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Negotiated care practices: The experiences of young people who question their gender, their parents and the healthcare professionals who support them

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ABSTRACT

Care, while having no clear boundaries, facilitates a nurturing that requires a disposition to act in another's interests. Care, however, is never disinterested and dividing practices vie with transformative potential, to define what is regarded as appropriate support. Current healthcare for young people who question their gender identity reflect this tension, particularly in the UK, where ideological inscriptions can subvert caring intent. In exploring this, our paper presents testimonial experiences from young people referred to the Gender Identity Development Service (GIDS) in England, their parents and clinicians responsible for their care. We consider how care is negotiated and (re)produced, by exploring how young people and their parents respond to gender questioning and seek resolution through their relationships with formal care providers. Using the work of Annemarie Mol, we provide an understanding of the creative calibration of elements that make up a situation, until they somehow fit and work, to define a caring environment characterised by complex, ambivalent and shifting tensions. Our conclusion assesses the possibilities for more inclusive caring practices, in which diversity of experience is acknowledged, along with the different ways that gender identity finds expression.

1. Introduction

While having no clear boundaries, care facilitates a nurturing that requires a disposition to act in another's interests, on the basis of "other centeredness" (Engster, 2005, p52). Care, however, is never "disinterested" but obliges a social participation (Martin et al., 2015, p34). This, although transformative, is realised within a biopolitics that enables a "dark side of care" to emerge (Fraser, 2008). Current healthcare for young people who question their gender identity, reflect these tensions especially in the UK, where the politics of identity can subvert caring intent. To explore this, our paper presents testimonial experiences from young people referred to the Gender Identity Development Service (GIDS) in England, their parents and the clinicians responsible for their care. In doing so, it offers a critical focus to understand the extent "persistent tinkering in a world full of complex, ambivalent and shifting tensions" can generate "good care", consistent with inclusive intent (Mol et al., 2010, p14).

By connecting everyday subjectivities to collective practices, care represents the social fabric, through which nurturing occurs and healing takes place (Singleton and Mee, 2017). This by enabling negotiability

provides a valuable lens, when exploring gender identities beyond the binary and cis-normative. Destabilising the relationship between social gender and biological sex offers the potential for multiple and fluid gender expressions, which enable an individual to pursue alternative possibilities (Annandale, 2024). A relational and dynamic gender (Butler, 1990) can subsequently be used to create an ethic of inclusive care able to realise these possibilities, as individuals prioritise what matters to them (Ricoeur, 1991). Care, however, is entangled with values, as it responds to vulnerability (Vandenberghe, 2017). Gender, for example, remains a situated experience, ordered through the pre-disposing process of social and cultural relationships (Epstein, 2007). "Gender practice is powerfully shaped by the gender order around us" and although we make our own gender, "we are not free to make it just as we like" (Connell, 2012, p874). Consequently, gender questioning can become a site of competing interests that attempt to regulate the physical and moral boundaries between biological sex and a socially realised gender. These competing interests create a logic of care able to frame autonomy, irrespective of personal intent (Sayer, 2005).

Cultural and political "debates" about the rights (and lives) of trans and gender diverse people, have particular implications for how care is

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understood and provided. Clinicians, for example, experience “considerable trepidation” (Langton et al., 2019, p200), as they manage a “stormy public discourse” (Cass Review, 2024, p13). This includes uncertainties about what care should look like, disagreements about the evidence-base and disputes about consent (McNamara et al., 2024). These difficulties occur across the Americas, Australia and Europe. Until recently, GIDS was the national specialist service for gender identity in England. The clinical and social landscape in England (and beyond) has changed significantly since the service’s inception in 1989 and its history could be read as a continual “tinkering” in response to “shifting tensions” (Mol, 2006). GIDS initially offered psychosocial therapeutic support, although sometime around 2011, it also assumed a gatekeeping role, by assessing suitability for onward referral to endocrinology, where a young person may be prescribed gonadotropin releasing hormone analogues (puberty blockers) or when over 16, cross-sex or gender-affirming hormones. This created an uneasy tension about the purpose of care, during which time the number of young people referred to GIDS - and similar services in Europe and USA - increased (Cass Review, 2024). In 2011/2012 there were 210 referrals. By 2021/2022 there were 3584. Waiting times remain high with three to four years between referral and accessing specialist support (Cass Review, 2024). Those accessing care have also changed, which again is not unique to the UK. Ten years ago, referrals were predominantly young people assigned male at birth. Now, those assigned female at birth make-up 73 percent of referrals (Cass Review, 2024). Further, those referred are increasingly presenting with co-occurring neurodiversity and mental health conditions (de Graaf, N et al., 2018). Less than two percent of young people in the UK are thought to have autism, whereas 35 percent of young people presenting at GIDS have moderate to severe autistic traits (Manjra and Masic, 2022).

