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# 'Letting him know that we love him': the experiences of young people who question their gender and the parents who support them

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karl.atkin@york.ac.ukReceived 20 September 2024  
Accepted 29 November 2024**ABSTRACT****Background** Gender identity services for children and young people are currently being reorganised in England and Wales. Provision is required to negotiate clinical uncertainty and a public debate that cannot agree on what care should look like.**Objectives** To explore how young people, parents and young adults respond to gender dysphoria, distress or discomfort; and to understand how they negotiate referral, assessment and possible interventions.**Design** Qualitative study, using narrative interviews with young people, aged between 12 and 18 years old (n=14), referred to a gender identity service; their parents (n=12); and young adults, aged between 19 and 30 years old (n=18), who sought gender affirming care. The study took place between March 2022 and December 2023.**Results** Young people in our study describe supportive relationships with parents, but regard them as too cautious when discussing medical pathways. Young people enter specialist care with a sense of urgency. They are disappointed when realising that access to medical pathways does not occur immediately. They do, however, come to appreciate talking about their experiences. Parents face considerable anxieties and, like young people, value the support they receive from specialist clinicians.**Conclusions** Young people who question their gender require access to safe and effective treatments, alongside respectful therapeutic support. Young people and their parents emphasise the importance of an open-minded approach, where they are given space to explore and understand their experiences, before making decisions about the future. The young adults we spoke to confirmed the importance of this.**INTRODUCTION**Healthcare agencies manage a 'stormy public discourse' when providing support for young people who present with gender dysphoria.<sup>1</sup> This includes uncertainties about the organisation of care, disagreements about the evidence base, and controversies about consent.<sup>1,2</sup> When the study took place, young people in England and Wales could seek referral to a national Gender Identity Development Service (GIDS). GIDS offered a psychosocial evaluation and assessed young people's suitability for onward referral to an endocrine clinic where they may be prescribed gonadotropin releasing hormone analogues (puberty blockers) or, when over 16, cross-sex or gender-affirming hormones (oestrogen**WHAT IS ALREADY KNOWN ON THIS TOPIC**

- ⇒ Gender identity services for children and young people negotiate clinical uncertainty and public controversy. NHS support is currently being reorganised.
- ⇒ There is uncertainty about what an appropriate model of care should look like.
- ⇒ The experiences of young people and their parents, by prioritising what matters to them, offer important insights when developing future care.

**WHAT THIS STUDY ADDS**

- ⇒ Young people and their parents may have different expectations of service support. Young people are often more confident than their parents about what to do next. Parents' caution can sometimes frustrate young people.
- ⇒ Young people and their parents value specialist care. Young people say it helps them develop confidence. Parents appreciate the opportunity to discuss their anxieties and explore different pathways.
- ⇒ Our sample of young adults represented a diverse range of outcomes and pathways, some of which may not have been apparent to them when young.

**HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY**

- ⇒ Through contact with specialist care, young people realise that they have to overcome their initial sense of urgency, by talking about their experiences. They find this helpful but worry that it is preventing them from living the life they want. Successful policy has to negotiate this tension.
- ⇒ Families expect an open-minded approach that enables a young person to establish a life, with which they feel comfortable. For some this requires supporting a trans identity and negotiating medical pathways, while for others this requires exploring alternative options. Young adults emphasise the importance of this.

or testosterone).<sup>3</sup> GIDS faced several challenges during this time. First, the number of young people referred to GIDS—and similar services in Europe and the USA—had been increasing.<sup>1</sup> In 2011/2012 there were 210 referrals. By 2021/2022 there were 3584. Waiting lists of 3 to 4 years, before accessing▶ <http://dx.doi.org/10.1136/archdischild-2024-327992>

