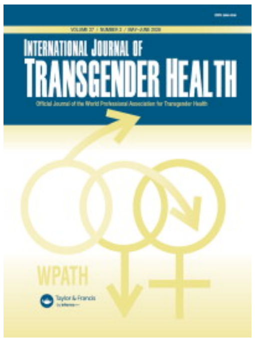

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Pathologising Legacy Measures and over-assessment: reconceptualising ethical assessment and data collection practices in trans children's healthcare

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ABSTRACT

Background: Trans children's healthcare services increasingly utilize Patient Reported Outcome Measures (PROMs). Many tools in current use were developed in past decades, under a different healthcare paradigm that did not center depathologisation or rights-based practice. This legacy may impact negatively on their appropriateness for use in modern trans-positive healthcare services.

Aims: This article investigates the appropriateness of Patient Reported Outcome Measures used in trans children's healthcare, reviewing them for signs of pathologisation and over-assessment.

Methods: 5 measurement domains that dominate trans children's healthcare were investigated, including: i) gender related concepts (e.g. gender dysphoria); ii) appearance and body image; iii) social function; iv) mental health; and v) quality of life. Directed content analysis was utilized to examine and evaluate the appropriateness of these measures, identifying evidence of pathologisation and over-assessment within each PROM.

Results: Pathologisation is widespread across the PROMs commonly utilized in pediatric trans healthcare. It is particularly pronounced in tools relating to gender, body image and multi-concept tools. Overassessment is noted as a second serious concern in trans children's healthcare, with a majority of reviewed PROMs showing signs of over-assessment.

Discussion: PROMs bearing signs of pathologisation are here defined as 'Pathologising Legacy Measures' (PLMs) – clinical measures or tools impacted by a legacy of historic pathologisation and problematisation of trans identities – that continue to persist in trans healthcare today. We note the harms of PLMs and the harms of over-assessment of trans children. We call for greater consideration of the appropriateness of PROMs, with attention to pathologisation and service user data burden.

Implications: As trans healthcare scholars, advocates and clinicians we call for effort to remove PLMs and action to significantly reduce over-assessment of trans children, shifting toward ethical, depathologised and trans-positive healthcare provision.

KEYWORDS
Children; PROMS; healthcare; transgender

Introduction

Trans children's healthcare services have changed substantially over the past fifty years. In many locations, services originally designed to control, restrict, study and prevent gender diversity have evolved into services that support and affirm trans youth (Ansara & Hegarty, 2012; Marrow, 2024). This evolution from a historic trans-hostile service to modern trans-positive provision is not always simple. In particular, evolving services need to contend with the legacy and impact of pathologisation on trans children (Horton, 2022a; Suess Schwend et al., 2018). Across this article we use the phrase 'trans child' to refer to legal minors within a given jurisdiction who are trans or non-binary.

Pathologisation in trans healthcare involves treating transness as a disorder, a problem or illness, something inherently undesirable (Suess Schwend, 2020). Pathologisation impacted on

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every part of past trans healthcare services, shaping the questions that trans people were asked, the 'treatments' that were provided, the data that was collected, and the means by which service effectiveness was evaluated (Ansara & Hegarty, 2012; Bryant, 2006; Suess Schwend et al., 2018). Pathologisation is a direct act of harm and violence to trans children and has no place in modern clinical practice (Suess Schwend, 2020).

Depathologisation remains a challenge in pediatric trans healthcare, with service users reporting negative experiences related to questioning and assessing trans identities, both in pathologising services as well as in services that are nominally trans-positive (Horton, 2022a, 2022b). Continuing pathologisation can be seen in the measures utilized in pediatric trans healthcare, with services continuing to use older measures that are pathologising and problematic: measures developed for a different time, when clinics were operating under a fundamentally different paradigm (Ansara & Hegarty, 2012; Bryant, 2006).

In recent years there has been a shift toward greater prioritization of Patient Reported Outcome Measures (PROMs) in trans healthcare, although questions remain on the appropriateness of current measures and the degree to which trans communities have ownership of and agency over which measures are prioritized (Jackman et al., 2024). PROMs are instruments that enable data collection, often through questionnaires, capturing service user perspectives on reported symptoms, personal functioning, health perceptions, and health outcomes (Kamran et al., 2023). PROMS and associated assessments are widely utilized and embedded into pediatric trans healthcare services in countries including the US, Canada, Australia, the Netherlands and the UK. A 2023 systematic review found such assessments and measures in studies of trans youth from over 30 countries, most commonly in research from the US, Germany, the Netherlands, Italy and the United Kingdom (Kamran et al., 2023). In some of these locations including the UK, trans children and families report extensive, invasive and exhausting questioning and data collection processes (Horton, 2022b, 2026; Stepney et al., 2025), with continued use of tools that service users consider "dehumanising" (Kamran et al., 2024, p. 4).

A recent global review of PROMs in trans healthcare contrasted the measures used in adult trans healthcare with those used for trans people under-18. It noted a significant PROM data burden in pediatric trans healthcare, with trans children asked an average of 116 items, compared to 57 items in adult care (Kamran et al., 2023, p. 4). This has led to concerns about over-assessment in pediatric trans healthcare. This can occur due to a lack of attentiveness to service user 'data burden', with services adding new and revised questions to their clinical practice, without actively removing older measures. It can also be an indication of 'defensive clinical practice' (Garland et al., 2023), where clinics respond to anti-trans activists' accusations of a lack of rigor by requiring service users to complete an ever-increasing breadth and depth of assessment domains. Over-assessment can further be utilized as part of a delayed transition or conversive approach, lengthening the required assessments as an intentional strategy to delay and deny affirmative support (Ashley, 2023). Across trans children's healthcare services there is a recognized deficit of service user trust in approaches to questioning and data collection (Kamran et al., 2024), which may be exacerbated by over-asssessment, gatekeeping access to care behind these assessments, and the use of measures that do not reflect service user priorities.

In this article we review a non-exhaustive sample of PROMs used in trans children's healthcare. A comprehensive stocktake of measures utilized in trans healthcare identified over 205 PROMS (Kamran et al., 2023) and we do not attempt to analyze every measure. This review instead presents and categorizes a sampled subset of tools and assessment domains commonly used in trans child, adolescent and young adult healthcare, with a detailed focus on appropriateness for use in trans youth healthcare. Our assessment of appropriateness here focuses on indications of pathologisation or over-assessment within these measures, recognizing that these are identified areas of concern in trans youth healthcare (Bloom et al., 2021; Jackman et al., 2024).

