Delivering Care in the Face of Existential Threat: A Narrative Inquiry with Clinicians at the End of the Gender Identity Development Service

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"The universe is made of stories, not of atoms." ***Muriel Rukeyser***

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“If you're not careful, the newspapers will have you hating the people who are being oppressed, and loving the people who are doing the oppressing.” Malcom X

Abstract

The decommissioning of the NHS Gender Identity Development Service (GIDS) occurred within a period of unprecedented clinical, political, and public scrutiny of gender identity healthcare in England. Whilst debate has largely focused on models of care, policy, and evidence, comparatively little attention has been paid to the experiences of the clinicians who worked within the service during its final years. This thesis explored how former GIDS clinicians made sense of their experiences of working within, and living through the closure of, the service, with particular attention to experiences of moral distress and moral injury.

The thesis comprised a scoping review and an empirical narrative inquiry. The scoping review examined the literature on moral distress and moral injury within child and adolescent mental healthcare, identifying important gaps relating to gender identity services and the organisational, relational, and sociopolitical contexts in which moral experiences arise. The empirical study adopted a social constructionist epistemology and narrative inquiry methodology. Eight former GIDS clinicians participated in in-depth narrative interviews. Individual narrative portraits were constructed before being brought into cross-narrative dialogue to identify shared storylines whilst preserving the integrity and context of each participant's account.

Participants narrated the closure of GIDS not as a singular organisational event but as a prolonged relational, ethical, and narrative process. Four interconnected storylines were identified: resisting simplification, caring under untenable conditions, the consequences of caring under untenable conditions, and what remains. Collectively, these storylines illustrated how clinicians sought to preserve psychologically informed, relational approaches to care whilst negotiating organisational uncertainty, public scrutiny, competing narratives, and profound ethical responsibility. Moral distress and moral injury were understood not as isolated ethical dilemmas but as cumulative consequences of sustained attempts to provide care within conditions participants increasingly experienced as untenable. The findings also demonstrated how participants used narrative to preserve professional knowledge, reclaim accounts of their work they felt had become marginalised, and bear witness to the relational and ethical dimensions of care that they believed had become obscured within wider institutional, political, and public narratives.

This inquiry extends understandings of moral distress by locating it within wider narrative, organisational, and sociopolitical processes. It also contributes to ongoing debates surrounding gender identity healthcare by sharing how clinicians experienced public narratives, institutional responses, and wider political contexts as shaping both care and the conditions under which care became possible. More broadly, the inquiry raises important questions about how knowledge, expertise, and care are negotiated within highly contested areas of healthcare, particularly where the lives of marginalised communities become the subject of political and public debate. In doing so, it demonstrates the value of narrative inquiry for illuminating the relational, moral, and organisational dimensions of healthcare practice during periods of profound uncertainty and change.

Chapter 1: Introducing the Inquiry

1.1 Introduction

This study emerges from a moment in which stories about care, identity, responsibility, and risk have been told with unusual volume and certainty. In recent years, the Tavistock and Portman Gender Identity Development Service (GIDS), formerly the sole specialist NHS (National Health Service) for children and young people experiencing gender-related distress in England, became the focus of sustained political, media, professional, and institutional attention. What unfolded was not only a process of service review and closure, but a broader public re-narration of gender identity healthcare itself, in which complex clinical realities were increasingly condensed into simplified, morally charged, and often polarised accounts (Cass, 2024; NHS England, 2022; Noone et al., 2024).

This period was characterised not only by increased visibility but by a marked shift in the tone and intensity of public discourse surrounding trans lives and healthcare. Media coverage expanded substantially over the past decade, with analyses suggesting both a significant increase in reporting and a predominance of negative or conflict-oriented framing (Baker, 2019; Faye, 2021; Prosser, 2022; Smith et al., 2023). Questions concerning gender identity increasingly became framed through debates about risk, safeguarding, evidence, legitimacy, childhood, and social change. Whilst these debates emerged across multiple sites and moments, they often came to be experienced as a coherent narrative landscape within which particular understandings of gender identity healthcare acquired increasing public visibility and authority (Andrews et al., 2008; Noone et al., 2025; Pearce et al., 2020).

I came to this research not as a neutral observer, but as a clinician in training within the NHS, aware of how care is both practised and spoken about within institutional contexts. During the period in which GIDS was subject to escalating public commentary, I became increasingly aware of a dissonance between the narratives circulating publicly and the realities I understood of clinical work. Accounts presented with confidence in policy and media spaces often bore little resemblance to the uncertainty, relational labour, and complexity that characterise care in practice (Austin et al., 2022; Greenhalgh & Hurwitz, 1999; Montgomery, 2006). This dissonance did not resolve into a single alternative account. Instead, it opened a space of sustained curiosity. If the publicly circulating accounts of clinical work were necessarily partial, what experiences remained less visible, and under what conditions could they be told? (Frank, 2010; Riessman, 2008)

Clinicians working within GIDS became increasingly present within public discourse, although fuller accounts of their experiences remained comparatively less visible. A prominent exception was Barnes's (2023) *Time to Think*, an investigative journalistic account drawing on documentary research

and interviews with former GIDS clinicians and others connected to the service. Barnes's work makes clear that clinicians had previously contributed to dominant public accounts of GIDS, while also raising questions about how those experiences became represented. Within *Time to Think*, clinicians' testimony is selected, contextualised, and woven into a wider narrative of the service. This draws attention to an important distinction between clinicians' voices being present within an account of GIDS and their experiences providing the starting point from which that account is developed.