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specialist support, were common. The characteristics of those accessing care, although not unique to the UK,<sup>4</sup> have also changed.<sup>5</sup> In 2014 referrals were predominantly young people assigned male at birth. In 2021, those assigned female at birth now made-up 73% of referrals.<sup>1</sup> Further, those referred were increasingly presenting with co-occurring autistic spectrum conditions<sup>6</sup> and mental health conditions.<sup>7–9</sup> Second, concerns about the quality of care offered had been raised. In 2020 an inspection by the Care Quality Commission (CQC), despite rating GIDS ‘good’ for care—with families reporting that clinicians treated them with compassion and kindness, respected their privacy and dignity, and understood their needs—gave an overall rating of ‘inadequate’, with significant improvements required in risk management, record keeping (including recording consent) and leadership.<sup>10–12</sup> In responding to the CQC report, GIDS implemented changes regarding assessment, consent and decision making. A multiprofessional review group was also established to review assessments for puberty blockers. Third, there is little information available to families on the long-term consequences of care and treatment.<sup>1</sup>

In July 2022, NHS England announced that regional centres would replace GIDS.<sup>13</sup> This created more uncertainties for families. The Cass Review<sup>1</sup> made recommendations, proposing further changes to care and NHS England paused the use of puberty blockers (except when prescribed as part of a clinical trial). The Cass Review also reinforced the need to improve access, via the regional centres, by using them to (1) establish wider (interdisciplinary) service networks and (2) establish an evidence-based culture, when providing care.<sup>1</sup>

## METHOD

The research question employed biographical narrative interviews<sup>14</sup> to (1) explore ways young people, their parents and young adults respond to gender dysphoria, distress or discomfort; and (2) understand how they experience and negotiate referral, assessment and possible interventions. Fieldwork took place between March 2022 and December 2023. Interviews lasted between 60 and 90 min.

Sampling was purposive, to reflect the experiences of young people at different stages of the assessment process and young adults who sought gender affirming care, to facilitate transition. Young people were primarily recruited through GIDS. Clinicians introduced the study to eligible families, although, to facilitate diversity, young people were also recruited through community organisations and private practice. If interested in taking part, young people and/or their parents contacted the research team. Those aged over 16 consented themselves, and parents of those under 16 consented on behalf of the young person, with the young person assenting.

The research interviewed 14 young people, aged 12 to 18 years old, who sought care from GIDS (table 1). Nine of those were assigned female at birth and five assigned as male. Four were on ‘medical pathways’; eight continued to be assessed; and two were waiting for their first appointment. Most young people described themselves as trans, although one described themselves as non-binary. Several continued to explore labels. Three young people were neurodiverse. Twelve parents were interviewed (seven mothers and five fathers), after we obtained consent from their child. The sample comprised eight family groups, from diverse family structures including two-parent families, single-parent families and separated families. To include a diversity of experiences, including those who sought care outside formal NHS provision, we recruited three parents, not related to the young people we spoke to, through private practice and community organisations.

Including a sample of young adults (aged 19 to 30 years old) enabled an understanding of how experience is projected forward (table 2). Six community organisations, who held a range of positions (and wished to remain anonymous), circulated invitations to take part in the research. We also sampled young adults using one of the UKs Adult Gender Identity Clinics, and recruited a few who had contacted the Cass Review and asked to take part in research. Our sample of young adults included eight trans men and four trans women. Four young adults identified as non-binary or gender queer, including two who used to identify as trans but no longer used the label. Two participants identified

**Table 1** Sample characteristics, young people and their parents

Young person (YP)	Age	Sex assigned at birth	Parental involvement in research	Patient journey
Bailey	17	Female	No	Undergoing assessment
Bella	17	Male	No	Prescribed puberty blockers and cross-sex hormones
Dylan	17	Female	No	Prescribed puberty blockers and assessment ongoing
Freddie	17	Female	No	Waiting to self-refer to adult services
Henry	18	Female	Amanda and Craig	Undergoing assessment and waiting for transfer to adult services
Isaac	16	Female	No	On the waiting list for Gender Identity Development Service (GIDS)
Jordan	17	Female	No	Undergoing assessment
Logan	12	Female	Eric and Laura	Undergoing assessment
Remy	15	Male	Rachel	Undergoing assessment
Rory	15	Female	Alice	Prescribed puberty blockers and assessment ongoing
Rowan	17	Male	No	Prescribed puberty blockers and assessment ongoing
Sage	13	Male	No	Undergoing assessment
Summer	17	Male	Simon	Undergoing assessment and waiting for transfer to adult services
Will	17	Female	Hannah and Larry	Prescribed puberty blockers and cross-sex hormones
YP not interviewed. Parents recruited through private practice	NA	Female	Jane and Kevin	Parents chose not to seek a GIDS referral
YP not interviewed. Parents recruited through private practice	NA	Male	Natalie	On the waiting list for GIDS
NA, not available.				