Some regard GIDS as too “affirmative”. They accuse the service of not adequately exploring the circumstances in which a young person questions their gender and failing to consider other potential outcomes, beyond a trans identity (Cass Review, 2024). Others, however, regard GIDS as inappropriately preventing young people from realising their affirmed identity (Horton, 2023). This polarisation circumscribes operational intent. In 2019 a claim for Judicial Review was brought against GIDS. This questioned the ability of those under 18 to consent to the administration of pharmaceutical interventions that prevented puberty. In 2020 an inspection by the Care Quality Commission (CQC) took place in response to concerns raised by the Children’s Commissioner for England. Despite GIDS being rated ‘good’ for care (with families reporting that clinicians treated them with compassion) the overall rating was ‘inadequate’, with significant improvements required in risk management, record keeping (including recording consent) and leadership. GIDS implemented changes, although a further Judicial Review challenged these on the grounds they were discriminatory (Gender Intelligence, 2023). In response to these controversies, NHS England (2022) announced that Regional Centres would replace GIDS and that the use of puberty blockers would be paused (except when prescribed as part of a clinical trial).

Projecting ethical and moral dilemmas onto care provision, however, is not unique to gender identity (Lynch et al., 2021). Locating controversies within broader conceptual debates can help develop care, particularly as it counters exceptionality. Annmarie Mol’s work, by emphasising a contingent performativity that requires social negotiation, has analytical value when exploring this. For Mol, there is no agreed reference point, from which to assess care. Instead, care is generated through a continuous practice, responsive to circumstances that reflect multiple and shifting accounts, in which individuals attempt to make their situations “work” (Mol, 2006). These situations and the relationships they generate, shape care and generate practical consequences. For those referred to a gender identity clinic this creates a precarity of care, in which they have to justify their questioning, while encountering a risk that their experience may not be believed, as it becomes subject to a contested enactment generated by controversies

about the purpose of care (Singer, 2015). This is projected onto practice, in which those seeking care work with clinicians, who are required to negotiate their own precarities (see above), to find solutions (Mol et al., 2010). This involves “tinkering”, as those who question their gender - and the clinicians who support them - continually respond, as situations change and unfold (Mol et al., 2010). Consequently, reducing our understanding of care to a fixed reference point becomes untenable, as does a concern with effectiveness (Skovgaard et al., 2024). Instead, our focus should be on the various “effects” of care and their connection to the intricacies of daily life. This necessitates a care that is open and responsive, albeit one bounded by prioritisation, in which discursive practices about gender, institutional logics, diagnostic categories and the use of medical technologies mediate experience (Law and Mol, 2002). Our research uses this “specificity”, to “get across the importance of good care” (Mol et al., 2010, p2), by providing an understanding of “tinkering” that involves “the creative calibration of elements that make up a situation, until they somehow fit and work” (Mol, 2006, p410-411).

2. Doing the research

Our research, commissioned by (but independent from) the Cass Review (<https://cass.independent-review.uk/>), presents the experiences of those receiving and delivering care. Our research took place between March 2022 and December 2023 and was led by two cis-gendered researchers, including one who identifies as a member of the LGBTQIA community. Our objective was to understand current care, to establish more inclusive practice. First, we interviewed fourteen young people, aged 12–18 years old who sought care from GIDS. When inviting young people to take part, we sought to capture diverse experiences. Young people were primarily recruited through GIDS, where clinicians introduced the study to eligible families, although to facilitate diversity, including contacting those at different points of the assessment process, some young people were recruited through community organisations.