This distinction prompted further curiosity rather than an assumption that any one account might provide a definitive history of the service. What might become more visible when experiences are approached through an established narrative about GIDS (Barnes, 2023), and what might become harder to see? In a discourse increasingly organised around questions of risk, safeguarding, and harm, this also raises questions about how risk itself is understood, whose experiences inform its definition, and which possible harms are afforded greatest attention. Such questions do not require choosing between competing accounts of care or harm, but invite attention to experiences that may sit less easily within either (Austin et al., 2022; Beischel et al., 2022). More broadly, the prominence of particular accounts raises questions about narrative authority: how certain representations of GIDS came to acquire public attention, how they intersected with already circulating narratives about gender identity healthcare, and whose experiences or contexts became more or less visible in the process.

These questions sit within a broader recognition that experiences do not speak for themselves. Rather, people make sense of events through stories that draw upon available cultural, social, institutional, and personal resources (Andrews et al., 2008; Bruner, 1990; Riessman, 2008). Narratives do not simply reflect reality; they participate in shaping what becomes meaningful, intelligible, and worthy of attention. This applies to the present inquiry too. I do not claim neutral or unmediated access to clinicians' experiences: as a researcher, I inevitably participated in the selection, interpretation, and representation of participants' accounts. Narrative inquiry instead offered a means of beginning with clinicians' own meaning-making, attending to how they narrated care, responsibility, relationships, uncertainty, and the ending of the service before placing those accounts in dialogue with one another and with wider societal narratives.

This thesis therefore explores how clinicians who worked within GIDS make sense of their experiences during the final years of the service. Beginning with individual narrative portraits allowed participants' accounts to develop on their own terms before they were placed in dialogue with one another and with wider societal narratives. The study is interested not in establishing a singular or definitive account of what happened at GIDS, but in what might become possible to

understand when clinicians' experiences, rather than an existing account of what GIDS was or what happened there, provide the starting point for inquiry.

Before outlining the study itself, it is necessary to consider the epistemological and theoretical assumptions that inform how narrative, meaning, knowledge, and experience are understood within this thesis.

1.2 Epistemological Foundations: Narrative, Authority, and Meaning

While the public re-narration of the Gender Identity Development Service (GIDS) initially sparked my curiosity, the focus of this inquiry shifted toward the underlying processes by which specific accounts acquire legitimacy, authority, and influence. If dominant public narratives appeared partial or simplified, I became interested in the conditions that made them so persuasive. I sought to understand which voices were amplified, which remained difficult to hear, and the conditions under which certain stories come to define reality while others are marginalised.

These questions reflect the understanding that experiences do not become meaningful simply because they occur. Instead, meaning emerges through iterative processes of interpretation, communication, and narrative (Andrews et al., 2008; Bruner, 1990; Riessman, 2008). Events are encountered within social, cultural, historical, and institutional contexts and are understood through the stories available to explain them (Foucault, 1980; Hall, 1997; Haraway, 1988). From this perspective, narratives are not merely retrospective descriptions of reality: they are active processes through which people organise experience, construct coherence, negotiate uncertainty, and make sense of themselves and the worlds they inhabit (Bruner, 1990; Riessman, 2008).

Narratives also circulate beyond the individual. Stories are repeated, reinterpreted, challenged, and taken up within wider social and institutional contexts, shaping how particular events, identities, and forms of practice come to be understood (Andrews et al., 2008). In this sense, meaning is not located solely within individuals but emerges relationally through ongoing processes of telling, retelling, and interpretation. What becomes accepted as legitimate knowledge or credible experience is therefore inseparable from the social, cultural, and political conditions in which narratives circulate.

This is particularly relevant in contexts characterised by intense public scrutiny, where language does not simply reflect reality but helps to constitute it (Austin, 1962; Butler, 1997; Foucault, 1980). Through institutional endorsement and public circulation, certain accounts may acquire an appearance of inevitability or certainty. As Butler (1997) suggests, language is performative because it has the capacity to produce social realities and establish the boundaries of legitimacy. Similarly,

Foucault (1980) highlights the ways in which knowledge and power become intertwined, influencing which accounts are authorised as credible and which forms of experience remain obscured.

These concerns are salient in the realms of gender and healthcare, where dominant narratives often determine which lives are considered intelligible or worthy of protection (Ahmed, 2017; Butler, 2004; Pearce et al., 2020). Within such contexts, the ability to tell one's own story is often a contested privilege. Concepts such as epistemic injustice (Fricker, 2007) and epistemic exclusion (Dotson, 2011) draw attention to the ways in which individuals may be disadvantaged as knowers when their experiences are rendered less credible within dominant frameworks.

Consequently, this study does not assume that any single account can offer a definitive representation of events. It proceeds from the position of situated knowledges, recognising that multiple understandings coexist based on the specific histories, relationships, and locations of the narrator (Haraway, 1988). The aim is therefore to attend to how meaning has been constructed and sustained within a context where the very legitimacy of care was being publicly redefined.