**Table 2** Summary of sample characteristics, young adults

Name	Participant self-identification
Ali	A 30-year-old trans femme/gender queer person
Avery	A 19-year-old, who does not identify with any gender, but once regarded themselves as trans
Ben	A 19-year-old trans man
Blake	A 26-year-old trans woman
Cameron	A 20-year-old trans man
Chloe	A 20-year-old trans woman
Daniel	A 26-year-old trans man
Dominic	A 28-year-old trans man
Freya	A 26-year-old trans woman
Hayden	A 26-year-old trans non-binary person
Jack	A 29-year-old trans man
Jesse	A 22-year-old who identified as trans when younger but no longer uses gender labels
Joshua	A 27-year-old trans man
Liam	A 28-year-old trans man
Morgan	A 21-year-old, who is detransitioning
Oliver	A 25-year-old trans man
Robin	A 28-year-old trans man
Sarah	A 30-year-old who is detransitioning

as detransitioners. Five young adults were neurodiverse. Three belonged to an ethnic minority.

The interviews covered similar ground, to ensure analysis could compare responses, while creating an environment that enabled participants to reflect on their specific experiences.<sup>15</sup> Topic guides were developed from the relevant literature and through discussions with young gender diverse people, who also commented on the study as part of patient and public involvement. Interviews, held online using video conferencing software, lasted around 60 min. With consent, interviews were audiorecorded and transcribed. Most participants were interviewed once but we adjusted our approach to support their needs. Neurodiverse participants were able to meet with a researcher for shorter periods. Three young people wished their parents to be present during the interview.

In analysing our material, we used data familiarisation and open coding before generating themes. We compared these themes, across the entire set of interviews, to highlight potential similarities and differences,<sup>16</sup> before discursively reflecting on how these themes shaped our participant's interpretative meaning.<sup>17</sup> Consistent with 'reflexive thematic analysis'<sup>18</sup> that foregrounds a 'meaning-based interpretive story', analysis focused on how responses generated expectations about care. Our analysis prioritises the experiences of young people and their parents. It uses the young adults' narratives to contextualise these experiences. Names used are pseudonyms. When presenting our analysis, we use the term young people to include those aged between 12 and 18 years old; and young adults to include those aged between 19 and 30 years old.

As with any research, our findings can only include the experiences of those who agreed to speak to us. Despite our commitment to diversity, clinicians may have been reluctant to consider difficult and complex cases for inclusion in the research. Nor did our research include young people who had recently left or been discharged from services and only a small number currently waiting for a referral. There was also not a great deal of ethnic diversity in our sample of young people, although this may reflect current caseloads.<sup>19</sup> Some participants, initially

interested, expressed a reluctance to take part, because of what they regarded as hostile public discussions, including responses to the interim Cass Review. Our voluntary sector networks also spoke of research fatigue.

## FINDINGS

### Responding to difference

Young people in our study described an initial sense of difference, which they found difficult to explain. This caused discomfort. Seventeen-year-old Dylan explained:

I had people telling me constantly, like, why are you acting like this, you're a girl not a boy. Like, I would just be thinking to myself like why are people trying to make me a girl when I'm genuinely not a girl? So yes, that was probably the most confusing time of my life.

Common experiences included bullying, dismissal and rejection by others. Most, however, described supportive relationships with their parents. This is despite parents' initial confusion. Summer said:

He's [her dad] just the biggest supporter ... but at the time I could tell he was so concerned and so confused, he said absolutely nothing.

Young people appreciated how difficult it was for their parents. Dylan remarked:

It was sort of a realisation that I knew I had to tell my mum because she's living with a kid who's completely changing their life around and she has no label for it and she's still confused whereas I know exactly what's going on.