Young people aged over 16 consented themselves, parents of those under 16 consented on behalf of the young person, who also provided assent. Our sample included nine young people assigned female at birth and five assigned as male. They lived in different parts of Great Britain. Four were on ‘medical pathways’, having been assessed for endocrine treatment and prescribed puberty blockers, and/or cross sex hormones; 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. When interviewing young people, we explored how their gender questioning became defined, within the context of social networks, to create a narrative in which they could articulate their aspirations. Second, we interviewed twelve parents (seven mothers and five fathers) of young people, who sought support from specialist services. This comprised eight family groups, from diverse family structures including two-parent families, single-parent families and separated families. (We asked young people for consent before contacting their parents). To include 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 voluntary organisations. Interviews explored parents’ initial responses to their child’s gender questioning and the challenges they faced when accessing care. Third, we interviewed twenty-three clinicians about the challenges of negotiating care. All GIDS clinicians were invited to take part in research. Participating clinicians (n = 21) represented all regional teams; had a variety of different backgrounds (i. e., clinical psychologists, psychological and family therapists, social workers and specialist nurses); varied in the time spent working in the service; and included those with managerial responsibilities. We also interviewed a youth worker, based in a third sector organisation and a clinician in private practice.

We wished to cover similar ground with participants, to ensure we could compare responses, while creating an environment that enabled

them to reflect on their specific experiences. Topic guides were developed from the relevant literature and through discussions with young gender diverse people, who also commented on the make-up of the sample and study focus. Interviews, held online using video conferencing software, lasted between sixty and 90 minutes. With consent, we audio-recorded and transcribed interviews. We interviewed most young people once but adjusted our approach to support their needs. Neurodiverse participants, for example, were able to meet with a researcher for shorter periods. Three young people wished their parents to be present during the interview.

Doing research on gender identity presents challenges. Some families expressed a reluctance to take part in research, because of what they regarded as hostile public discussions. Publication of the interim Cass Review during recruitment, for example, impacted on a willingness to participate in the study. Our voluntary sector colleagues also spoke of research fatigue, particularly since previous encounters had undermined trust in research processes. The use of GIDS' clinicians to generate our sample of young people may have meant the research did not capture more complex cases. Their caseloads also offer little ethnic diversity (De Gaaff et al., 2019). Our sample reflected this.

In analysing our material, we used open-coding before generating themes, by reviewing and exploring the significance of our codes for each interview. We reflected on how our themes shaped our participant's interpretative meaning, before comparing them across the entire set of interviews to highlight potential similarities and differences (Braun and Clarke, 2022). When writing up narrative research, no particular rules determine which themes best represent the diversity of the material (Riessman, 2007). Analysis presents three interlinking themes, to explore how participants engaged in "creative calibration" to (re)produce care (Mol, 2006), as the basis for generating insights, with which to understand and improve care. Our first theme explores how young people and their parents respond to gender questioning and seek resolution. This generates expectations, which require negotiation. Our second theme focuses on this. The third theme considers how the "shifting tensions", generated by negotiation, define practice.

3. Caring practice

3.1. Responding to gender questioning

Creating an understanding, through which to articulate difference, requires young people - and their parents - to negotiate an emergent identity, in which precarity occurs alongside transformative potential. Once young people understand their "difference", they are keen to realise its possibilities. Care is sought to facilitate this. Parents' engagement with care, however, is less certain and more likely to reflect doubt. For young people, gender questioning begins with a feeling of difference. Many do not immediately associate this with gender but when they do, use binary ideas to give meaning to their experience. Seventeen year old Dylan, who identifies as trans, explained:

So obviously, until around eight or nine when I really understood what makes girls and boys different, I thought I was just, as this male because to myself, I didn't know any different, even though I had people telling me constantly, like, why are you acting like this, you're a girl not a boy. 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.

Most young people describe supportive family relationships despite an initial confusion. Eighteen year old Summer said:

My dad was extremely confused. He said basically nothing [...] Like now, he's just the biggest supporter of it ever but at the time I could tell he was so concerned and so confused, he said absolutely nothing.

Young people appreciate how difficult their parents found the experience. Dylan said:

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.

Disagreements occurred but young people acknowledge that their parents "worked hard" to maintain dialogue. Eighteen year old Henry, who is awaiting transfer to adult services to access endocrine treatment, having privately accessed "top surgery", said that although his parents remained hesitant:

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

Nonetheless, many young people felt their understanding was "way ahead" of their parents, who they regarded as too cautious. Parents would agree and have different expectations of care.

An emerging understanding of diverse LGBTQIA identities and communities enabled young people to "name" their experience. Sixteen year old Isaac, who is yet to receive specialist care, said:

As a kid I always knew something was up, you know, but I didn't know that trans people existed so I didn't know, like, what it was, but I know I just always felt, like, very different about my gender.

Young people, however, are clear. Naming does not create them. It does, however, enable them to come out. Summer remarked:

I came out when I was twelve [...] like until five years ago I was still questioning all of it and I went through loads of phases of different identities and trying different things out, until I got to like a trans woman and then I was like okay, that makes sense.