1.3 Researcher Positioning

If knowledge is understood as situated and partial, then reflexivity must be approached as an ongoing ethical and methodological practice of examining how the researcher is implicated in the questions asked and the meanings constructed (Finlay, 2002; Haraway, 1988; Pillow, 2003). I do not approach this inquiry as a neutral observer, but as a clinician, a researcher, and a queer person who has worked within NHS structures for fifteen years. My professional identity has been forged within a healthcare system defined by governance, audit, and shifting performance demands through changing governments (Ballatt & Campling, 2011; Fotaki, 2015; Greenhalgh & Papoutsi, 2018). Throughout this time, I have witnessed how care is frequently required to stretch and compensate for structural absences, particularly in contexts where demand exceeds available resources (Ballatt & Campling, 2011; Featherstone et al., 2018; Tronto, 1993, 2013)

Ethical tensions are rarely encountered as exceptional events in clinical life: they are woven into the everyday realities of practice where clinicians navigate competing responsibilities, institutional controls, and the inherent uncertainty of what constitutes good care (Carel & Kidd, 2014; Fourie, 2015; Mol et al., 2010; Tronto, 1993). During the period in which the Gender Identity Development Service (GIDS) was subject to escalating scrutiny, I became aware of a profound dissonance between the narratives circulating in the public sphere and the complexities of the clinical room. While public discussions were often organised around polarised certainties and risk, they appeared to leave little space for the relational labour and ethical ambiguities that accompany clinical practice.

My positioning as a queer person provides a specific sensitising lens for this work. It does not serve as a framework for categorising experience, but as a way of listening that is attuned to how normativity operates through institutional language (Ahmed, 2017; Butler, 2004). This background fosters an awareness of how particular forms of knowledge become authorised while others are rendered suspect, and how claims of impartiality can often obscure underlying relations of power. Furthermore, an awareness of historical patterns of marginalisation shapes my interest in questions of voice and representation: whose experiences are considered, and what becomes possible when people are repeatedly spoken about rather than listened to (Dotson, 2011; Fricker, 2007).

At the same time, I recognise the limits of my perspective. I did not work within GIDS, nor was I subject to the professional risks and organisational pressures experienced by the participants. My position is therefore best understood as an adjacent witness: someone professionally and ethically invested in questions of care and responsibility while remaining outside the immediate institutional context under study (Berger, 2015; Dwyer & Buckle, 2009; Haraway, 1988). This position requires a constant attentiveness to the boundaries of my own understanding and a commitment to ensuring that the participants' accounts are not reduced to simple positions of advocacy or defence, but approached as situated, complex, and co-constructed accounts of experience (Andrews et al., 2008; Finlay, 2002; Riessman, 2008).

These experiences directly informed the development of this study. Rather than seeking to adjudicate competing public claims, I have chosen to centre the accounts of clinicians as the primary site of inquiry. By focusing on how those delivering care made sense of their responsibilities during a period of institutional threat, this thesis seeks to honour the complexity of clinical practice within a context where the meaning of that work was being publicly and politically redefined (Andrews et al., 2008; Bruner, 1990; Hall, 1997).

1.4 Reclaiming Complexity: The Rationale for Narrative Inquiry

These epistemological and positional commitments reflect a broadly social constructionist understanding of knowledge, in which experiences become meaningful through language, relationships, and wider social processes rather than existing as self-evident facts. As discussed more fully in Chapter 3, this broad perspective is developed into a moderate social constructionist epistemology situated alongside a critical realist ontology. It shaped both the questions informing this research and the nature of the knowledge it sought to generate. If professional experiences are understood as situated within wider social and institutional contexts, then understanding clinical life requires more than documenting events or establishing factual accounts; it requires attention to how people make sense of those experiences and understand themselves in relation to them.

This perspective was particularly relevant to the closure of GIDS. As public, political, and institutional attention intensified, discussions surrounding the service became increasingly organised around questions of risk, protection, and harm. Contemporary media environments and policy processes do not simply transmit information; they shape which forms of knowledge become visible and persuasive (Couldry, 2012; Hall, 1997). Narratives that are coherent and emotionally resonant often circulate more readily than those characterised by ambiguity, uncertainty, or contradiction, privileging some understandings while obscuring others.

This observation is salient within healthcare, where professional practice frequently involves navigating uncertainty rather than resolving it. Clinical work unfolds through competing responsibilities, evolving understandings, and decisions whose consequences may remain unknown (Ballatt & Campling, 2011; Greenhalgh & Hurwitz, 1999; Montgomery, 2006; Ruch et al., 2018). Such experiences are difficult to represent within public narratives that favour clarity and decisive action. The challenge is not simply that some narratives become dominant, but that the very conditions of circulation privilege specific forms of understanding while marginalising the nuanced realities of practice (Andrews et al., 2008; Couldry, 2012; Hall, 1997).

Narrative inquiry offered a methodology uniquely suited to these concerns. It begins from the premise that people organise experience across time and relationship in ways that allow coherence to emerge from complexity (Andrews et al., 2008; Bruner, 1990; Clandinin & Connelly, 2000). Rather than seeking to determine which account of events is most accurate, this approach attends to how experiences were understood, narrated, and incorporated into ongoing professional identities. This orientation reflects an ethical commitment to taking participants' accounts seriously as forms of situated knowledge (Haraway, 1988). Narrative inquiry provided a way of engaging with the "comparatively absent" accounts of clinicians while resisting the temptation to reduce them to fixed categories or predetermined conclusions.

The study therefore approaches participants' accounts of their professional experiences not as objective representations of reality, but as situated acts of meaning-making through which identities and responsibilities are negotiated (Andrews, 2007; Andrews et al., 2008; Clandinin & Connelly, 2000; Riessman, 2008). These accounts are shaped both by lived experience and by the broader cultural and institutional worlds through which that experience becomes meaningful (Andrews, 2007; Andrews et al., 2008; Bruner, 1990; Frank, 2010). From this perspective emerged the central questions guiding this inquiry: how clinicians understood care, responsibility, and professional identity within a field and service marked by existential threat.

1.5 Politics of Naming: Language, Meaning, and Terminology.

The words available to individuals and communities fundamentally influence what can be recognised, articulated, and responded to within social and institutional worlds (Butler, 2004). Within the fields of gender identity and professional practice, terminology is rarely fixed or universally agreed: instead, it continues to evolve across diverse communities, disciplines, and social contexts (Andrews et al., 2008; Butler, 2004; Hall, 1997).