Some young people regard their parents as too cautious. Most, however, explained that their parents, despite disagreements, 'worked hard' to maintain dialogue. Henry explained that although his parents remained hesitant about medical pathways:

They've always been absolutely amazing with it. They wanted to make sure I'm safe, make sure I'm happy.

Social transitioning provided comfort for young people. Parents encouraged this and, although not without ambivalence, they hoped transition would reduce their child's discomfort. School holidays offer a time for young people to explore clothing, haircuts, pronouns or name changes, before deciding to transition in other areas of their social life. Transition remained dynamic, flexible and individual. It could also be strategic. Young people and their parents, however, remain sensitive to how others may respond. This includes the possibility of hostility. A father, Craig, explained:

I don't like all the politics involved ... These are children at the end of the day and think they need to be listened to and take their feelings honestly and without any sort of agenda really.

Parents would have liked more support, when initially negotiating their child's social transition, but felt none was available.

Resolving discomfort generated the need for more formal support. Parents usually initiated this by contacting primary care and/or Child and Adolescent Mental Health Service (CAMHS). Families described a lack of knowledge and understanding, when first accessing care. Dylan remarked:

Well, my GP was actually quite blunt and said, 'What you're going through is just a phase' ... Who just ignored what I said and thought I'd grow out of it.

Accessing support was described as a constant battle by families, who felt their experiences were not taken seriously. Parents especially described the intensive emotional labour required to

advocate, lead and educate healthcare professionals, schools, wider family and local communities: ‘everywhere you go you are having to educate others’. They found this exhausting.

Families said their first contact with GIDS offered reassurance, particularly given their exposure to critical voices, hostile to their experiences. A 3-year wait before a first appointment was, however, common. For young people this created considerable self-doubt. Henry felt:

... completely left in the dark and that’s quite scary.

His mother, Amanda agreed:

I was just really stuck with keeping him alive and safe really.

Families commented on the lack of support, while waiting. They felt they had to find their own solutions. This included seeking advice by contacting voluntary organisations, using online resources or pursuing a referral to private practice.

Diagnosis, when it occurred, provided validation. For young people, dysphoria was a useful medical label, helping explain their experience. It also justified asking for support, including accessing medical pathways. Jordan explained:

The best way to describe it is just like extreme discomfort with everything about yourself. Yes, I wouldn’t describe it as pain necessarily, it’s more like emotional pain in a sense. I feel like a diagnosis would help quite a lot because it would reassure me that that’s what I’m going through.

During contact with specialist services, some young people, although continuing to understand the value of dysphoria, thought it could represent an unhelpful diagnosis, in which their experience could only be regarded as authentic if a medical label were attached. Parents were less concerned about this. They regarded diagnosis as legitimising their experiences and their child’s distress. Young adults agreed that diagnosis could help validate experience and facilitate access to medical pathways, but became aware that it did not define them, in the way they felt it did, when younger.

### Young people’s expectations of care

Most young people regarded a referral to GIDS as providing access to medical pathways. Waiting, they said, had provided plenty of opportunity to think about what should happen next. Will explained that accessing medical pathways felt like ‘life or death’. Many young people, therefore, expressed disappointment when realising that access to medical pathways did not occur immediately. Young people accommodated this and many began to value reflection and exploration, as their contact with GIDS progressed. This occurred irrespective of the pathway. Seventeen-year-old Bailey, said:

At first, it [talking] didn’t feel helpful. I didn’t really know why ... because they can’t really give you a quick-fix ... I feel like when you’re a kid, you just want everything to be fixed ... so, that was frustrating, but I’ve, kind of, come to terms with the fact that it’s a slow, kind of, like, therapy process, and it’s not all about just medication and stuff like that.

Nonetheless, for some young people, frustrations and occasional anger occur as part of this accommodation, particularly if they wished to pursue a medical pathway. Bella said:

It’s a human right. We should have hormones. Like come on.

Summer believed the requirement to ‘talk’ denied her agency over her body:

I expected to do the talking first but I didn’t think it’d take long. [That] they’d want to get me on puberty blockers as soon as possible ... it was just really frustrating because obviously there was nothing I could do about it. Like, it’s my body but I have no control over it.

