then receiving that [BN] diagnosis, you just conflate anorexia with restricting, thinness, [and] underweight. And, you know, for me and a lot of other people with an eating disorder, that's the goal, you want to be perceived as thin. Whether it's internally like yourself, or by others around you. And that [AN diagnosis] is like a huge validating thing, like, oh, yeah, I'm doing something, right. But then you're diagnosed with bulimia, and then that weight criterion is gone. It explicitly says you're probably normal weight. I guess it kind of feels dismissive of how you want others to perceive you. Like that's one of the goals of my eating disorder is to be very thin and perceived that way. And when you get the diagnosis of bulimia, you're like, okay, that must not be true.* (Sarah)

For Sarah, diagnosis became a point of contention between her and her doctor over what symptoms (e.g., BMI or disordered eating behaviors) are the most clinically significant. Sarah said that although she had been told by clinicians that she needed treatment at "healthy weights and being underweight" she felt "people perceive you as having a more severe disease if you are underweight". Sarah noted that while she does participate in restrictive eating behaviors at times, she identified "more so with bulimia because the bingeing and purging is the main concern." After her fourth experience with diagnostic crossover (i.e., AN to BN to ANBP to BN to ANBP) Sarah said "I really strongly reacted against the anorexia diagnosis. I was like that is not me. It doesn't represent what I do." Sarah said that despite telling her clinician that she has BN, she felt her care providers "only see what they want to see, instead of listening to what you're telling them." Sarah expressed that clinicians "need to evaluate eating disorders on a more holistic basis, rather than just grouping people by clinical presentation." The struggle over ED diagnosis for these two women is reflected by Sarah: "you're just looking at one piece of the puzzle, which is my weight."

Diagnosis as Dividing, Stigmatizing, and Clinically Unhelpful

In their accounts, both women indicated that clinicians and treatment providers treated patients differently based on ED diagnosis in a stigmatizing manner. At the same time, participants noted the therapy provided during inpatient treatment was inappropriate for their behavioral symptoms. In Madison's experience, ED staff treated patients differently depending on diagnosis and would "put you into categories based on your weight." Madison described during her hospitalization:

> *We had to do weigh-ins once a week, and the staff would take all of the anorexics to one area and all the other people who weren't underweight to another (…) The non-anorexics could just wear their clothes while they got weighed while the anorexics had to change into a hospital gown to be weighed in a separate room. After weigh in time we would go into the group room, so one by one the people who had to change*

> *would come in later while the group who didn't change were already there waiting (…) It made it so obvious that it was a bigger deal for the underweight people, whereas, 'we don't really care about your weight because you've been stable, so your weight isn't in danger, we just have to do it'.* (Madison)

Madison said the segregation made it clear to everyone in the facility which patients were actually "in danger." Madison recalled an instance when a patient walked to the "wrong scale" and was informed by another patient: "oh no, we don't go to that scale, we go to the *fat* person scale." Madison also felt that staff perceived people with BN as "dirty and gross" and associated more "shame and secrecy" around BN compared to AN.

After weight restoration, Madison stated that she "didn't have to take my clothes off anymore because I was above that BMI" and was diagnosed with BN (for the second time). Madison was not explicit about her second experience with diagnostic crossover, but showed that it was significantly distressing, stating she "will never set foot back" in inpatient ED treatment and is "bitter about how [the treatment facility and staff] treated you differently based on your weight." Sarah described a different experience with the treatment facility she went to:

> *It doesn't really matter what your weight status is which is great. [The treatment facility is] definitely weight inclusive. And I would say at any point in time, the ward is like more than half atypical anorexia. So they have people who are overweight or obese with an anorexia diagnosis, which I think does a lot to kind of deconstruct the stigma.* (Sarah)

Despite being in a weight inclusive environment, Sarah said "you also get treated differently by the patients in the ward by how you're presenting. There's definitely like a hierarchy, which is total BS. But people are like, oh, you're anorexic? So alright, you're a real one." During treatment, Sarah believed her diagnosis overshadowed who she was as a person and believed the staff and clinicians attached certain personality traits to her and other patients based on their diagnosis:

> *When you're someone that restricts or someone who is diagnosed with anorexia, you're kind of approached from a different way like 'oh you must be a perfectionist, so you know you must do really well in school' (…) for bulimia I feel like the clinicians I worked with assumed that I'm someone who's messy and disorganized and somebody who doesn't have willpower, doesn't have good self-control, like maybe someone who tried dieting tried restricting but were not successful, so they started binging and purging.* (Sarah)

While diagnosis was understood as largely influential to how patients were treated and viewed, the therapy provided by treatment facilities was noted as unhelpful and inappropriate for both women's symptoms. Madison spoke about the therapy programs she went to in inpatient treatment, and Sarah echoed similar sentiments:

> *The programs were always centered around the idea of restriction and anorexia (…) so if you were there for bulimia, you could get help but you really had to steer the conversation that way, which can be a hard thing to do in a group.* (Madison)

> *You go to treatment and you're trying to get help for your problem and you're kind of an afterthought. In the groups, the behaviors described are mostly talking about restricting. You can't even say the words binge and purge (...) I need help, but the way that [the treatment facility is] giving me help is really not for what I'm struggling with.* (Sarah)

Sarah later said:

> *As I've grown older, and kind of had more experience living with my eating disorder, I've realized like, okay, well, it's not really what is important, what people are kind of calling me, it's if I'm able to get the help I need and sometimes it's just not even the case. Treatment is very anorexia centric, and they just don't have a lot of skills or, like options to help somebody who binges and purges.* (Sarah)

As a result of their experiences with diagnostic crossover, Madison and Sarah prefer to use the term eating disorder to refer to their condition. Instead of saying anorexia or bulimia explicitly, 'eating disorders' is inclusive of all ED symptoms.

Discussion

For the participants in this study, diagnostic crossover was an unhelpful and stigmatizing experience. Participants described being physically assessed by clinicians to determine ED diagnosis, relying on oversimplifications of complex realities via bodily standards of AN and BN. In particular, participants report being diagnosed with different EDs solely based on BMI change, despite an absence of change in any other symptoms. In their experiences with diagnostic crossover, participants indicate a tendency of clinicians to focus on physical measure of illness, such as weight, while behavioral and psychological aspects of the illness were overlooked or under-recognized. For the participants in this study, feeling that their illness was trivialized was a common experience and elicited reactions of annoyance, frustration, and ambivalence towards treatment and recovery.

The experience of diagnostic crossover had similar distressing impacts on participants. For Madison, the experience of diagnostic crossover led to an intentional intensification of restrictive eating behaviors and an undue influence of body weight on self-evaluation. This finding is consistent with current research detailing the experience of being viewed as "not sick enough" as a significant factor to the deterioration in ED symptoms and recovery progress (Eiring et al., 2021; Gotovac et al., 2020). For Sarah, the movement between diagnoses felt dismissive of the aspects of the illness that were important to her and influenced how care providers treated and viewed her. Both participants report feeling not supported by their care providers. Several studies have confirmed that feeling supported and understood by care providers is an important resource for an individual in recovery from EDs (Geller et al., 2021; Linville et al., 2012; Mitrofan et al., 2019). While identification and clinical management appeared dominated by a patients' weight, both participants noted therapy options provided during treatment as inappropriate for their behavioral symptoms.

The findings in this study highlight several areas that warrant further discussion. Weight stigma is important to consider in regard to treatment seeking and treatment outcomes, as weight gain often is viewed as synonymous with recovery but may not reflect meaningful improvements in ED psychopathology. Body weight assessment procedures that are standard across ED types and BMI could reduce unnecessary separation of patients and reduce patients' focus on weight, as previous research indicates weight stigma and body shame are associated with disengagement from treatment or health care and higher severity in ED symptoms (Martin-

Wagar & Weigold, 2023; McEntee et al., 2023; Mensinger et al., 2018; Salvia et al., 2023). The participants in this study also expressed a desire to be included in the diagnosing process, specifically when there is a change in diagnosis. Person-centered recovery frameworks, where individuals are able to determine what outcomes are important in their own recovery journey, allow clinicians and individuals with lived experience to acknowledge the complexity of recovery and creates space for individuals' autonomy (Kenny & Lewis, 2023). Adopting person-centered practices in the context of diagnostic crossover could include collaborative discussions between the diagnosing clinician and patient prior to changing diagnosis. For example, a patient who had met criteria for AN but is now newly weight-restored a clinical diagnosis of AN in partial remission may be most accurate (and informative) rather than a change in diagnosis. This kind of communication between care providers and patients may empower a patient to be more involved in their ED recovery journey, foster a patient's sense of agency and autonomy, and facilitate the inclusion of patients' subjective experiences and recovery definitions -- which have been found to be central to the recovery process of ED patients (Mirabella et al., 2023).