We note that assessments of PROM appropriateness can focus narrowly on an evaluation of PROM methodological validity, using approaches such as

COSMIN (Mokkink et al., 2010). These methodological validity assessments however, should only be applied after identification and conceptual agreement on the outcomes or concepts of interest that matter to a given healthcare domain (Gagnier et al., 2021). Guidance on an effective process for PROM selection identified important steps that need to be prioritized before assessment of PROM validity, including a first step on 'conceptual considerations', "*agree(ing) in detail upon the construct (i.e. outcome or domain) to be measured*" (Prinsen et al., 2016, p. 3). The analysis of PROM appropriateness in this article, including evaluation of pathologisation and over-assessment within PROMs, is considered a component of this first step of 'conceptual considerations' that needs to pre-date assessment of COSMIN style PROM validity.

Methodology

PROM sampling methodology

A convenience sample of PROMs utilized in trans children's healthcare was collated from four selected English language sources. This included extracting PROMs from: i) a literature review of research on social transition (Horton, 2023b); ii) a systematic review of PROMS used in pediatric trans healthcare (Jackman et al., 2024); iii) validated measures from a review of trans healthcare related PROMs (Kamran et al., 2024); and iv) a study protocol (Trans20) for research with trans children attending a pediatric gender service (Tollit et al., 2019).

Identified PROMS were categorized according to the 'constructs measured' outlined in a systematic review of PROMS in trans healthcare (Kamran et al., 2023). Our focus is on five major constructs that dominate trans children's healthcare: i) gender related concepts (e.g. gender dysphoria); ii) appearance and body image; iii) social function; iv) psychological functioning and mental health; and v) quality of life (see Tables 1–6). Tools were included if they assessed one or more of these constructs. Purely to manage the length of this analysis we decided to exclude the single measure within this sample that assesses voice satisfaction, the Transsexual Voice Questionnaire for Male-to-Female Transsexuals' (Dacakis et al., 2013). The questions included in each sampled tool were identified, compiled and analysed. An abridged version of our analysis is provided in Annex 1. We cannot publish the full suite of analysed questions due to copyright restrictions. We note the ways in which copyright restrictions can reduce transparency on the questions that trans children are asked in clinical care. We encourage ethical researchers and clinicians to uphold a duty of transparency to service users and trans communities, avoiding usage of tools with copyright restrictions that create barriers to community accountability.

Research methodology

The sampled tools and questions were reviewed through directed content analysis (Hsieh & Shannon, 2005). Each tool was coded according to the presence or absence of five 'concepts of interest', that are outlined below (Potter & Levine-Donnerstein, 1999). The five concepts of interest were proposed and defined by the research team, drawing upon existing literature and discourse related to pathologisation in trans healthcare, in line with our selected research methodology of directed content analysis (Potter & Levine-Donnerstein, 1999).

Concepts of interests

Within this research we evaluate tools based on five concepts of interests, corresponding to four aspects of Pathologisation [P]—Authenticating Transness [P1], Intrusion [P2], Delegitimization [P3], and Transnormativity [P4]—alongside one domain related to Over-assessment [O].

Authenticating Transness [P1] describes measures that seek to evaluate or arbitrate a trans person's identity, in a context where cis identities and genders would not similarly be assessed or arbitrated (Davy et al., 2018).

Intrusion [P2] captures measures that intrude on a person's personal life, in ways that have been identified as invasive, inappropriate and harmful by trans healthcare users in the empirical literature (Pearce, 2018).

Delegitimization [P3] encapsulates a measure that delegitimises trans people, for example through misgendering, or framing trans identities as invalid or suspect (Ansara & Hegarty, 2012).

Transnormativity [P4] designates tools that include stereotyped assumptions about transness and transition, reinforcing an assumption of there being one normative or valid way of being trans (Riggs et al., 2019).

Over-assessment [O] encapsulates tools that ask an excessive range or number of questions that are tangential or unclearly relevant to clinical need or service user priorities, contributing to a growing data burden in trans healthcare (Horton, 2026).

Analysis, categorization and scoring methodology

Each PROM was first reviewed by the first author, documenting where examples of pathologisation or overassessment were found, and categorizing each tool according to the presence or absence of indications of pathologisation. This initial coding was then reviewed sequentially by two other authors (RP, LK), highlighting any areas of disagreement, followed by discussion and consensus building to develop a shared understanding of agreed scores for each tool, in line with an intentionally inter-subjective approach to directed content analysis (Potter & Levine-Donnerstein, 1999). The research team's final consensus coding and categorization of tools is provided in annex 1.

Our coding is impacted by our knowledge and positionality as trans healthcare service users, researchers, advocates and clinicians from English-speaking countries (UK, Australia, Aotearoa New Zealand). We approach this research as affirmative trans healthcare researchers and practitioners, a majority of whom are trans, all of whom prioritize rights-based and de-pathologized approaches to trans healthcare (Horton et al., 2024; Horton & Pearce, 2025). The coding was not intended to capture every occurrence of a concept of interest within a tool, rather it intended to answer a binary question: Is there evidence of each domain of pathologisation or overassessment within that tool, yes or no. In keeping with our epistemological approach (Byrne, 2022), and in line with a projective approach to content analysis (Potter & Levine-Donnerstein, 1999), we view researcher knowledge and (lived) experience as strengths deepening and strengthening our coding and analysis.

Each measure of pathologisation [P1, P2, P3, P4] is rated as Y (= yes) where pathologisation is found in the tool, M (=maybe) where pathologisation may be seen depending on context, and N (=no) where pathologisation is not found. Tools are rated Y for risk of over-assessment where either i) there are 10 or more questions for one concept or ii) the questions asked bear no clear relevance for trans healthcare, M where there are 5-9 questions, and N where there are under 5 questions. These parameters for categorizing a tool as at risk of over-assessment are recognized as only indicative—they are here used to highlight concerns about over-assessment rather than as categorical determinants, as reviewed further in the discussion section. The five scores are combined for a numerical rating out of 5. We here define scores of 2 or above as showing pathologisation and scores of 3 or above as showing strong pathologisation.

Evaluating appropriateness

We note here that pathologisation ratings are categorically different to over-assessment ratings. Tools rated as pathologising, we contend, are always inappropriate to use in modern trans healthcare, since they are intrinsically harmful. Where tools show signs of pathologisation, we here suggest, it is inappropriate to even try to secure service user review or approval of those tools.