Language functions as more than a means of description. It is a mechanism through which understandings of some Ibodies, identities, and experiences become authorised while others are marginalised (Butler, 2004; Foucault, 1978; Fricker, 2007). Historically, the power to define and categorise has been unevenly distributed, with the experiences of LGBTQ+ communities often interpreted through frameworks developed outside of those communities (Butler, 2004; Fricker, 2007; hooks, 1984). Within this thesis, stories and images circulating around particular identities are understood as socially mediated imaginaries. Drawing on Butler's concept of the phantasmatic, these constructions often function as powerful organising frameworks that shape what becomes recognised as credible or threatening, long before a clinical encounter occurs (Butler, 2004, 2024; Riessman, 2008).

This thesis draws on terminology from gender identity healthcare, clinical practice, narrative theory, and moral philosophy. As readers may come from diverse professional and disciplinary backgrounds, the following working definitions are provided to support clarity and consistency throughout the thesis. These definitions are not presented as fixed or universal; rather, they reflect contemporary community, clinical, and theoretical understandings while recognising that language and its meanings continue to evolve.

As a cisgender male researcher, I do not claim the authority to define the identities of trans, non-binary, or gender-diverse people. More broadly, I do not assume that any researcher holds the authority to define another person's identity. Instead, the terminology adopted here is informed by contemporary community and clinical usage at the time of writing, while recognising that no set of terms can fully capture the complexity of lived experience. Consistent with the principle of situated knowledges, meaning is understood as relational and contextual (Haraway, 1988). The definitions therefore reflect a commitment to epistemic humility by remaining attentive to whose knowledge is recognised and legitimised within research and practice (Dotson, 2011; Fricker, 2007).

Table 1.1: Working definitions of key terms used throughout this thesis

Category	Term	Working terminology	Key source(s)
Gender and identity	**Gender identity**	An individual's internal sense of their gender, which may align with, differ from, or exist outside the sex assigned to them at birth.	American Psychological Association (2021b); Coleman et al. (2022)
	Sex assigned at birth	The classification (typically female or male) recorded at birth based primarily on observed physical sex characteristics. This designation should not be understood as equivalent to gender identity.	American Psychological Association (2021b); Coleman et al. (2022); GIRES (n.d.)
	AFAB / AMAB	Assigned Female at Birth (AFAB) and Assigned Male at Birth (AMAB) refer to a person's recorded sex assignment at birth. These terms describe assignment rather than identity.	American Psychological Association (2021b); GIRES (n.d.)
	Cisgender	Describes individuals whose gender identity aligns with the sex they were assigned at birth.	Coleman et al. (2022); Stonewall (2022)
	Trans / Transgender	An umbrella term describing individuals whose gender identity differs from the sex assigned to them at birth.	Coleman et al. (2022); Stonewall (2022)
	Non-binary	An umbrella term for identities that do not fit exclusively within the categories of woman or man, including identities such as gender-fluid and agender.	Coleman et al. (2022); Stonewall (2022)

	Gender diverse	A broad inclusive term referring to people whose gender identities or expressions differ from dominant cisnormative expectations.	Coleman et al. (2022); Stonewall (2022)
	TNB	Shorthand used throughout this thesis to refer collectively to trans and non-binary people and communities.	Defined for this inquiry.
Clinical and healthcare	**Gender incongruence**	A marked and persistent incongruence between a person's experienced gender and assigned sex. Unlike gender dysphoria, it does not necessarily imply distress.	World Health Organization (2019); Coleman et al. (2022)
	Gender dysphoria	Clinically significant distress associated with an incongruence between experienced gender and assigned sex. Distress, rather than identity itself, is the focus of the diagnosis.	American Psychiatric Association (2022)
	Gender-affirming care	Social, psychological, legal, and medical interventions that support individuals in living congruently with their gender identity. Care is not limited to medical intervention and may include psychosocial and family-based support.	Coleman et al. (2022)
	Transition	The highly individual process through which a person comes to live more congruently with their gender identity. Transition is not assumed to be linear or to involve every domain described below.	Coleman et al. (2022)

	Social transition	Changes such as name, pronouns, clothing, appearance, or social role.	Coleman et al. (2022)
	Psychological transition	Changes in self-understanding, embodiment, and identity development.	Coleman et al. (2022)
	Relational transition	Changes in how an individual is recognised within families, friendships, schools, workplaces, and wider social relationships.	Coleman et al. (2022)
	Legal transition	Changes to identity documents or legal recognition of gender.	Coleman et al. (2022)
	Medical transition	Clinical interventions such as puberty suppression, hormone therapy, or surgery where clinically appropriate and desired.	Coleman et al. (2022)
Service, research and conceptual terminology	**Gender Identity Development Service (GIDS)**	The national NHS specialist service for children and young people in England during the period relevant to this research.	Cass (2024); NHS England (2022)
	Children, Young People and Families (CYPF)	Collective term used throughout this thesis to refer to services involving children, young people, parents, carers, and wider family systems.	Defined for this inquiry
	Clinician	Throughout this thesis, *clinician* refers collectively to the healthcare professionals who participated in this study. Participants represented multiple professional disciplines, and the term is used for brevity rather than to imply professional homogeneity.	Defined for this inquiry