It is also important to extend traditional clinical understandings of ED treatment options. Research indicates that about 50% of patients do not respond to standard treatments (e.g., cognitive behavioral therapy for EDs) (Monteleone et al., 2022; van den Berg et al., 2019). In general, there are multiple barriers to accessing ED treatment, some of which are related to the patient (e.g., stigma, secrecy, fear of change), systemic barriers (e.g., racism, poverty) or service-related (e.g., availability and/or accessibility of specialist treatments) (Acle et al., 2021; Hamilton et al., 2022; Johns et al., 2019). Self-help interventions, such as online guided self-help programs, yoga, and ED recovery support groups (e.g., overeaters anonymous, ANAD) have the potential to alleviate some of these barriers, by giving people with EDs timely access to relatively low-cost interventions, minimizing perceived shame and stigma, and empowering them to take the lead in their own recovery in the process (*ANAD | Free Eating Disorder Support Groups & Services*, 2021; Bray et al., 2021; Ostermann et al., 2019; Rohrbach et al., 2022). While findings on the efficacy of these options are limited and mixed, self-help interventions are considered superior to waiting for treatment or not accessing treatment at all. Accordingly, additional research is needed to better understand where these kinds of interventions fit in to the current ED therapeutic apparatus.

Finally, the diagnosis-centered model in working with eating disorders has also been put to question. While diagnosis as a clinical tool has clear empirical and epidemiological advantages, systems that identify and classify diseases like the DSM-5 have been criticized for overlooking individual variability within specific ED diagnoses in terms of impairment, personality characteristics, and overvaluing cultural overlays (e.g., "Western" thin idealization) (Lowe et al., 2018; Wilkop et al., 2023). Research supporting the de-emphasis on diagnostic boundaries for EDs also cite high rates of diagnostic instability and high frequency of transition between diagnoses at different ages of DSM-5 diagnostic categories (Levinson et al., 2022; Waller, 1993; Walsh et al., 2023). Despite the small sample size of the present study, the narratives articulated here are robust in detail and could inform future discussions regarding the best way to determine ED diagnostic crossover in a person-centered way within the DSM. In such discussions, it will be important to consider the clinical validity and utility of diagnostic categories, as well as how transition between ED diagnoses may have an impact on the patient.

The main strength of this study is that it is one of the first phenomenological analyses of diagnostic crossover (see Mortimer, 2019). Secondly, this study provides a platform for the voices of individuals who are typically left out in ED discourse. Despite study strengths, there are limitations to consider. Given that this study draws from the accounts of two young adult women, the generalizability of the results is limited and may reflect specific accounts of feminine enculturated values. It is important to note these accounts are not reflective of all ED experiences. Future studies should include the experiences of men and of older individuals as

previous research indicates these populations seek and receive treatment less often for EDs (Samuels et al., 2019; Silén et al., 2021). The recruitment method of this study may have influenced the findings by including participants with more extensive eating disorder histories.

Conclusion

The findings in this study offer novel evidence that, from the perspective of individuals diagnosed with EDs, using BMI as an indicator of presence, severity, or change of an ED may have adverse consequences to well-being and recovery, and may lead to mischaracterization or misclassification of health status. The aim of the present study was to gain an in-depth understanding of the experience of diagnostic crossover for women with an eating disorder. The goal of this paper is to raise attention to the ways patients interact with and value the labels applied to them. There was a strong consensus that treatment should address behavioral and psychological aspects and reduce the focus on weight. Future research should explore the ways diagnostic crossover is experienced by patients in larger sample sizes, diverse populations and across more ED types (e.g., BED, atypical AN).

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