Tools rated at risk of over-assessment, on the other hand, can be considered context-specific in whether they are appropriate or not. One long tool, asking more than 20 questions, for example, may be entirely appropriate in certain contexts. This could occur when the tool is a high priority topic of interest for service users, when it is used on its own, or when it is used in research studies outside of routine healthcare provision that a young person voluntarily opts into. That same tool may be entirely inappropriate in other circumstances: when not a topic of significant service user interest, when combined with a suite of other measures into a question set that is burdensome, or when imposed as a mandatory or coerced part of access to healthcare. The appropriateness of tools rated as being at risk of over-assessment needs to be appraised with service users, in the specific context and wider data burden in which it will be applied.

Findings

Findings are presented according to the major PROM constructs in trans children's healthcare: i) gender related concepts; ii) appearance and body

Table 1. Tools related to gender.

Tool ID	Title	Author	What it measures	#Qs	Pathologisation & Over-assessment					Total score
					P1	P2	P3	P4	O	
G1	Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults	(Deogracias et al., 2007)	Gender Identity & Expression, body image	27	Y	Y	Y	Y	Y	5/5
G2	Utrecht Gender Dysphoria Scale	(Steensma et al., 2013).	Psychiatric diagnosis of gender dysphoria	11-12	Y	Y	Y	Y	Y	5/5
G3	Utrecht Gender Dysphoria Scale - Gender Spectrum (UGDS-GS)	(McGuire et al., 2020).	Psychiatric diagnosis of gender dysphoria	18	Y	Y	Y	Y	Y	5/5
G4	The Gender Identity Questionnaire	(Johnson et al., 2004),	Stereotypes associated with gender identity	15	Y	Y	Y	Y	Y	5/5
G5	The Gender Preoccupation and Stability Questionnaire	(Hakeem et al., 2017)	Discomfort or confusion related to gender identity	16	Y	Y	Y	Y	Y	5/5
G6	Trans20 'Introducing You' tool and a Gender Slider	(Blacklock et al., 2021)	Identity	3	N	N	N	M	N	0.5/5

image; iii) social function; iv) psychological functioning and mental health; and v) quality of life. We also included a sixth category for tools that assessed multiple constructs. In each section, tools are analyzed for appropriateness in trans youth healthcare, identifying evidence of pathologisation [P1-P4] and over-assessment [O].

Gender related concepts

We identify 6 tools that are used in children's trans healthcare services to assess gender-related concepts (see Table 1). These assess constructs such as gender identity [G1, G4, G7], gender dysphoria [G2, G3], gender non-conformity [G4], bodily discomfort [G2, G3, G4], and gender preoccupation and stability [G5]. These tools utilize between 3 and 27 questions.

There is evidence of **Authenticating Transness (P1)** across 6 out of 7 tools measuring gender related concepts. A majority of these tools are overtly designed to assess and authenticate transness, rather than simply asking a person to define their own identity. For example tool G1 utilizes 27 questions to investigate and categorize a person's identity, including "*In the past 12 months, have you dressed and acted as a man?*".

There is evidence of **Intrusion (P2)** across 6 out of 7 tools measuring gender related concepts, for example tool G2 checks agreement with the statement "*I like to behave sexually as a girl/woman*". There is evidence of **Delegitimization (P3)** across 5 out of 7 tools measuring gender related concepts. Several tools [G1, G2, G4] overtly misgender and delegitimise trans people throughout the tool (for example asking trans men how they feel about "*being a woman*"), while adapted tools [G3] utilize minor amendments to remove only the most overt delegitimization.

There is evidence of **Transnormativity (P4)** across a majority of these tools [6 out of 7 tools]. One tool [G6] is assessed as a maybe, for including binary gender sliders, with the authors highlighting a potential need for validity checking on whether trans children find the tool useful and meaningful. Many tools include questions and wording that privilege one way of being acceptably trans, conflating medical transition with trans identity. For example, one tool [G1] asks a trans man "*have you wished to have hormone treatment to change your body into a man's?*" [G1], privileging the idea that a trans person cannot be a man without or before hormonal treatment.

There is evidence of **Over-assessment (O)** across 6 out of 7 tools measuring gender related concepts. These six tools respectively ask 10, 15, 16, 18, and 27 questions related to gender and identity, all of questionable clinical usefulness, a clear indication of over-assessment. The only tool not to be considered at risk of over-assessment is tool G6.

A majority of tools measuring gender demonstrate strong pathologisation. The only gender-related tool to show acceptable levels of pathologisation is tool G6.

Appearance and body image

We identify 4 major tools that are used in children's services to assess appearance and body image (see Table 2). These assess body image

Table 2. Tools related to appearance and body image.

Tool ID	Name of tool	Author of tool	What does it measure	No of questions	Pathologisation & Over-assessment					Total score
					P1	**P2**	**P3**	**P4**	**0**	
BI1	Body component of the Gender Distress and Gender Positivity sub-scales	(Bauer et al., 2021a) and (Bauer et al., 2021b),	Body Image	14	Y	Y	N	Y	Y	4/5
BI2	BIS: A body image scale for evaluating transsexuals	(Lindgren & Pauly, 1975)	Body Image	52	Y	Y	N	Y	Y	4/5
BI3	Body Image	Mcguire et al. (2016)	Expression and Body image	7	Y	Y	N	Y	M	3.5/5
BI4	Chest dysphoria scale	(Olson-Kennedy et al., 2018)	Chest dysphoria	17	N	M	M	N	Y	2/5

[BI1, BI2, BI3] and chest dysphoria [BI4]. The tools utilize between 7 and 52 questions each. A majority assess body image across an extensive list of body parts (especially tool BI2).

There is evidence of **Authenticating Transness (P1)** across 3 out of 4 tools measuring appearance and body image. Historically, dislike of one's current body was a core criteria for authentication of the type of trans person eligible for medical transition (Serano, 2016; Winters, 2011). This pathologising legacy appears to be the root of the assumption that a generic assessment of body image is needed.

There is evidence of **Intrusion (P2)** across all 4 of these tools. Tool BI2 asks children to rate how happy they are with 26 body parts, asking which body parts they would like to surgically change, including body parts that cannot be changed through medical intervention (e.g. hands). These questions do not adopt a trauma-informed approach, and many may be experienced as abusive. Tool BI1, for example, asks how children like to pee and how they feel about looking at their body naked, questions which are clinically unnecessary and likely to be experienced as a significant intrusion of privacy by service users.

There is evidence of **Transnormativity (P4)** across 3 out of 4 of tools measuring appearance and body image. Questions that conflate body parts with gender present a transnormative judgment on acceptable embodiment for a trans person. For example, clinical questioning about responses to the statement "*I wish I were born in a different body*" could convey a negative message about current bodies [Tool BI1].