	Professional identity	An individual's evolving understanding of themselves as a professional, shaped through practice, relationships, organisational contexts, and ethical commitments.	Pratt et al. (2006); Trede et al. (2012)
	Care	The relational, ethical, and emotional labour involved in responding to the needs of others within complex institutional systems.	Puig de la Bellacasa (2017); Tronto (1993)
	Trauma-informed practice	An approach recognising the impact of adversity, trauma, and power on engagement with services, prioritising safety, trust, collaboration, and empowerment.	SAMHSA (2014)
	Phantasmatic construction or **Phantasm**	Socially and culturally mediated narratives and imaginaries through which people, identities, and practices become understood prior to direct experience, shaping fears, hopes, and interpretations.	Butler (1993, 2004, 2024)
Moral experience	**Moral distress**	Distress arising when professionals recognise an ethically appropriate course of action but encounter barriers that prevent them from acting accordingly.	Fourie (2015); Jameton (1984)
	Moral injury	More enduring psychological, relational, or existential impacts associated with experiences that transgress deeply held moral beliefs or expectations.	Williamson et al. (2021)

1.6 Understanding the Gender Identity Development Service

Established at the Tavistock and Portman NHS Foundation Trust in 1989, the Gender Identity Development Service (GIDS) was, for over three decades, England's sole national specialist NHS service for children and young people exploring or experiencing questions about their gender identity. As a national service, GIDS received referrals from across England and worked collaboratively with young people, families, and local professional networks.

While public discussions frequently focused on medical interventions, the service itself was built upon a comprehensive, multidisciplinary, and holistic model of care. Clinical teams were composed of professionals from a wide array of backgrounds, including endocrinology, family therapy, nursing, paediatrics, psychiatry, psychology, psychotherapy, and social work (Carmichael et al., 2021; Cass, 2024; NHS England, 2022). This diverse staffing supported a clinical approach informed by developmental, relational, and systemic perspectives, which necessitated active engagement with parents, schools, and local services alongside direct work with the young person (Carmichael et al., 2021; NHS England, 2022; Noone et al., 2024; Pearce et al., 2021),.

The service prioritised understanding a young person's experience within the broader context of their life. Clinical assessment and intervention typically involved a sustained consideration of emotional wellbeing, identity development, and family dynamics (Carmichael et al., 2021; Pearce et al., 2021). Formulations were developed through iterative reflection and multidisciplinary consultation, ensuring that gender identity was never viewed in isolation from wider developmental and social influences (Carmichael et al., 2021; NHS England, 2022; Noone et al., 2024).

For some individuals, care pathways included referral to specialised endocrine services: however, medical intervention represented only one component of a much broader psychosocial framework (Carmichael et al., 2021; Cass, 2024; Pearce et al., 2021). Clinical decision-making was characterised by extended periods of assessment and formulation, reflecting the intricate responsibility of supporting young people whose needs often resisted straightforward solutions. Consequently, the work within GIDS involved navigating developmental, ethical, and organisational considerations that were frequently as complex as they were contested,.

Understanding this institutional architecture is essential, as it provides the material context for the professional experiences explored in this inquiry. During the final years of its operation, the service became the site of unprecedented public, legal, and political attention, leading to a period of intense inspection and eventual closure. The major legal and policy developments of this period, which profoundly shaped the professional environment for clinicians, are summarised in the timeline below:

Table 1.2: Timeline of major legal, organisational, and policy developments affecting the Gender Identity Development Service, 2020–2024 (Author's own).

Date	Event	Significance
2009–2020	Sustained increase in referrals to GIDS.	Referral numbers increased substantially over the decade, becoming a key driver of concerns regarding service capacity, waiting times, and future service provision.
September 2020	Independent Review of Gender Identity Services for Children and Young People (Cass Review), Hillary Cass commissioned by NHS England.	Commissioned in response to increasing referral numbers and wider questions regarding service provision.
December 2020	Kiera Bell v Tavistock High Court judgment.	The Court ruled that it was unlikely that children under 16 could provide informed consent to puberty blocker treatment, resulting in temporary changes to prescribing practice.
January 2021	Care Quality Commission (CQC) inspection report published.	GIDS received an overall rating of "Inadequate". Concerns related primarily to waiting lists, risk management, record keeping, variation in clinical practice, and organisational leadership. The Caring domain was rated "Good".
February 2021	NHS service transformation programme commenced.	A national improvement programme was established to address issues identified by the CQC and support service redevelopment.
Summer 2021	Meetings between Health Secretary Sajid Javid, Dr Hilary Cass, and NHS England.	Discussions took place regarding the future configuration of gender identity services for children and young people.
September 2021	Bell v Tavistock appeal judgment.	The Court of Appeal overturned the earlier ruling, returning responsibility for assessing competence to consent to treating clinicians.
Summer 2022	Closure of GIDS announced by NHS England.	Plans were announced to replace the national service with a network of regional centres.
September 2023	Follow-up CQC inspection undertaken.	Inspection findings indicated progress against many previously identified concerns, although the service remained scheduled for closure.
March 2024	GIDS formally closed.	The national Gender Identity Development Service ceased operation after 35 years.

April 2024	Final Cass Review published.	Recommendations included service restructuring, changes to care pathways, and further development of regional services.
2024 onwards	Implementation of new service model.	Regional services were introduced alongside significant changes to the provision of gender identity healthcare for children and young people in England.

1.6.1 Increased Visibility, Demand, and Complexity

During the final decade of GIDS, referral numbers increased substantially. NHS England data indicate a marked rise in the number of children and young people referred to specialist gender identity services, resulting in growing waiting lists and increasing demand upon the service (Cass, 2024; NHS England, 2022). This growth formed an important backdrop to many of the developments that followed, including the commissioning of the Cass Review and subsequent discussions regarding future service provision.