Despite ongoing feelings of ambivalence, young people, irrespective of their desired pathway or where they were in the assessment process, agreed that talking helped them develop confidence. Young people come to appreciate having access to a relaxed and non-threatening space. Bailey said:

They make you talk about all the doubt you have, because that’s one big thing for me, is I worry about, if I am doubting it. They made me realise that doubt is a good thing. If you doubt it, then it’s setting your journey ... I feel better about the doubts now, because they’ve made me realise that if I am wrong, then it’s fine

When talking, the young people we spoke to distinguished between affirming how they feel, which is non-negotiable, and accessing a therapeutic space, which enables exploration of what these feelings mean for them and their body. Young people are sensitive to any suggestion that they do not take their gender seriously or that their questioning is a lifestyle choice. Bella explained:

I have been ... bullied because of it, but like I’ve never ... hated myself because of how I am ... Like it’s not really a decision, it’s just who I am.

Talking enabled young people to relieve distress, consider different options and plan for their future. Some young people, for example, used the space to reflect on the impact of medical pathways. For others different ways of social transitioning emerged alongside alternative forms of identification. Thirteen-year-old Sage said:

They’ve [clinicians] supported me through discovering I was non-binary ... And they have told me everything about, all different things I can do if I feel uncomfortable and it’s who I am, so yes, they’ve been really good.

For young people, successful clinical relationships establish respect, build trust and encourage openness. Dylan said of this contact with GIDS:

They give you a safe place to talk as personal as you want and it doesn’t go anywhere [else], you can trust them, and you feel validated and like what you’re saying really matters.

### Parents’ expectations

The parents we spoke to talked about the challenges of caring for their child, while acting in their best interests. Henry’s mother, Amanda, explained:

Not assuming one way or the other ... letting him know we love him. And support him ... trying to clear the path in front of him to anticipate what’s about to happen and try and arrange everything before we get there so that it’s as smooth as possible.

Parents reacted differently to the possibility of medical pathways. There are those who expressed frustration at the lengthy process required before accessing them. Will’s mother, Hannah, explained:

The Tavistock felt like the gatekeeper to the endocrinology service ... so we knew that we had to jump through that hoop ... that’s not to say that the therapists weren’t skilled because I’ve got immense amount of respect for [name of clinician] but I think it was just, it’s flawed, isn’t it? It’s an immensely flawed service.

For parents, such as Hannah, specialist care was insufficiently 'affirmative'. They worried that care could dissuade their child from pursuing a pathway that was right for them. One father, Eric, said he felt judged, when expressing openness for medical pathways:

That's quite difficult because, you know, to suggest that you might be wanting to affect or harm your child for your own ends is quite insulting [laughs] so yes, my motivation is just to have a happy, healthy kid.

Parents, less certain about what should happen next, regard the possibility of medical pathways with apprehension and do not wish for them to be introduced too early. A few had avoided a referral to GIDS because of concerns about its 'affirmative' approach. Others doubted the extent clinicians could understand their child. Some worried that gender questioning was connected to neurodiversity or aligned with their child's poor mental health. A father, Kevin, said:

We're the best people to know our child and she was going through a lot of depression, a lot of self-harm and even not talking about gender ... the gender thing was just a result of what she was going through and at no point did we say to her no, you can't explore these things because we said to her it's natural for her age to have different feelings and you should explore them but wanted her to look at the reasons for ... the mental health side of things first ... but we never at any point said no, you're not going to, you know, you can't explore it, because we just said at your age, 12 years old, you're quite young, you still have time, let things pan out a bit and see where you are in a few years.

These parents, however, believe that their anxieties could be misunderstood. Kevin's wife, Jane, explained:

We find that when you're in this situation and you're not one of those parents who affirm, you're very much alone. You're very much alone. People will accuse you. I confided in another parent at the school, who accused us of, 'Don't you love your child? You do what's best for your child'.

Most parents, irrespective of their concerns, come to appreciate the 'safe space' offered by GIDS. Will's mother, Hannah, remarked:

It always felt like a supportive, enabling space that was quite safe for him to talk and I think that's because of [her] skill as a therapist.