There is evidence of **Overassessment (O)** across all 4 of these tools. Tool BI3 includes a question about tattoos, a topic unrelated to trans healthcare. Tool BI2 asks up to 52 questions on 26 different body parts. This type of extensive and clinically untargeted questioning can be understood as a legacy of historic pathologising clinical approaches where trans children, by default, were expected to tolerate any range of clinical questions, including those of ill-defined clinical utility (Marrow, 2023).

A majority of tools measuring appearance and body image demonstrate strong pathologisation. The only body image related tool that might be considered acceptable in terms of pathologisation is tool BI4. This tool would be considered pathologising and inappropriate if applied generically to all transmasculine children. Assessing chest dysphoria may be irrelevant for children not seeking top surgery, and can be upsetting and lacking clinical benefit if used with trans children who are not currently at a point of eligibility for top surgery (for children with chest dysphoria who experience financial, age-based or waiting-list based barriers to surgical care). This tool is also rated as being at risk of over-assessment – 17 questions on different aspects of chest dysphoria could be considered excessive even when utilized as a single use tool in surgical care. Services intending to use this tool would do well to ask their specific service users, in their specific context, whether 17 questions on chest dysphoria is an acceptable data burden.

Social function

We identify 5 tools that are used in children's gender services to assess social support or social functioning (see Table 3). These assess constructs such as social transition [SF1], social gender dysphoria [SF2], generic family functioning [SF3], generic parental support (not specific to

Table 3. Tools related to social function.

Tool ID	Name of tool	Author of tool	What does it measure	No of questions	Pathologisation & over-assessment					Total Score
					P1	**P2**	**P3**	**P4**	**0**	
SF1	Trans20 study, the instrument titled 'About Socially Transitioning'	(Tollit et al., 2019), detailed in Buckingham et al., (2025).	Social transition	3 (× 6)	N	N	N	N	N	0/5
SF2	Social component of the Gender Distress sub-scale and the Gender Positivity sub-scale	(Bauer et al., 2021a), (Bauer et al., 2021b)	Social gender dysphoria	11	N	N	N	N	Y	1/5
SF3	General Family Functioning (gff) Index	(Byles et al., 1988).	Family functioning in general	12	Y	Y	Y	N	Y	4/5
SF4	The Child and Adolescent Social Support Scale	(Kerres Malecki & Kilpatrick Demary, 2002)	General parent supportiveness	20	N	Y	Y	N	Y	3/5
SF5	Extra-familial social support	Durwood et al. (2021)	Trans supportiveness	7	N	N	N	N	M	0.5/5

transness) [SF4], and social support related to transness [SF5]. These tools utilize between 3 and 20 questions.

These tools demonstrate limited pathologisation. Three of the tools [SF1, SF2, SF5] score one or less for pathologisation. Tools that assess generic family functioning and generic parental support (not specific to transness) [SF3 and SF4] can be understood as being rooted in a pathologising assumption that families with trans children need to be assessed for family dysfunction. We note past clinical practice that regarded a trans child as a consequence of negative family influence (McFadyen et al., 2025). Given the widespread scrutiny upon parents of trans children, unnecessary assessments of family functioning can be experienced as stressful and harmful, hindering rather than helping family dynamics (Horton, 2023a). Assessments of social and parental support that are specific to transness, as well as assessing potential for trans-associated family rejection and violence are more likely to be appropriate.

These tools show some signs of overassessment. SF2 at 11 questions can be considered at risk of overassessment, particularly when combined with multiple other tools. SF3 and SF4, on generic family functioning and generic parental support can be considered at strong risk of over assessment, comprising 11 and 20 questions respectively, and being unclearly relevant to trans supportiveness or trans health. Such measures add to a growing data burden on trans children and families whilst providing no clear benefit. Measures of general family functionining can be distinguished from measures of trans-specific family support or family well-being that are more likely to align with a depathologised approach. The latter would include, for example, questions on family trans supportiveness, family trans awareness, family minority stress related to advocating for a trans child, and extra-familial social support (see SF5).

The tools with greatest promise for being appropriate for trans health are tools SF1 (on social transitioning) and SF5 (on extra familial social support), that are rated at low risk of both pathologisation and overassessment.

Psychological functioning and mental health

We identify a wide range of tools that are used in children's services to assess psychological functioning and mental health (see Table 4). These can assess constructs such as anger [MH1], depression [MH2, MH3], anxiety [MH3, MH4], self-harm [MH5], eating disorders [MH6], suicide risk [MH7], resilience [MH8, MH9], trauma [MH10], insomnia [MH11], and neurodiversity [MH12]. A majority are generic mental health tools developed for use in mental health care, rather than specific to trans healthcare. We note that mental health as a concept can sometimes be framed in a pathologising manner, including through assessments that retain dated psychiatry-inspired language to evaluate 'internalising psychopathology' (Giordano, 2025).

We identified medium levels of pathologisation in these mental health tools [combined pathologisation scores between 2 and 3]. In Table 4,

Table 4. Tools related to psychological functioning and mental health.

					Pathologisation & over-assessment					
Tool ID	**Name of tool**	**Author of tool**	**What does it measure**	**No of questions**	**P1**	**P2**	**P3**	**P4**	**0**	**Total score**
MH1	State-Trait Anger Express Inventory-2 Child and Adolescent	(Schamborg et al., 2016)	Anger	35	N	Y	N	N	Y	2/5
MH2	Beck depression Inventory for Youth	(Beck et al., 2001)	Depression	20	M	M	M	M	Y	3/5
MH3	ProMIs short form for anxiety and depression	(Varni et al., 2012)	Anxiety and Depression	14	M	M	M	M	M	2.5/5
MH4	Liebowitz Social Anxiety Scale (LSAS)	(Heimberg et al., 1999)	Anxiety	21	N	Y	N	M	Y	2.5/5
MH5	The Self-Harm Behavior Questionnaire	(Gutierrez et al., 2001)	Self-Harm	26	M	Y	M	M	Y	3.5/5
MH6	The Branched Eating Disorder Test v2		Eating Disorders	31	N	Y	M	M	Y	3/5
MH7	Risk assessment from the Columbia Suicide Severity Scale	(Posner et al., 2011)	Suicide	2+	M	M	M	M	N	2/5
MH8	Brief Resilience Scale	(Smith et al., 2008)	Resilience	6	N	N	N	N	M	0.5/5
MH9	Pride and Community scales of the Gender Minority Stress and Resilience	(Testa et al., 2015)	Resilience	13	N	N	N	N	Y	1/5
MH10	The Child and Adolescent Trauma Screen	(Sachser et al., 2017)	Trauma	15 +20	N	Y	M	N	Y	2.5/5
MH11	Insomnia Severity Index	(Bastien et al., 2001)	Insomnia	7	N	N	N	N	Y	1/5
MH12	The Social Responsiveness Scale	(Constantino & Gruber, 2012)	Social responsiveness	65	M	M	M	N	Y	2.5/5

several mental health tools are assessed as M (maybe) for pathologisation rather than Y or N. These tools can, in some cases, be an indication of pathologisation, whilst in other circumstances may be used without pathologising associations.