Young people remain sensitive to accusations that they only begin questioning, after discovering different expressions of gender. Gender questioning, they said, came first. When legitimating their difference, social transitioning provided comfort. Some young people explored different ways of social transitioning before coming out, although others explained that their parents encouraged such exploration. Parents' encouragement, however, is not without ambivalence but they hoped social transition would resolve their child's distress. Young people often took a staged approach, with school holidays providing opportunity to explore clothing, haircuts, pronouns or name changes, before deciding to transition in other areas of their social life. Social transition, however, remained dynamic and flexible. It could also be strategic. Families remain sensitive to the perception of others. Transphobia remained an ongoing concern, which for young people, became associated with restricting the opportunities for reflection. Parents spoke about how hostility impacted on their child's happiness. A father, Craig, whose son Henry is eighteen and awaiting transfer to adult services, remarked:

I don't like all the politics involved with [...] different groups using different arguments to support their particular standpoint [...]. 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.

Attempts at understanding and resolving gender questioning often generated the need for more formal support. Parents usually initiated this. Families' initial experiences of discussing gender in a general healthcare setting was rarely positive. 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.

Parents described the intensive emotional labour required to advocate, lead and educate healthcare professionals, schools, wider family and local communities. Several parents echoed the sentiment that "everywhere you go you are having to educate others". Henry's mother, Amanda, when reflecting on the difficulties, said: "I was just really stuck

with keeping him alive and safe really". A referral to GIDS represented a major step for families. Many, however, experienced a three year wait before their first appointment. This created considerable anxiety and self-doubt. Henry felt, "completely left in the dark and that's quite scary" and wondered whether services were "prioritising [seeing] other people because they're more trans than I am?"

A consideration, when accessing formal care, concerned the extent to which gender questioning could be transformed into "dysphoria". Most young people, when looking to relieve distress, recognised "dysphoria" as a useful diagnostic category that helped to legitimise experience. Seventeen year old Jordan is in the early stages of assessment, after four years waiting to see a GIDS clinician. They described what dysphoria meant to them:

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.

A diagnosis could justify asking for care, including seeking access to medical pathways. Seventeen year old Freddie has begun to socially transition. He is not, however, 'out' at home and is waiting until he is old enough to make a self-referral to adult services. For him, the diagnostic process was not conditional to his trans experience, but necessary to access care:

I feel like the whole diagnosis is a bit weird. But [...] it's not going to change what I think [...] because I've always had dysphoria. I know I have. I don't need some paper to tell me that I have it. But I think it's, like, some kind of ticket to be able to finally progress because you can't really do anything without it.

For parents, a diagnosis of dysphoria offered reassurance, validated family' experiences and justified treatment decisions. The acceptance of dysphoria was, however, not without ambivalence and some families felt it could represent an unhelpful diagnosis, in which their social experience could only be regarded as legitimate if a medical label were attached.

3.2. Expectations of care

The complex and diverse experiences of trans and gender questioning young people, in which uncertainties vie with transformative opportunities, create expectations for care that are rarely linear, but continually negotiable. Young people value what is nearby and are concerned with the immediate. Their parents - with some exceptions - reflect more on long-term trajectory (as do clinicians). Families agree, however, that their first contact with GIDS provided legitimisation, particularly given their exposure to critical voices, suspicious of their experiences.

Most young people saw a referral to GIDS as offering access to life-affirming medical interventions, which enabled them to embody their experiences. Wating, they said, had provided plenty of opportunity to understand how care could help them. They were confident about what should happen next. Their priority was to "fix" the problem. This provided certainty and removed doubt. Care was negotiated - at least initially - on this understanding. Many young people, therefore, express disappointment when they realised that access to medical pathways did not occur immediately. Summer, who had waited three years before her first appointment at GIDS, was now awaiting transfer to adult services to begin a medical pathway. She 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.

Many young people felt (embodied) medical pathways would help resolve distress and facilitate their future. Without them, they regard their life "on hold". A few young people had entered the service prior to the increase in waiting times. Bella and her family had been supported by GIDS for ten years. She had been prescribed puberty blockers and cross-sex hormones. Bella explained that although she does not use the label trans, she does locate and understand her experiences, with reference to the lives of other trans and gender queer people. She considered herself "lucky" to have received timely access to care and contrasted her experiences to the current struggles facing trans people:

And for me, [non-medical pathways] wasn't really an option because I needed that oestrogen just to give me, like get me down the pathway that I wanted. It's amazing to be on oestrogen. [...] but like I know a lot of other trans people out there still needing oestrogen and it's a human right. We should have hormones. Like come on.