The drivers of this increase have become the subject of extensive academic, clinical, political, and public debate. Explanations emphasising changes in social conditions point to increased visibility of transgender and gender-diverse identities, greater awareness of specialist services, reduced stigma, evolving understandings of gender, and the role of digital communities in facilitating identity exploration and access to support (Cass, 2024; Pearce et al., 2021). Competing accounts have proposed explanations centred on social contagion, peer influence, diagnostic expansion, or iatrogenic effects associated with gender-affirming care (Cass, 2024; Littman, 2018). These competing accounts reflect not only empirical uncertainty, but also fundamentally different assumptions about gender identity, adolescent development, and the kinds of evidence afforded epistemic authority within healthcare. Consequently, the debate has often extended beyond scientific disagreement into highly polarised public, political, and clinical discourse, with significant implications for transgender and gender-diverse people, their families, and the professionals working alongside them. Within the current academic and clinical literature, no single explanation is accepted as sufficient to account for these complex developments (Ashley, 2020; Cass, 2024; Temple Newhook et al., 2018; WPATH, 2022).

Questions involving identity development, social change, healthcare accessibility, and adolescent maturation intersect in ways that resist reductive interpretation (Erikson, 1968; Hall, 1997; Pearce et al., 2020). Consistent with broader understandings of child and adolescent mental health, attempts to identify a single causal explanation risk oversimplifying experiences that are inherently relational,

developmental, and situated within wider social contexts (Bronfenbrenner, 1979; Lerner et al., 2015; Viner et al., 2012). Contemporary approaches to gender identity care have therefore shifted away from seeking definitive explanations and towards creating psychologically safe spaces in which identity, distress, and uncertainty can be explored collaboratively over time (Carmichael et al., 2021; Riggs et al., 2023; WPATH, 2022). Such work is necessarily relational and longitudinal, recognising that self-understanding may evolve as identities, relationships, and developmental circumstances change. Rather than resolving complexity prematurely, the clinician's role becomes one of supporting exploration whilst tolerating uncertainty (Andrews et al., 2008; Bruner, 1990; Butler, 2004).

For the clinicians at GIDS, these developments held significance far beyond referral statistics. The surge in demand necessitated navigating prolonged waiting lists while managing heightened public scrutiny, patient safety and escalating organisational pressures (Cass, 2024; NHS England, 2022; Noone et al., 2024). As referral numbers climbed, the professional, institutional, and societal contexts of care became increasingly multifaceted (Cass, 2024; Noone et al., 2024). This environment is essential for understanding the professional experiences explored in this study and the broader controversies that have come to define gender identity healthcare for children and young people.

1.6.2 Public Narratives and Gender Identity Healthcare

In recent years, discussions concerning gender diversity, healthcare, childhood, and safeguarding have extended well beyond clinical settings to become embedded within broader cultural and political debates (Butler, 2024; Noone et al., 2024; Pearce et al., 2020). Questions of gender identity came to be framed not only as matters of healthcare, but also as issues of evidence, risk, rights, protection, ideology, and social change (Butler, 2024; Cass, 2024; Noone et al., 2024).

These wider debates formed an important part of the context in which GIDS clinicians were working. Contemporary media environments and policy processes do not simply transmit information; they shape which forms of knowledge become publicly visible and persuasive (Couldry, 2012). As Hall (1997) argues, meaning is produced through systems of representation rather than simply reflecting an objective reality. During the period relevant to this thesis, UK media coverage of trans people increased substantially and was frequently characterised by hostile or negative framing (Baker, 2019; Faye, 2021; Prosser, 2022). Although the relationship between media representation, political discourse, and public attitudes remains complex, surveys suggested declining public support for some aspects of trans rights and gender-affirming healthcare during the same period (Smith, 2022). Collectively, these developments shaped the wider social, political, and institutional environment in which GIDS clinicians practised.

Public debates concerning GIDS frequently became organised around narratives of risk and protection. These included claims regarding the rapid increase in referrals, social contagion, rapid-onset gender dysphoria (ROGD), the safety of puberty blockers, and concerns regarding detransition; whilst such claims received considerable public attention, many remained contested within academic and clinical literature (Ashley, 2020; Littman, 2018; Noone et al., 2024; Restar, 2020). Within some critical accounts, these concerns were framed as a response to what was perceived to be an overly affirmative or insufficiently exploratory approach to gender-related distress, with greater caution and exploration positioned as necessary to protect young people from premature or inappropriate intervention (Barnes, 2023; Cass, 2022). Such concerns therefore also invoked complexity and clinical curiosity as important features of good care.

Yet the distinction between affirmation and exploration is itself contested. Affirmation need not imply certainty about a young person's identity or the direction their care should take, just as exploration is not necessarily neutral in its assumptions or effects. GIDS was also criticised from a different direction for being overly cautious and requiring prolonged exploration and waiting (Osserman & Wallerstein, 2022), suggesting that positioning affirmation and exploration as opposing approaches risks reproducing another binary. Young people were often positioned as the subjects of these debates, while their own experiences and perspectives remained less visible within public discussion and policy processes (Noone et al., 2024).

These differing constructions of care and risk draw considerable moral force from culturally entrenched ideas regarding childhood innocence, vulnerability, and safeguarding (James et al., 1998; Prout & James, 2015). While the desire to protect children is a near-universal commitment with deep ethical grounding, such language can also function as a potent rhetorical tool to foreclose further questioning or nuance. Where a particular stance becomes positioned as the necessary means of protecting children, an implicit binary can emerge in which alternative approaches become associated with a failure of protection or a source of harm (Butler, 1997). Such dynamics need not be confined to one position within debates surrounding GIDS; different narratives located risk, certainty, and potential harm in different places.