Mental health tools can be used as a form of **Authenticating Transness (P1)**, when mental health diagnoses are required for children to prove themselves sufficiently distressed to be eligible for medical transition. This is a pathologising relic of a past paradigm where medical and social transition were only justified as a last resort treatment for mental health distress (Marrow, 2024).

Tools assessing psychological functioning and mental health can be **Invasive [P2]**, for example where all children are required to undergo questioning on a wide range of mental health and neurodevelopmental conditions and differences simply for seeking access to trans healthcare. Here we note a significant difference between mental health screening tools, that could be offered to trans children to better identify additional support needs, and the use of mental health measures as PROMs on the assumption that they are integral expected outcomes of access to trans healthcare (a topic we return to in the discussion).

Tools assessing psychological functioning and mental health can be used as a form of **Delegitimization (P3)**, where mental health assessments are utilized in search of an alternative 'cause' for being trans (positing trauma, depression or eating disorders as alternative causes of so-called gender confusion). They can also be used in a delegitimising manner when mental health or neurodiversity related diagnoses are sought out and utilized to deny or delay access to trans healthcare (Ashley, 2025).

We note concerns with defining mental health outcomes as a central goal of trans healthcare. Trans healthcare is not a 'treatment' for mental health conditions, and an emphasis on mental health can be considered a legacy of past pathologisation (World Health Organisation, 2020). Mental health PROMS may also be ineffective in evaluating trans healthcare (Moore et al., 2025). Some trans children do not experience poor mental health, and this positive mental health may continue throughout access to trans healthcare (Olson et al., 2016). Some trans children may experience mental health challenges that are not erased by trans healthcare access (Chen et al., 2023). This is particularly the case for multiply-marginalized trans children who experience intersecting forms of oppression, including trans children impacted by racism, and neurodivergent trans children who experience mental health burdens related to living in an allistic-dominant world. Some trans children can be expected to experience declining mental health through access to necessary trans healthcare, especially in contexts of growing minority stress, persecution and hostility. For all of these reasons PROMS focused on mental health may be insensitive to the impacts of trans healthcare.

We question whether wrapping multiple assessments and screenings for multiple mental health and neurodevelopmental conditions and differences (including for neurodiversity or anger) is genuinely necessary as a core part of trans children's healthcare. Where screening for referral to additional support services is the key purpose of a mental health measure, these screenings should be transparent and optional. Trans people have a right to access neurodiversity and mental health assessments and supports in their own time, according to their need and preference, without these screenings being unclearly merged into trans healthcare services.

Recognizing the widespread problematisation of trans children, we highlight that wide-ranging mental health assessment can convey a negative impression of trans children, potentially negatively impacting on trans children's self-perception, as well as impacting on care-giver and clinician perspective. For example, assessing all trans children for anger [MH1], risks reinforcing a negative association between transness and uncontrolled emotion, a legacy from a period where being trans was itself deemed a disturbance associated with problem behavior (Winters, 2011).

Overassessment (O) is a very significant concern with these tools, with 9 out of 12 tools [MH1-2, M4-6, MH9-12] assessed as demonstrating overassessment. This comprehensive range of tools, if asked in combination, comprises a dizzying 275 questions. Within the UK we see evidence of this type of overassessment in current healthcare practice for trans children, where the use of multiple mental health assessment tools combines with other areas of inappropriate over-assessment to create a significant data burden for trans young people, including as part of the NHS's PATHWAYS study (Horton, 2025; Simonoff & Absoud, 2025). We can also note concerns over measuring and monitoring concepts that are not directly relevant to trans health, for example anger and insomnia. Only tools M3 (anxiety and depression), M7 (suicide risk) and M8 (resilience) are at medium or low risk for overassessment.

Most of these mental health PROMS are at risk of both pathologisation and over-assessment. For all of these tools, their use as a PROM (rather than a screening tool) needs to be explicitly articulated and justified. This needs to include explicit recognition of the risk of pathologisation, alongside recognition of the contribution of oppression and structural drivers of marginalization to mental health inequalities. For all of these tools, there is a significant risk of over-assessment, particularly where multiple tools are combined and imposed on trans children within routine trans healthcare.

Quality of life

We identify several tools that are used in children's trans healthcare services to assess quality of life (see Table 6). These assess constructs such as general quality of life [QL1], self-worth [QL2], school attendance [QL3], general school connectedness [QL4], bullying [QL5], victimization [QL6], and attraction and sexual relationships [QL7]. These tools utilize between 2 and 52 questions.

We see generally low levels of pathologisation in these quality of life tools [combined pathologisation scores between 0 and 1], with the exception of SF7. SF7 asks questions about relationships and sexual orientation. It can be considered inappropriate, with intrusion into trans people's sexuality and relationships a legacy of historic pathologising approaches to transness (Pearce, 2018).

Overassessment (O) is a much bigger concern with these quality of life tools, with 5 tools [QL1, QL2, QL4, QL5, QL7] evaluated as demonstrating risk of overassessment. This comprehensive range of tools, if asked in combination, comprises 130 potential questions, many of which are vague and unclearly linked to trans healthcare. The short

Table 5. Questions asked in Kidscape-10.

In the last week: 1. Have you felt fit and well? 2. Have you felt full of energy? 3. Have you felt sad? 4. Have you felt lonely? 5. Have you had enough time for yourself? 6. Have you been able to do the things that you want to do in your free time? 7. Have your parent(s) treated you fairly? 8. Have you had fun with your friends? 9. Have you got on well at school? 10. Have you been able to pay attention?

Table 6. Quality of life measures.

