DSM Steering Committee, *American Psychiatric Association*
5 January 2026

Dear DSM Steering Committee,

I am a PhD Candidate at the University of Western Australia and the Kids Research Institute Australia, where my doctoral research focuses on improving eating disorder (ED) treatment for trans and gender diverse (TGD) people. I would like to provide a comment on the proposed changes to the DSM-5-TR ED criteria, with a focus on their impacts on TGD people living with EDs.

Changes to Anorexia Nervosa Criteria

I strongly support the proposed removal of body mass index (BMI) as the sole indicator of illness severity in anorexia nervosa. This change is particularly important for trans people, for whom BMI can systematically misrepresent medical risk and symptom severity. One study reported that TGD adolescents with EDs required hospitalisation at higher BMI percentiles than cisgender peers, despite similar severity of bradycardia, systolic hypotension, and diastolic hypotension (Chaphekar et al., 2022). Additionally, Nokoff et al. (2021) reported that TGD young people had significantly poorer cardiometabolic profiles compared to BMI-matched cisgender peers. Collectively, these findings indicate that BMI does not effectively map onto health risk within this population.

One contributing factor is that gender-affirming hormone therapies can result in substantial changes to body composition that are not captured by BMI. Gender-affirming hormone therapies are associated with significant changes to fat mass, fat distribution, and lean muscle mass (Gois et al., 2025; Klaver et al., 2018). A systematic review and meta-analysis reported an average increase in BMI of 0.55 kg/m² for those taking estrogen and 0.92 kg/m² for those taking testosterone (Gois et al., 2025). However, the body composition of these increases differed by regimen. In people receiving testosterone, BMI increases

primarily reflected gains in lean mass alongside reductions in fat mass, whereas oestrogen was more commonly associated with reductions in lean mass and increases in fat mass. For TGD children and some adolescents who have accessed pubertal suppression or other gender-affirming medical interventions, BMI is further complicated by its interpretation via sex-based growth charts. Depending on whether BMI is compared to sex assigned at birth or gender identity norms, percentiles may inflate or disguise potential risk (Kidd et al., 2019). Given that BMI does not distinguish between fat and lean mass, it may be an unreliable indicator of symptom severity in TGD people with EDs accessing gender-affirming hormone therapies.

Earlier ED intervention is associated with higher chances of remission and recovery (Austin et al., 2020). Therefore, I believe that the proposed changes have the potential to improve timely recognition of medical instability in TGD people and thus their chances of meaningful, long-term recovery from anorexia nervosa. However, the efficacy of these changes will be highly dependent on the alternative measures of symptom severity selected.

Changes to Bulimia Nervosa & Binge Eating Disorder Criteria

I am also supportive of the proposed changes to bulimia nervosa and binge eating disorder criteria. Existing evidence suggests limited validity and clinical utility of frequency of binge and/or purge episodes per week as an indicator of symptom severity (Dakanalis et al., 2017; Grilo et al., 2015). Episode frequency is commonly determined from patient retrospective self-report, which is vulnerable to recall bias. This is especially true when behaviours fluctuate, are concealed due to shame or safety concerns, or occur in states of distress or dissociation. As a result, frequency thresholds can misclassify people whose clinical risk and impairment are high, despite reporting fewer episodes.

This concern is especially salient for TGD people. A recent systematic review and meta-analysis reported that TGD people have around a 40% higher risk of cardiovascular disease compared with cisgender

people (van Zijverden et al., 2024). Additionally, gender-affirming hormone therapies can alter QTc interval, with oestrogen prolonging intervals and testosterone shortening them (Grouthier et al., 2025). Long QT syndrome is associated with a higher risk of death in the context of eating disorders, potentially increasing risk in TGD populations, especially trans feminine individuals (Jáuregui-Lobera & Jáuregui-Garrido-Garrido, 2012). Therefore, a move away from binge and/or purge frequency has the potential to better capture clinically meaningful severity in this population.

Careful Consideration of Alternative Severity Indicators is Needed

While I am wholeheartedly supportive of the proposed changes, the usefulness of new severity indicators in TGD people will depend substantially on which indicators are selected. In bulimia nervosa, a common medical admission criterion is hypokalaemia (Hay et al., 2014). Many trans feminine people utilise the anti-androgen medication spironolactone, which can raise potassium levels, potentially masking or preventing hypokalaemia developing (Hayes et al., 2022). This means that a severity framework that leans heavily on potassium thresholds risks under-recognising severity or medical risk in trans feminine people, even when other markers of instability are present.

As such, I strongly encourage the DSM-5 committee to ensure that the alternative severity criteria are multi-dimensional, rather than dependent on a single biomarker or other specifier.

Some potentially relevant domains could be:

- Comprehensive assessment of medical instability markers (E.g., ECG and QTc, hydration status, broader electrolyte profile, syncope, hypotension, bradycardia)
- Functional impairment and acute risk (E.g., inability to maintain daily roles, suicidality, repeated emergency presentations)
- Cognitive and affective ED severity (E.g., overvaluation of weight and shape, compulsivity, distress, loss of control)

- Compensatory behaviour profile that captures method, intensity, and risk, not only weekly frequency (E.g., self-induced vomiting, laxative misuse, diuretic misuse, etc.)

Conclusion

I strongly endorse the proposed changes to DSM-5-TR criteria for anorexia nervosa, bulimia nervosa, and binge eating disorder. However, I urge the committee to consider the applicability of alternative severity indicators in diverse populations, including TGD people with EDs, to ensure that chosen indicators meaningfully represent clinical risk and do not embed biases that delay diagnosis and create barriers to timely treatment.

Sincerely,

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