In these contexts, narrative authority is often secured by those whose social positioning affords them institutional visibility or whose accounts are most frequently repeated (Austin, 1962; Foucault, 1980; Hall, 1997). This authority is neither socially nor historically neutral. Feminist and intersectional scholarship has traced how appeals to protection and vulnerability have been shaped by racialised and gendered relations of power, including the particular authority historically afforded to white women's claims to vulnerability and protection (Ahmed, 2017; hooks, 1984, 1990; Weeks, 1981).

Such processes can contribute to epistemic exclusion, where experiences outside dominant frameworks become less readily heard or recognised (Dotson, 2011; Fricker, 2007). As discussed earlier, the controversies surrounding GIDS can also be understood through broader phantasmatic constructions, in which social anxieties and hopes become attached to particular bodies and institutions (Butler, 1993, 2004, 2024). What becomes consequential, then, is not only whether harm is invoked, but how harm and protection become defined, which possibilities become most readily intelligible as risks, and who is authorised to make those judgements.

Political actors also contributed to these processes. Public statements by ministers and parliamentarians frequently framed developments in gender identity policy through narratives of protection, safeguarding, truth, ideology, and risk. For example, public statements by former Equalities Minister Kemi Badenoch explicitly linked the commissioning and implementation of the Cass Review to the influence of "gender-critical" voices within government and framed opposition to what she termed "gender ideology" as an effort to protect children from harm (Badenoch, 2024). Similar themes can be identified across wider political and media discourse during this period, where questions of gender identity became increasingly entwined with broader debates concerning social values, public institutions, rights, and national identity (Butler, 2024; Kuhar & Paternotte, 2017). For clinicians working within GIDS, these debates were not external to practice. They formed part of the wider professional, ethical, and organisational context within which care was delivered. Understanding this context is important because participants' narratives were produced within a period in which gender identity healthcare had become publicly visible, politically charged, and morally contested (Andrews et al., 2008; Riessman, 2008).

1.7 Potential of Moral Distress and Moral Injury

What drew my attention during this inquiry was not the inherent complexity of clinical work, but the extent to which the meaning of care itself became publicly constructed through competing political, institutional, and media narratives (Butler, 2024; Couldry, 2012; Hall, 1997). During the final years of GIDS, these narratives increasingly developed beyond the therapeutic encounter, often privileging ideological, political, or experiential claims over the situated knowledge of those directly involved in care (Dotson, 2011; Fricker, 2007; Haraway, 1988). In doing so, they did not merely describe clinical practice; they became institutionally consequential, shaping organisational responses, policy decisions, and the everyday realities of clinical work (Cass, 2024; Pearce et al., 2021).

Through previous clinical work and training, I had encountered literature exploring moral experience: the ways professionals understand, negotiate, and live through situations they perceive to carry ethical significance (Hunt & Carnevale, 2011). Within this broader literature, the concepts of moral

distress and moral injury have been developed to understand experiences arising when professionals perceive themselves to be constrained from acting in accordance with their ethical commitments, or experience more enduring psychological, relational, or existential consequences as a result (Fourie, 2015; Jameton, 1984; Rushton, 2018; Williamson et al., 2021). The final years of GIDS brought questions of moral experience into focus. Clinicians continued to hold responsibilities towards young people and families while working amid organisational uncertainty, public scrutiny, and competing understandings of care, risk, and protection (Cass, 2024; NHS England, 2022; Noone et al., 2024). Focusing on clinicians offered a way of exploring how ethical commitments were understood and negotiated as the organisational and sociopolitical conditions surrounding care were changing. Moral distress and moral injury provided sensitising concepts for approaching these experiences, while leaving open whether either would adequately capture how clinicians understood them. It also remained unclear how these concepts had been understood and applied within literature concerning professionals working with children, young people, and families specifically. The conceptual development and application of these concepts, and the rationale for the scoping review, are explored in greater depth in Chapter 2.

Against this backdrop, I found myself returning to a series of questions. How were clinicians understanding and negotiating these experiences while continuing to provide care to young people and families? How did they respond when systems, policies, or expectations changed around them, sometimes in ways that altered the care they were able to provide? I sought to understand what happened when clinicians experienced tensions between their professional values, organisational expectations, and perceived responsibilities; what enabled them to remain engaged in the work; and how these experiences shaped their professional identity and wellbeing (Monrouxe et al., 2015; Rushton, 2018). These concerns informed the overarching research aim and guiding research questions.

Research Aim

To explore the lived experiences of clinicians delivering care during the decommissioning and closure of the Gender Identity Development Service (GIDS), with particular attention to how they understood, negotiated, and made sense of providing care within a rapidly changing organisational, political, and sociocultural context.

Guiding Research Questions

This narrative inquiry was guided by the following questions:

1. How did clinicians experience delivering care during the decommissioning and closure of GIDS?
2. How did clinicians understand and negotiate the organisational, political, and ethical challenges that arose whilst continuing to care for young people and their families?
3. How did participants describe the impact of these experiences on their professional identities, wellbeing, and sense of ethical responsibility?
4. How were experiences of moral distress, moral injury, and related moral tensions narrated and understood within the broader context of care?
5. What broader narratives about healthcare, institutions, and care emerged across participants' accounts, and what might these illuminate about working within services experiencing profound organisational and sociopolitical change?