Tool ID	Name of tool	Author of tool	What does it measure	No of questions	Pathologisation & Over-assessment					Total score
					P1	P2	P3	P4	0	
QL1A	Kidscreen tool	(The Kidscreen Group, 2004)	Generic well-being	52	N	N	N	N	Y	**1/5**
QL1B	Kidscreen tool short form	(The Kidscreen Group, 2004)	Generic well-being	10	N	N	N	N	Y	**1/5**
QL2	Harter self-Perception Profile for Children	(Harter, 2012)	Self-worth	36	N	N	N	N	Y	**1/5**
QL3	Trans20 School attendance	(Tollit et al., 2019)	School attendance	2	N	N	N	N	N	**0/5**
QL4	The Psychological Sense of School Membership scale	(Goodenow, 1993)	School belonging	18	N	N	N	N	Y	**1/5**
QL5	The Gatehouse Bullying Scale	(Bond et al., 2007)	School bullying	15	N	N	N	N	Y	**1/5**
QL6	'Gender victimization'	(Durwood et al., 2021)	Victimisation	2	N	N	N	N	N	**0/5**
QL7	Trans20 Questions on Attraction and Relationships		Attraction and Relationships	5	M	Y	M	N	Y	**3/5**

version of QL1 (Kidscreen-10) asks ten questions that are mostly completely irrelevant to trans health (see Table 5).

Kidscreen-10, along with its equally irrelevant 52 question variant, is the key PROM for the UK's puberty blocker trial (Simonoff & Absoud, 2025). Answers to the ten questions in Kidscreen-10 are unlikely to be significantly impacted by access to trans healthcare, making this an example of over-assessment. We note also the potential for inaccurately targeted measures to be used by actors who are unsupportive of affirmative healthcare to argue for the ineffectiveness of trans healthcare, as we have seen in the UK's Cass Review (Moore et al., 2025). Tools that focus on generic quality of life or 'well-being' are also likely to be ineffective in measuring the impact of trans healthcare in contexts where external pressure, including targeted persecution, impacts significantly on general life opportunities and well-being. Tools seeking to measure the effectiveness of trans healthcare need to focus more narrowly on the desired and expected benefits of specific interventions.

The tools that are most appropriate for measuring quality of life are QL3, QL6, and possibly QL5.

Multiple-concept tools

We identify 2 multi-concept tools that are used in trans children's healthcare, M1 and M2 (see Table 7). These tools utilize 118 and 38 questions respectively. It is noted that M1 (the Child Behavior Checklist) can be selected by clinicians as a general mental health screen for common childhood mental health conditions and neurodevelopmental differences including depression, anxiety, ADHD, ODD, conduct disorder, self-harm, and suicide risk. Licensing rules associated with M1 mandate the use of the full 118 questions even where clinicians are only interested in responses to certain questions.

Both of these tools are rated as deeply pathologising [scoring 4.5/5 and 5/5]. They both show evidence of **Authenticating Transness (P1)** through equating trans children with problematic behavior, and evaluating 'gender distress'. A focus on assessing trans children for problematic behavior is a legacy from a period where trans children were by definition expected to be at the margins of society, engaged in socially illicit, dangerous or criminal behavior (Winters, 2011). They both show examples of **Intrusion (P2)**, asking questions on any and all possible deficiencies, or asking about intimate body parts and sex lives.

Table 7. Tools related to multiple categories.

Tool no.	Name of tool	Author of tool	What does it measure	No of questions	Pathologisation & Over-assessment					Total score
					P1	P2	P3	P4	0	
M1	The Child Behavior Checklist's	(Achenbach, 1991)	Problem behaviors, mental health, academic performance etc	118	Y	Y	Y	M	Y	4.5/5
M2	The Gender Congruence and Life Satisfaction Scale)	(Jones et al., 2019)	Gender distress, body distress and well-being	38	Y	Y	Y	Y	Y	5/5

Both tools are very clear examples of **Overassessment (O)**. They both assess concepts that are clinically un-useful, asking a huge number of unneeded questions across multiple clinically irrelevant topics. For example, M1 assesses academic performance across a range of subjects. Neither of these multi-concept tools can be considered appropriate based on a consideration of either pathologisation or over-assessment.

Discussion

Our research has identified pathologisation as widespread across the PROMs utilized in pediatric trans healthcare. It is particularly pronounced in tools relating to gender, body image and multi-concept tools. A majority of tools related to gender were originally developed by clinicians and in clinical centers operating under an explicitly pathologising paradigm, where being trans was considered a mental health disorder to be clinically investigated, managed or corrected (Marrow, 2024). These tools are inappropriate for ongoing use in in pediatric trans healthcare today.

The Utrecht Gender Dysphoria Scale [G2], for example, is one of the most commonly used measurement tools in trans children's healthcare (Jackman et al., 2024). It was originally developed in the 1990s and used throughout the 2000s, at a time when trans identities were deeply pathologized and problematized (Steensma et al., 2013). It was designed to identify children who fit the criteria for the DSM-IV psychiatric diagnosis of gender identity disorder, later adapted for the DSM-5 psychiatric diagnosis of gender dysphoria. Similarly, the Gender Identity Questionnaire [G4] was co-developed by Kenneth Zucker, a clinician widely critiqued by healthcare rights advocates (Tosh, 2011) and who was identified by Ansara and Hegarty (2012) as a central force in pathologising scholarship and practice on trans children. The measure was adapted from an earlier tool applied to gender non-conforming children by Richard Green in the 1980s, which was designed to assess gender non-conforming behaviors and toy preferences in clinical contexts associated with conversion and harm (Bryant, 2007). These tools are predicated on an assumption that trans people will submit to extensive questioning on their identity and that trans identities need to be assessed, categorized and approved by clinicians.

Many of the tools for assessing gender ask an excessive number of questions with limited clinical value. Tool G1 takes 27 questions to ask whether a child is trans, putting a significant burden on a child for minimal utility. All of the reviewed tools could be replaced with a simple question about an individual's gender identity, as shown by tool G6. The routine use of excessive and invasive clinical questioning about a trans identity risks conveying to a child that there is something non-typical, worthy of scrutiny, and potentially problematic about their identity. Pathologisation can be communicated implicitly through the identities that are accepted without issue, as cisgender children's identities are accepted, and the identities that are subject to clinical scrutiny (Davy et al., 2018).

Body image tools used in pediatric trans healthcare are also consistently pathologizing, with no consideration of the potential harm from asking trans children to rate how they feel about every item of their body (Vincent, 2020). An alternative approach to questioning trans people about their body image is possible. Trans people who are explicitly seeking surgical care can be asked questions specific to the surgical care they are seeking. For instance, young trans men and non-binary people seeking top surgery could be asked questions about how they feel about their chest area, without being asked about their feelings about their feet, hands and genitals. Trans people seeking endocrine care can be asked questions that are directly relevant to the specific expected or preventative impacts of hormonal changes. The idea that all trans children need to be asked a wide range of invasive questions about how they feel about many different body parts is a relic of a past era when clinicians were expected to arbitrate on validity and eligibility, in place of patient-centered care and individualized healthcare goal setting (Jacobsen, 2024).