Irrespective of expectations and feelings of ambivalence, young people come to appreciate having a relaxed and non-threatening space in which they can talk. Frustrations - and occasional anger - remain unresolved, as the value of "talking" occurs alongside the feeling that it may be "slowing" down progress. Seventeen year old Bailey, who had socially transitioned when fourteen and continued to explore labels and possible medical pathways, said:

At first, [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.

Bailey, like many other young people, spoke about how talking helped them develop confidence:

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.

Consequently, many young people value their engagement with the service. Bella, who we have seen expressed concerns about services, remarked:

The Tavistock stuff [...] it honestly changed my life. Like I don't think I would be where I am now to be honest. It almost saved my life.

When reflecting on the value of "talking" young people distinguish between affirming their identity, which they regard as non-negotiable and accessing a therapeutic space, which enables exploration of what this identity means for them and their body. Young people remained sensitive to any suggestion that trans and gender diverse identities are a preference or lifestyle choice. Bella remarked:

I have been [...] bullied because of it, but like I've never [...] hated myself because of how I am. But yeah, I always like, agreed with my decisions. Like it's not really a decision, it's just who I am.

For young people, successful caring relationships establish respect, build trust and encourage an openness, when exploring experiences. Dylan was referred to GIDS aged twelve and having been prescribed puberty blockers, was now awaiting assessment for cross-sex hormones: He said:

They give you a safe place to talk [...] you can trust them, and you feel validated and like what you're saying really matters.

Young people believe they have a right to be flexible, as they search for an identity, with which they feel comfortable. For some, this meant becoming aware of the different ways of being trans, while others said talking encouraged them to explore identities beyond the binary, which may not have been initially apparent to them. Thirteen year old Sage explained:

They've supported me through discovering I was non-binary. It was my parents a lot but they were like, really helpful. They've helped me, with [...] like if I ever need any support or anything, then they definitely help. 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.

With reflection, young people struggle with 'transnormative' narratives that require a fixed, permanent and linear experience, with little space for diversity or doubt, to render their trans or non-binary identity intelligible (see Johnson, 2016). That exploration or fluidity could become associated with them not taking their gender seriously, worried young people. Nonetheless, "talking" encouraged many young people to reflect on the challenges of realising their gender, by introducing ideas of trajectory, including a consideration of future aspirations, beyond the immediate.

Each parent - even when disagreeing with their child - emphasised how they acted in what they understood to be the child's best interests. Henry's mother, Amanda said:

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.

Most parents understood GIDS as enabling children to explore their gender. They also understood that GIDS provided access to medical pathways and an important gatekeeper. Some parents regarded this as inappropriate, albeit for different reasons. There are those who expressed frustration at the lengthy process required before accessing medical pathways. Seventeen old Will explained that accessing medical interventions felt like "life or death". His mother, Hannah, agreed, although pleased that Will had received puberty blockers, became annoyed, when told they would not receive cross-sex hormones:

The Tavistock felt like the gatekeeper to the endocrinology service [...], so we knew that we had to jump through that hoop [assessment] [...] 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" and several associated it with encouraging their child to consider options, inconsistent with how they felt. One father, Eric, whose child is thirteen, explained that the family requested a change of clinician following their initial appointments:

We didn't feel we could trust them because we felt that [...] some of them really didn't believe it and they were actually trying [...] to get Logan to desist from it, trying to get him to change his mind.

Eric felt judged, when asking about 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 assumptions about its affirmative approach, and instead sought private psychological provision, through which medical pathways were not available. These parents spoke about their reluctance to

consider medical pathways, preferring to prioritise an exhaustive therapeutic process. Some parents' caution reflects their anxieties about the extent clinicians understood their child. Some worried that gender questioning was connected to neurodiversity or aligned with their child's poor mental health. When expressing their uncertainties, parents worry that their anxieties could be misunderstood and regarded as unsupportive. One mother, 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?"

Jane's husband, Kevin spoke about the difficulties they faced, when negotiating care:

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, twelve 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.