The time taken by clinicians to understand their child reassured parents. Craig explained:

I was quite relieved when the counselling with GIDS went on [for] a long time ... because that just slowed it all down a bit. I think Henry wanted to rush, rush, rush, get the diagnosis, get his testosterone, get his top surgery done and then his life would be brilliant again ... I wanted it to slow right down and take that time talking, for GIDS to make a proper assessment and yes, and for me to be able to trust their assessment ... I felt safe with them, they portrayed that calmness, even though it was quite traumatic for us at times.

Parents feel there is a lot for them to navigate and describe feeling overwhelmed. Amanda, Henry's mother, explained:

I think [we] just need us to swallow our own discomfort and stuff about it, and sit with [the child], and not judge, and not, not tell them how to be or what to do, to just, to standstill with it. And that's really hard for some people I think because it is mind blowing stuff if you let yourself dwell on it.

Parents understand that the priority is to support their child but believe that their own needs are sometimes neglected. Parents also worry about getting it 'wrong', although they remain

unconvinced that there is a 'right' approach. Logan's father, Eric, remarked:

I think that's part of the problem ... because the system would like there to be a clear problem to solve and a clear route in which to solve it and I'm afraid it just isn't the case.

### Young adults' reflections

Many young adults benefitted from access to medical pathways, which they said had enabled them to lead the lives they wanted. They also gained from a growing awareness of equally empowering options, such as social transitioning and more fluid and non-binary expressions of gender. Young adults explained how the diversity of transition generated possibilities, which may not have been immediately apparent to them, when growing up. Daniel explained:

But actually, I've learnt that you grow into it and you start to understand yourself more and you begin to love yourself because of it.

Similar to young people, young adults described an initial sense of urgency, much of which focused on accessing medical pathways. For many, this urgency becomes less important. Ben said:

Yes, I think that's to do with me growing up and to do with maturing as an individual as well. It's, like, a mix of things of, like, as I grow up I get more educated, I get the right vocabulary, I'm able to have the confidence to advocate for myself more. There is also a bigger community that I've connected with so I'm more knowledgeable as an individual.

Most young adults found transitioning liberating and those we spoke to are proud of their journeys, which they say, have brought them fulfilment. Hayden remarked:

And exploring my gender in that way has been just such a joy.

Like other young adults, Hayden spoke about the importance of not focusing on what was lacking in your life:

The messages that we consume, they are very much like: what are you not? Rather than what you can be and what you are, what would bring you joy rather, save yourself from this uncomfortable feeling.

What young adults dislike is when others try to define—or make assumptions about—who they are. Like young people, young adults do not regard their gender questioning as a lifestyle choice. It is who they are. Two young adults, however, experienced regret. Physical transition had initially helped them. They now felt it was a mistake. Looking back, they would have liked more therapeutic support when considering transition (which they had done outside the NHS). They also described a lack of support available to those who wish to detransition.

Most young adults continued to describe supportive family relationships. Several who had initially found their parents' caution unhelpful, came to recognise its value, as their experience evolved. A few, however, described less positive family relationships, which had deteriorated over time. This caused them considerable upset.

Many young adults, when reflecting on their own experiences, explain that while it can be difficult and uncomfortable, it is important for young people to take their time, ask for the support when needed and make decisions that are right for them. Robin explained:

Go slow, go calm, just don't rush it. Go at your own pace.

Young adults, however, spoke of the difficulties of accessing appropriate care at the time, when you realise you need it. Internalised and socially realised transphobia, homophobia and misogyny especially concerned young adults. Ali explained:

Identity is so rarely static, and I think, as a young person ... when you're questioning identity but not necessarily sure what it is, you can easily latch on to the first thing that feels right for you. For some people that might be the exact right thing, but for other people it might be something different.

Young adults feel endlessly judged and held accountable for their difference and believe this closes down discussion and makes it more difficult for a person to take the path that is right for them. Ben explained:

I would tell [services] to ... make it more of a personalised process [that] is really important because not everybody, kind of, falls under this neat little umbrella ... much like gender—it's not confined to little boxes—the service cannot be confined to little boxes because it will then exclude so many more people.