Prioritizing mental health assessments above other clinically relevant and person-centered areas of care is also reflective of a pathologizing psychiatry-centered approach to trans healthcare. Whilst some limited screening for mental health concerns may be clinically useful to understand whether a trans child might be offered concurrent mental health care, requiring all trans children seeking gender-affirming care to be put through a wide breadth and depth of repeated mental health assessments is likely to reinforce pathologising assumptions about an inherent connection between transness and poor mental health. It risks centering transness as a mental health problem, distracting from minority stress related drivers of mental health inequalities. Services that center mental health outcomes may end up focusing on individualized mental health treatment as a core service provision, overlooking external factors that exacerbate mental health differentials, including the impact of the hostile world trans children have to navigate.

Pathologising Legacy Measures

Through our analysis, we have identified and refined a concept we are calling 'Pathologising Legacy Measures'. Pathologising Legacy Measures are tools and measures, impacted by a legacy of pathologisation in trans healthcare, that continue to be used in modern healthcare practice, despite their known harms. This term draws attention to the fact that pathologising PROMs are rooted in a transphobic legacy in trans healthcare, as indicated through both the geneaology of specific tools such as G4, and the pathologising and transnormative assumptions that underpin tools such as BI2 and M1.

We note that there is a pressure in trans healthcare services, including those that are trans-positive, to demonstrate the longer-term effectiveness of interventions, which necessitates the use of longitudinal datasets. This pressure disincentivises changing healthcare measures, pushing services to continue to use previously psychometrically-validated legacy measures, under the assumption that they support greater 'rigor', even where they are known to be inaccurate, unuseful or harmful. Here we call attention to an overarching duty of care to trans children—longitudinal datasets based on Pathologising Legacy Measures are inappropriate in trans youth healthcare. Pathologising Legacy Measures fail to meet a central purpose of an effective PROM, facilitating "an emphasis on patient priorities" (Krogsgaard et al., 2021, p. 970). Pathologising Legacy Measures perpetuate harm against trans children and should not be considered acceptable in modern trans children's healthcare.

Table 8. Pathologising Legacy Measures.

Concept	Tool names
Gender	(G1) Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults; (G2) Utrecht Gender Dysphoria Scale; (G3) Utrecht Gender Dysphoria Scale - Gender Spectrum (UGDS-GS); (G4) The Gender Identity Questionnaire; (G5) The Gender Preoccupation and Stability Questionnaire
Body image	(BI1) Body component of the Gender Distress and Gender Positivity sub-scales; (BI2) BIS: A body image scale for evaluating transsexuals; (BI3) McGuire Body Image
Multi-concept	(M1) The Child Behavior Checklist (M2) The Gender Congruence and Life Satisfaction Scale)

From this analysis we highlight PROMS that show significant pathologisation, being here defined as Pathologising Legacy Measures (see Table 8). We recommend these are rapidly discontinued and withdrawn from use in trans children's healthcare.

Overassessment

Overassessment is a serious problem in trans children's healthcare. If a clinic chose to ask all the questions outlined in this review, across 36 distinct tools, that would amount to 793 questions. Even if only a quarter of these tools are used, that would still amount to a completely unreasonable 200 questions. PROMs aside, trans children face a huge data burden in trans healthcare, including questions probing identity and 'developmental history' that are asked throughout their engagement with trans healthcare services (Horton, 2026). Where questions are asked of trans children, services need to more clearly justify and communicate the purpose of data collection, whether for service evaluation, research, clinical assessment, relationship-building, support, or therapy. PROMs designed to monitor healthcare outcomes that are valued by service users need to be more clearly distinguished from tools designed to screen or triage for additional care needs. Measures designed for research purposes need to be disconnected from routine healthcare, with greater commitments to informed consent for research participation. Services should prioritize measures and approaches that are clinically relevant and meet the data needs of service users.

Services should not structure data collection systems as a component of 'defensive practice', catering to the often bad faith 'concerns' of those seeking removal of affirmative healthcare. Trans children's healthcare services currently risk being drawn into ever-increasing evaluation, measurement and data collection as a defensive reaction to trans-hostile critiques of the rigor of trans children's healthcare. Recognizing the limitations of past tools, services may supplement Pathologising Legacy Measures with additional, better tools, not noticing the growing data burden on trans children. Amidst a push for better data that more meaningfully meets the needs of trans children, we need to uphold a commitment to simultaneously reducing the data burden on trans children, removing tools that are ineffective, untargeted or unnecessary. Better tools cannot be considered and introduced until this vast suite of older, ineffective and harmful tools are discarded.

Validating PROMs

Trans children's healthcare as a field is facing demands for more robust data, including pressure to use 'validated' measures that have been academically tested and evaluated for their reliability and validity (Kamran et al., 2024). In trans healthcare older tools are more likely to have been 'validated', including those validated many years ago in services working within a pathologising healthcare paradigm.

PROMs measuring gender are some of the tools defined in the literature as 'validated' for specialist use in trans healthcare services (Kamran et al., 2024), including G1, G2 and the multi-concept tool M2 (Singh et al., 2010; Steensma et al., 2013). These three 'validated' gender measurement tools all score 5/5 for pathologisation, making all three clear examples of Pathologising Legacy Measures that are inappropriate for use with trans children, challenging their presumed rigor. The body image tool BI2 is another example of a 'validated' (van de Grift et al., 2016) tool that is also a Pathologising Legacy Measure. A tool having been 'validated' by research influenced by pathologisation, where service user voice is not centered, does not guarantee a tool is appropriate for modern healthcare, particularly when working with trans children. PROMS need to be assessed for 'conceptual considerations' (Prinsen et al., 2016), including appropriateness for trans-positive and depathologised healthcare provision, with direct input from trans children. This type of review needs to pre-date, and be given significant weight, in discussion of which PROMS are considered appropriate, validated and rigorous.

We also note the potential of validation processes to contribute to ending up with longer tools. Construct validity processes typically start with a wider range of questions, with questions tested, reviewed and selected based on psychometric properties. This process does not tend to prioritize shortening tools, giving little consideration to over-assessment and the data burden impacting on trans children. Tool simplification should be given greater priority within trans healthcare, with targeted efforts to reduce over-assessment during tool development, validation and selection.