Natalie, a mother, justified her reluctant to consider medical pathways because of concerns about the future:

[We] are very honest in terms of we don't believe he is trans, but we will support him on his journey if that is what he thinks, because he is 17, he is nearly 18, and it is going to be out of our control [...] Because my fear is that there are people out there who do transition, and then they de-transition because they regret it. And a lot of those young people do have ASD or do have other things that have prompted it, and I don't want him to be that person. I don't know where the guarantees are because I am sure those people, when they transitioned, really believed it was the right thing. [...] And my fear is that he will go down that path and he will realise, "I still feel shit. I am still this." But he finds that really hard to see and to understand.

Irrespective of their concerns, many parents who sought NHS referrals come to appreciate the "safe space" offered by GIDS, which they believe provides the opportunity for their child to explore gender, in an open way. Will's mother, Hannah, who as we have seen expressed reservations about care, explained:

I never felt that [Clinician] didn't believe Will. I never felt that she was looking for something else or trying to uncover something. 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.

For some, including Henry's father, Craig, this (re)established confidence in care:

I felt safe with them, they portrayed that calmness and even though it was quite traumatic for us at times, they were always quite grounding.

Craig, like many parents, mentioned "relief" when he realised the amount of time devoted to "talking":

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 [...]. Whereas [...] I wanted it to slow right down and take that time talking [...] to make a proper assessment and yes, and for me to be able to trust their assessment, [...] which I felt I did at the end of it.

Nonetheless, parents, irrespective of their expectations, continually worry about getting it “wrong”, although they remain unconvinced there is a straightforward resolution. Logan’s father, Eric, has yet to decide on supporting medical interventions, 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.

Parents’ continuing sense of being responsible for their child’s future explains their sensitivities when engaging with formal care, including the reluctance - for some - to fix outcomes. Parents feel there is a lot for them to navigate and describe feeling overwhelmed. Parents found the process of care emotionally challenging. 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.

3.3. Providing care

Families’ experiences highlight the complex work clinicians engage in. Clinicians agree and spoke about the difficulties of working within a changing cultural and social context, when attempting to negotiate the uncertainties associated with having no agreed reference point with which to judge the success of an intervention, let alone a societal consensus on an appropriate response to gender questioning. Clinicians commented on “respecting the anxiety” generated by what they do and say that it is a privilege to work with young people. Clinicians know their work is challenging. They believe it should be. It was also hugely rewarding.

Clinicians expressed concern that recent increases in waiting times mean families manage distress, with no support. Many young people, for example, enter GIDS having, to varying degrees, socially transitioned. Clinicians understand why this occurs but remark on how it could make opening up the space for exploration challenging, particularly when some young people - and their parents - come with fixed ideas about what they want from care. This requires clinicians to “unpick” what has gone on, which can undermine trust. Diagnosis also requires sensitive negotiation. Clinicians acknowledge that a diagnosis of dysphoria is necessary to facilitate access to care. This, they say, can usefully justify decision making. Clinicians, however, share families’ ambivalence and emphasise that gender identities exist independently of dysphoria. Consequently, some clinicians reflect on the dangers of having definitions too narrowly focused on distress. This, clinicians feel, could disadvantage young people:

I mean this is a lifetime work really, gender. It’s not something that ends with a medical intervention.

Clinicians understood that their role in providing assessment (and being a gatekeeper) for medical pathways, while offering therapeutic support, is potentially contradictory. Parents sympathise. Eric said:

Poor old Tavistock, it’s got a real [...] problem because they don’t know what they’re there for, if you see what I mean? Are they there to hand out drugs, are they there to do therapy [...] what are they there for? [...] But their problem is they’re so under scrutiny from people who just don’t understand the whole thing.

Clinicians worry that recent changes, associated with assessment, have reduced the time available for therapeutic care, while the implementation of standardised decision making tools, fail to reflect a “messiness” of practice (Fine, 2005), where it is difficult to fix outcomes. Clinicians worry that care is becoming regarded as a hazard, which has to be rendered safe, by subordinating it to a “reductive” and

“deterministic” heuristic. A psychologist explained the changing nature of their role:

It feels like my role is to protect the Trust [...] and show that the service is functioning in ways that it has to. Before it felt like my role [was] to help families to be gentle with each other in helping young people to navigate really difficult, painful growth in their identity development. To think about gender and what is this and what does it mean.

Clinicians, however, remain determined to support young people. A psychologist working in the service for four years, said:

I think it is [...] really taking a holistic look at the young people that come through the door and a very person-centred approach. I wouldn’t claim that any young person that comes through the door would need the same thing as the person who came to the door the hour previous. So really taking that person-centred approach. Looking at what they need to live well [...], to be happy, to flourish in the world.