## DISCUSSION

The needs of young people who question their gender identity are not that different from anyone seeking support. They require access to safe and effective treatments, alongside respectful therapeutic support, sensitive to their experiences, which enables them to make informed choices about their future. Family narratives suggest the importance of a personalised care, informed by an open-minded approach, in which no outcome is presumed and where the young person is given space for reflection. For some young people, this requires affirmation of a trans identity and the negotiation of medical pathways to support this. Others require alternative options as they search for an identity, with which they feel comfortable. This explains why families appreciate the safe and respectful space offered by therapeutic discussions. Trust in care is especially important. The young adults we spoke to confirmed this.

Families express a range of hopes, priorities and expectations. Their experiences highlight the complex work specialist support has to engage in. Despite tensions, families appreciate clinicians' compassion and thoughtfulness. Accessing timely care, however, is a problem. Families talk about the difficulties of waiting, in which they have to manage without specialist support, particularly given the shortcomings they describe, when accessing more generic services. Waiting created a sense of urgency for young people and a reluctance to explore their feelings at their initial meetings at GIDS. They want to get on with their lives. For many parents, however, engagement with specialist care is more likely to reflect caution and doubt.

Despite reservations for some, young people value 'talking', believing it helps them develop self-understanding and confidence. Young people do not see this as inconsistent with affirmation. Nonetheless, any ethos of explorative curiosity should not position young people as confused or incapable of acting in their own best interests. This is not the care that young people seek. Their priorities—and that of their parents—focus on inclusion and positive relationships, free from discrimination and in which gender questioning is respected, accepted and valued. Families expect care to be open, uncommitted and non-judgmental; realised through a willingness to continually respond.<sup>20</sup> This does not mean denying access to medical interventions or talking young people out of what they may think of as an appropriate pathway.<sup>21</sup> It is about providing a safe space in which young people can reflect on how they feel.<sup>22</sup>

The 'messiness' of practice is a reminder that care cannot always be reduced to an essentialised outcome.<sup>23</sup> Highlighting diversity, however, does not discredit those young people who are sure about the possibilities of transition and what should happen next. Nor should it exclude the voices of those who wish to explore the meaning of gender questioning. For young people, their priority is to establish relationships in which they can 'flourish'.<sup>24</sup> Parents share these aspirations, although have uncertainties about how best to facilitate this.

Enabling a young person to prioritise what matters to them<sup>25</sup> requires a care provider who carefully listens to what they are saying.<sup>26</sup> Reconciling the immediate, with a requirement to see beyond it, is what characterised the narratives of young people. Young adults' experiences further underlines the importance of this. Care, therefore, should be regarded as a 'wager on the unfinished nature of the present ... not by predicting the future, but on the ability to lure events in the direction of new possibilities'.<sup>27</sup>

## CONCLUSION

Our research can help service providers further understand the experiences of young people and their parents. Families highlight the need for a provision that is sensitive, reduces distress and supports young people to live well. Families recognise the value of open and honest discussions as long as it is done respectfully, in a trusting encounter, in which rapport has been established. This enables young people to achieve clarity about what their dysphoria means and make informed decisions about their future. The experience of young adults confirmed the importance of this.

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**Competing interests** None declared.

**Patient consent for publication** Not applicable.

**Ethics approval** This study involves human participants and was approved by South West Cornwall and Plymouth Research Ethics Committee (IRAS project ID: 306023). Participants gave informed consent to participate in the study before taking part.

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data availability statement** No data are available. The qualitative material is not currently available because of the sensitivity of what was talked about during the interviews and the high risk that participants could be identified. The study gained ethical approval on this basis.