One tool that scored lower for pathologisation (1.5/4) but is also considered 'validated' is the measure for chest dysphoria [BI4]. This tool was validated in an overtly depathologised clinical center, with an emphasis on establishing "face validity from the community perspective" (Olson-Kennedy et al., 2018, p. 433). This tool was still evaluated here as at risk of contributing to over-assessment, highlighting the need for validation to consider not only whether questions are acceptable, but also whether effective data can be obtained from a smaller number of questions, upholding a commitment to reducing a data burden on trans children. This review of appropriateness can also consider the context under which a measure has been 'validated'—BI4 might, for example, be considered appropriate in pre-surgical screening for young people pursuing chest surgery, whilst being considered inappropriate for general use in trans masculine children. Similarly, screening for neurodivergence may be clinically useful when actively desired by trans children, but becomes pathologizing when administered routinely as part of access to trans healthcare.

Potentially valid PROMs

We identified a small number of tools which do not raise concerns about pathologisation and which do not necessarily contribute to

Table 9. Potentially valid PROMS for trans children's healthcare.

Concept	Tool
Gender	(G6) Trans20 'Introducing You' tool
Social Functioning	(SF1) Trans20 instrument 'About Socially Transitioning'; (SF5) Extra-familial social support
Mental Health	(MH7) Risk assessment from the Columbia Suicide Severity Scale
Quality of Life	(QL3) School attendance; (QL6) Gender victimization

over-assessment. Each of these tools include a small number of questions that appear appropriate for general use in trans healthcare services for trans children (Table 9).

We need to raise the bar on what questions, tools and assessments are deemed appropriate for trans children. Across trans children's healthcare there needs to be a fundamental reevaluation of the tools and measures utilized, questioning whether they really add value in a modern and depathologised healthcare service, recognizing the harms of pathologisation and over-assessment. Even individually benign assessments, tools and lines of questioning can cumulatively contribute toward stress, strain, exhaustion and powerlessness in trans children. PROM selection needs to center the priorities and perspectives of trans children, understanding what measures are meaningful to them in supporting healthcare decision-making, prioritizing the outcome measures that matter most to service users.

Limitations and areas for future research

This study has excluded two areas that are potentially of significant interest, in which we recommend further study. Firstly, we did not focus on PREMS, or Patient Reported Experience Measures, including measures of 'satisfaction with care'. PREMS may be less influenced by historic pathologisation, given pathologising clinical centers did not regard patient satisfaction as a primary metric (Jacobsen, 2024; Marrow, 2023). Service user satisfaction with care is an important PREM construct in all areas of healthcare. We contend that it is even more important in trans children's healthcare given the frequency with which trans children's healthcare is associated with reports of institutional violence during healthcare delivery (Horton, 2022b, 2026). Satisfaction with care assessment needs to go beyond monitoring satisfaction with endocrine or surgical care outcomes, to encompass satisfaction with psychological assessment, therapeutic care, psychosocial care and wider pre-endocrine care, areas of trans health that are particularly associated with medical violence (Ansara & Hegarty, 2012; Horton, 2026; Marrow, 2024). We specifically welcome further research on satisfaction with care measures that capture not only the satisfaction with the care that was received, but also service users' perceptions on (dis)satisfaction with care that was denied, delayed or withheld, as well as satisfaction with the way in which care was delivered. Such PREMs need to be designed to capture the experiences of multiply marginalized trans children, including those impacted by racism and ableism in healthcare delivery.

Secondly, this study has focused on PROMs, primarily quantitative measures, held within formal published tools. Further research could focus on 'Pathologising Legacy Questions' asked verbally of trans children, families and young people within trans healthcare services that are asked outside of formalized PROMs (Horton, 2026). Here, too, there is potential for over-assessment, especially when taking a 'developmental history' of a trans child; as shown, for example, in the training materials for clinicians in England and Wales NHS children's gender services (Academy of Medical Royal Colleges, 2023).

Recommendations

The continued use of Pathologising Legacy Measures (PLMs) cannot be justified. Pathologisation is a direct act of harm and violence to trans children and has no place in modern clinical practice, including through the use of PLMs. We recommend practitioners and healthcare services review and actively monitor the measures they use, including the reasons underpinning every question asked of trans children.

We need to adopt a strong duty of care when using measures described as 'validated'. In contexts such as trans healthcare, where care paradigms have changed fundamentally over the past two decades, and where we are only recently seeing some commitments to a rights-based approach, tools and 'validations' rooted in a legacy of pathologising healthcare practice do not guarantee quality, validity or appropriateness in modern practice. We hypothesize similar flaws in 'validated' measures may be found in other areas of healthcare, especially healthcare related to marginalized and problematized minorities. PROM evaluation in the field of trans health should include screening for pathologisation biases and over-assessment, undertaken by subject-matter and lived experience experts, to guide ethical and truly rigorous measurement practices. We call for a revised definition of rigor in trans children's healthcare delivery and research, centering appropriateness for depathologsed healthcare provision.

We also call attention to the topic of over-assessment. In trans children's healthcare, over-assessment is not only inconvenient and inefficient, it comes from a legacy of clinical systems built on pathologisation and control of trans children, where children's time, comfort and healthcare priorities were not valued. Trans children face an unreasonable data burden, with ever greater data being collected that provides minimal utility to trans children and their clinical care. Greater effort is needed to understand the outcome measures that are valued by and of utility to trans children. This includes the information they need to inform their own healthcare decision-making, what measures they want to see tracked over the short, medium or longer term, and measures that have direct utility to the type of care they are receiving. This effort can include the development of abbreviated scales for constructs that are valued but overly-long. Measurement and data collection approaches need to be recentred around collecting and monitoring the measures that matter most to service users, moving away from historical approaches where measures of clinician interest were significantly at odds with service user priorities.

In an area of healthcare where critiques of data and evidence are often made in bad faith, underpinned by a wish to remove access to all trans children's healthcare (McNamara et al., 2024), the demand for more and better data is insatiable. We need to respond to demands for more, better and longer-term data by centering service users: in this case, trans children. Prioritizing the measures that are of benefit to them can inform better decision making and enable improved healthcare. This prioritization of trans children necessitates a fundamental rejection of pathologising measures, and a commitment to avoiding over-assessment, reducing the recognized data burden. As trans healthcare scholars, advocates and clinicians we call for effort to remove Pathologising Legacy Measures, and action to significantly reduce the over-assessment of trans children, shifting toward ethical, depathologised and trans-positive healthcare provision.

Author contributions

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Data availability statement

The authors confirm that the data supporting the findings of this study are available within the article [and/or] its supplementary materials.

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