Clinicians recognise that their role may be regarded as exploratory and to some extent cautious, although remarked that this was consistent with affirmation. This is maintained against a responsibility to ensure the best possible outcome, irrespective of what that outcome may be. An exploratory role may, for example, require supporting a trans identity and facilitating medical pathways. Clinicians are equally aware that through exploration, a young person may become more comfortable with a non-binary identity or that gender questioning resolves itself as the young person develops critical self-reflection. Sometimes, clinicians add, exploratory approaches help young people realise their sexuality, as a consequence of gender questioning:

Affirmative isn’t letting someone say yes that is what you are and you may do anything you like and off you go and we’re just very happy for you. Affirmative is respecting somebody’s sense of themselves [...]. You want to be called this. I respect that. You want these pronouns used. I respect that. And then I’m going to invite you in to explore with me your identity. But not because I’m challenging it, not because I’m trying to erode it, not because I’m trying to say I don’t believe you but so I can get to know you and help you make decisions about your medical care around your trans. And so that’s affirmative to me. But that’s exploratory as well.

That their work can be misrepresented is a frustration. An expectation that requires clinicians to position practice as either “exploratory” or “affirmative” is seen to disregard the complexities of care. Care, clinicians say, cannot be reduced to an essentialised label that is either/or. Consequently, many are keen to disrupt current terminology. A psychologist with almost a decade of experience, remarked:

Affirmative models are effective informed consent models where people when they enter a service would be given access to endocrine or medical treatments at a fairly early stage. That’s not what happens within GIDS. We have a very thorough assessment process that usually as a minimum would last probably about, the average assessment now the last time we looked at the figures was eight sessions probably over a course of roughly a year, you know, that would be an average expectation really for somebody coming in. [...] Tell me exactly why a four and a half year journey from start to end to access endocrinology treatment can be described as affirmative. It’s disingenuous at best and dishonest at worst.

Clinicians believe that encouraging a young person towards thoughtful and careful exploration, by enabling them to open up and talk about their gender, through “gentle” questioning, is the basis of good care. A team-leader with a background in child and adolescent mental health, explained:

So, we're not invested in any particular outcome. The investment is in trying to open up a curiosity, an interest and an understanding of one's own gender. I think there is a phrase that I often use is to gently complicate things which, you know, doesn't mean challenging people but it means, you know, really unpicking things in a helpful way to make sure that if eventually a decision is made about a medical intervention there is significant exploratory work has happened.

Clinicians acknowledge that some young people and parents may see this as a denial of care, but believe a young person has a right to continual reflection and reinterpretation of experience. They are aware of the emotional difficulties young people face when making decisions about their future, particularly when they often enter services with a sense of urgency. Clinicians say a difficulty facing families is not knowing the most appropriate outcome, at any particular time-point:

I think the most important thing isn't about solutions, it's about exploration, curiosity, understanding, holding different things in mind at the same time.

This explains why clinicians are sensitive to any perceived threats to their exercise of discretion, as they feel their work requires a speculative pragmatism, coupled with creative intent (see Gill et al., 2017). They remain cautious about what a "successful outcome" means but worry that current discussions reflect others' perspectives, rather than those of the young person.

4. Discussion

Our findings explore how "tinkering" as a characteristic of care, can offer insights, when developing inclusive support, in a contested and situated domain, consistent with the intricacies of an individual's life. Situations and relationships enact, shape and reproduce care, as expectations - and their potential outcomes - become subject to re-evaluation. As our analysis demonstrates, the purpose (and value) of care is open and conditional on shifting tensions, realised through a continual "tinkering" and "creative calibration" (Mol et al., 2006). This, by respecting the right to be (culturally) different - and the different ways identity can find expression - prevents the "hardening of the categories of the everyday" (Singleton and Mee, 2017, p133). A more "trustful" conversation is, therefore, possible (Fricker, 2007), as performativity - and the circumstances in which it occurs - can be interrogated (and disrupted) to identify the possibilities of "good" care, consistent with other-centeredness (Skovgaard et al., 2024).