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## REFERENCES

- 1 The Cass Review. Independent review of gender identity services for children and young people. 2024. Available: <https://cass.independent-review.uk/home/publications/final-report/>
- 2 National Institute of Health and Care Excellence evidence review: gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. 2024. Available: [https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726\\_Evidence-review\\_GnRH-analogues\\_For-upload\\_Final.pdf](https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726_Evidence-review_GnRH-analogues_For-upload_Final.pdf)
- 3 Butler G, De Graaf N, Wren B, *et al.* Assessment and support of children and adolescents with gender dysphoria. *Arch Dis Child* 2018;103:631–6.
- 4 Hall R, Taylor J, Heathcote C, *et al.* Gender services for children and adolescents across the EU-15+ countries: an online survey. *Arch Dis Child* 2024;109:s83–92.
- 5 Taylor J, Hall R, Langton T, *et al.* Characteristics of children and adolescents referred to specialist gender services: a systematic review. *Arch Dis Child* 2024.
- 6 Manjra II, Masic U. Gender diversity and autism spectrum conditions in children and adolescents: a narrative review of the methodologies used by quantitative studies. *J Clin Psychol* 2022;78:485–502.
- 7 Holt V, Skagerberg E, Dunsford M. Young people with features of gender dysphoria: demographics and associated difficulties. *Clin Child Psychol Psychiatry* 2016;21:108–18.
- 8 de Graaf NM, Cohen-Kettenis PT, Carmichael P, *et al.* Psychological functioning in adolescents referred to specialist gender identity clinics across Europe: a clinical comparison study between four clinics. *Eur Child Adolesc Psychiatry* 2018;27:909–19.
- 9 Jarvis S, Fraser LK, Langton T, *et al.* Epidemiology of gender dysphoria and incongruence in children and young people attending primary care practices in England: retrospective cohort study. *Arch Dis Child* 2024.
- 10 Royal Courts of Justice. Bell v Tavistock. [2020] EWHC 3274. n.d. Available: <https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf>
- 11 Care Quality Commission. Tavistock and Portman NHS Foundation Trust gender identity services: inspection report. 2021. Available: <https://api.cqc.org.uk/public/v1/reports/6e4fbf84-909c-46d7-835c-caf304cdd485?20221129062700>
- 12 Gendered Intelligence. Press statement on judicial review with NHS England. 2023. Available: <https://genderedintelligence.co.uk/services/publicengagement/jr-waiting-times.html>
- 13 NHS England. Implementing advice from the Cass Review. NHS Commissioning; 2022. Available: <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/implementing-advice-from-the-cass-review/>
- 14 Gergen MM, Gergen KJ. Narratives in action. *Narrat Inq* 2006;16:112–21.
- 15 Barbour R. *Introducing Qualitative Research*. London: Sage, 2008.
- 16 Riessman CK. *Narrative Methods for the Human Sciences*. London: Sage, 2007.
- 17 Gubrium JF, Holstein JA. *Analyzing Narrative Reality*. London: Sage, 2009.
- 18 Braun V, Clarke V. Conceptual and design thinking for thematic analysis. *Qual Psychol* 2022;9:3–26.
- 19 de Graaf NM, Manjra II, Hames A, *et al.* Thinking about ethnicity and gender diversity in children and young people. *Clin Child Psychol Psychiatry* 2019;24:291–303.
- 20 Mol A-M. Proving or improving: on health care research as a form of self-reflection. *Qual Health Res* 2006;16:405–14.
- 21 Horton C. Experiences of Puberty and Puberty Blockers: Insights From Trans Children, Trans Adolescents, and Their Parents. *J Adolesc Res* 2024;39:77–103.
- 22 McQueen P. The Role of Regret in Medical Decision-making. *Ethic Theory Moral Prac* 2017;20:1051–65.
- 23 Fine M. Individual, risk and the body: sociology and care. *J Sociol (Melb)* 2005;41:247–66.
- 24 Willen SS, Williamson AF, Walsh CC, *et al.* Rethinking flourishing: critical insights and qualitative perspectives from the U.S. Midwest. *SSM Ment Health* 2022;2:100057.
- 25 Singleton V, Mee S. Critical compassion: affect, discretion and policy-care relations. *Social Rev* 2017;65:130–49.
- 26 Mol A, Moser I, Pols J. Care: putting theory into practice. In: *Care in Practice: On Tinkering in Clinics, Homes and Farms*. Bielefeld: Verlag, 2010: 7–26.
- 27 Greco M. Pragmatics of explanation: creative accountability in the care of ‘medically unexplained symptoms’. *Social Rev* 2017;65:110–29.