Families, when responding to gender questioning, generate aspirations, which require negotiation. This is neither linear nor fixed but requires families to make gender "work" for them. Care is sought on this basis, in which trajectories and their transformative possibilities vie with precarity to define care, which if unacknowledged, generate partial accounts, insensitive to experience (Mol et al., 2010). Tensions remain as social division and anxiety risk the loss of care (Gill et al., 2017) and while intersectionality was not a strong feature of our account, the transformation of social divisions into sites of injustice requires a sensitivity to complexity, sometimes missing from current debates (Tironi and Rodriguez-Giralt, 2017). Disentangling personal subjectivities from ideological inscriptions, which associate them with problems of the social order (Meloni, 2016), although not unique to gender questioning, generates a conflict capable of disrupting care. Affirming a gender identity, outside conventional binary accounts, provides opportunities for contestation (Singer, 2015) and families express concerns about how their experience can be misinterpreted and misrepresented. By generating ambiguities and blurring boundaries, gender questioning can become associated with experiences regarded as untrustworthy or undesirable (Lorber, 2022). Considerable personal identity work is, therefore, required by families to avoid the erasure of experiences that exist "between and beyond the binary framework" (Darwin, 2020, p361). This means, when establishing an ethos of care, in

which they can recognise themselves, families have to reflect on how their voices are accorded credibility (Mishler, 2005). Collaboration with clinicians is necessary, who as our findings suggest, "explore, quibble, test and adapt until a suitable arrangement occurs" (Winance, 2010, p116).

These collaborations reproduce the "effects" of care (Mol, 2010), in which an iterative approach is threatened by narratives others regard as offering more suitable reference points, with which to provide care. This subverts the complexity inherent in family accounts and the "messiness" of practice described by clinicians. Trans and gender questioning young people are often presented as exceptional, in which the possibility of uncertainty, disagreements about appropriate models of support and controversies about suitable outcomes, act as a justification for care to be discouraged or withheld (McNamara et al., 2024). The impact of waiting, for example, can become lost in the process, particularly as it creates a sense of urgency, when entering formal care. Clinicians are aware of the tensions this creates, but see these as intrinsic to a pre-formative care, rather than a reason to doubt the young person's experience. In response young people come to value therapeutic support, particularly as it helps them consider their options, although this does not stop them regarding it as a potential barrier, preventing opportunities. The clinicians' role as a potential gatekeeper to medical pathways enforces this, while encouraging young people to locate their personal discomfort within a "dis-orderd" and medicalised body rather than a social experience, in response to a normative and discursive context hostile to difference. Young people also have to negotiate a gendering of their narratives, consistent with conventional (and embodied) understandings of masculinity and femininity (Johnson, 2016), while knowing that cisgendered and heteronormative assumptions can conspire with transnormativity, to hinder the development of an inclusive caring space and undermine ongoing and open reflection.

Countering this "require(s) special efforts to identify (and) protest it" (Fricker, 2007, p145), in which care can 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" (Greco, 2017, p122). A concern with the linear, in which a goal is established, treatment occurs and a fixed outcome recorded, requires young people "to perform (and produce) a gender permanence in a way that non-trans citizens are not required to do" (Grabham, 2010, p 109). This is counter to how families experience the unfolding of care. It is also counter to a caring practice, in which clinicians remain sensitive to compromise, including the possibility that a particular type of care may not work (see Mol, 2006). Contingency, uncertainty or doubt are, therefore, consistent with "good care". Instead, care can never be satisfied but requires consistent improvement, by a "tinkering" empowered to unravel and articulate tensions, "by cast[ing] them in the words that may allow them to travel, so that they may be more widely reflected upon" (Mol, 2006, p211). Nonetheless, when considering the context in which gender questioning occurs, any ethos of responsive 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 when they reflect on the value of "talking". Rather, they wish to use respectful, therapeutic support to consider how best to explore and embody their identities, before making decisions about the future. For some, this necessitates supporting a trans identity and negotiating medical pathways, while for others, this requires exploring alternative options. Young people's priorities - and that of their parents - focus on inclusion and positive relationships, free from discrimination and in which trans and gender questioning young people are accepted, respected and valued. This requires a particular temporality of care, which is realised through a willingness to continually respond, as situations unfold (Mol et al., 2010). Enabling a young person to prioritise what matters to them, requires a care that carefully listens to what they are saying. Reconciling the immediate, with a requirement to see beyond it, is what characterised the narratives of young people. As Fanon (1961) observed, the only subject is a living one and care is required to write this living into

time. We risk (re)producing injustice if gender identity services do not empower this.

CRedit authorship contribution statement

Christine Jackson-Taylor: Writing – review & editing, Writing – original draft, Validation, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Karl Atkin:** Writing – review & editing, Writing – original draft, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

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The authors declare that they have no known competing financial interest or personal relationships that could have appeared to influence the work reported in this paper.

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Data availability

The data that has been used is confidential.

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