The questions emerging from GIDS also prompted me to consider whether these experiences were unique to that particular service or reflected wider features of work with children, young people, and families. Such work frequently involves navigating developmental uncertainty, safeguarding responsibilities, family systems, competing perspectives, and decisions whose consequences may unfold over extended periods of time (Bowlby, 1988; Bronfenbrenner, 1979; Ruch et al., 2018). Professionals are often required to balance multiple, and sometimes competing, responsibilities while working within organisational demands, legal frameworks, resource limitations, and differing understandings of care, risk, and best interests (Munro, 2011; Ruch et al., 2018). Before examining clinicians' experiences within GIDS directly, I first sought to understand how moral experience, moral distress, moral injury, and related concepts had been conceptualised across CYPF services more broadly. The following scoping review was undertaken as an initial step towards addressing these questions.

Chapter 2: Mapping Moral Experience: A Scoping Review of CYPF Services

2.1 Introduction and Rationale

Moral distress and moral injury have received considerable attention within healthcare literature as frameworks for understanding the ethical challenges that arise when professionals experience tensions between their responsibilities, values, and capacity to act (Campbell et al., 2018; Fourie, 2015; Morley et al., 2019). While moral distress is commonly associated with perceived constraints on acting in accordance with one's ethical judgement, moral injury has been used to describe the more enduring psychological, relational, or existential consequences that may follow such experiences (Jameton, 1984; Rushton, 2018; Williamson et al., 2021). Existing reviews have examined these concepts across healthcare settings, highlighting both their clinical relevance and continuing conceptual ambiguity (Čartolovni et al., 2021; Morley et al., 2019). However, no synthesis has specifically examined how moral distress, moral injury, and related moral experiences have been conceptualised within literature concerning professionals working with children, young people, and families.

Professionals working with children, young people, and families frequently navigate developmental uncertainty, safeguarding responsibilities, family systems, organisational demands, and competing understandings of care, risk, and best interests. These features of practice suggest that moral experience may take distinctive forms within CYPF services that are not fully reflected in broader healthcare literature. This scoping review was therefore undertaken to map how moral distress, moral injury, and related moral experiences have been conceptualised within the CYPF literature, establishing the conceptual foundation for the narrative inquiry presented in the subsequent chapters.

2.2 Review Aim and Objectives

The aim of this scoping review was to map how moral distress, moral injury, and related moral experiences have been conceptualised, described, and understood within literature concerning professionals working in child, young person, and family-facing services.

Specifically, the review sought to:

- Examine how these concepts have been defined within the CYPF literature.
- Identify the forms of ethical tension and moral challenge described across diverse CYPF contexts.
- Explore the professional and practice settings in which these experiences have been reported.

- Examine the reported consequences for professional identity and wellbeing.
- Consider whether work with children and families gives rise to morally distinctive experiences when compared with broader healthcare literature.

2.3 Method

2.3.1 Design

This study utilised a scoping review methodology to map the extent, range, and character of literature concerning moral distress, moral injury, and the broader concept of moral experience among professionals working within child, young person, and family (CYPF) services. Given the conceptual ambiguity surrounding these constructs, the absence of agreed definitions, and the methodological diversity of the evidence base, the purpose of the review was not to evaluate intervention effectiveness or the quality of evidence, but to examine how these concepts had been defined, applied, and understood across CYPF research. A scoping review was therefore considered the most appropriate methodology, enabling the systematic exploration of heterogeneous evidence, clarification of key concepts, and identification of gaps within an emerging field (Arksey & O'Malley, 2005; Peters et al., 2020).

The review followed the five-stage methodological framework proposed by Arksey and O'Malley (2005), with refinements informed by subsequent best-practice guidance (Levac et al., 2010; Peters et al., 2020; Pollock et al., 2023; Tricco et al., 2018). The process comprised identifying the research question, locating relevant studies, selecting eligible articles, charting the data, and collating and synthesising the findings. Consistent with scoping review methodology, the process remained iterative throughout, allowing the search strategy and eligibility criteria to be refined as familiarity with the evidence base developed (Arksey & O'Malley, 2005; Levac et al., 2010).

2.3.2 Eligibility Criteria

Eligibility criteria were developed using the Population, Concept, Context (PCC) framework to ensure the review remained focused yet inclusive of the varied ways in which moral experiences are represented in CYPF literature (Peters et al., 2020). The population of interest comprised professionals within CYPF services, while the concepts explored included moral distress, moral injury, and related moral experiences such as ethical tension, moral conflict, and moral residue. The context was defined broadly to encompass healthcare, mental health, social care, and safeguarding settings. To support conceptual clarity, the criteria excluded studies focused on technology-driven ethical contexts, such as artificial intelligence or organ transplantation, and was restricted to publications from 2020 onwards to reflect the recent rapid evolution of these concepts.

The geographical scope was restricted to the United Kingdom and United States to provide a manageable and contextually relevant evidence base. The UK provided direct relevance to the professional and service context of the wider programme of research, while inclusion of the US broadened the evidence base to a substantial body of Anglophone literature in which moral distress and related concepts have been developed and applied across health and care settings. Together, these parameters enabled sufficient breadth to explore the review questions while maintaining a clearly bounded scope.

Table 2.1: Inclusion and exclusion criteria

Inclusion criteria	**Exclusion criteria**
Studies published in English	Studies published in languages other than English
Studies published between January 2020 and June 2026	Studies published before 2020
Studies involving professionals working with children, young people, and/or families within healthcare, mental health, social care, safeguarding, or related CYPF services	Studies focused exclusively on adult populations
Studies exploring moral distress, moral injury, ethical tension, moral conflict, moral uncertainty, moral dilemma, moral residue, or related moral experiences	Studies not focused on moral distress, moral injury, or related moral experiences
Studies situated within child-, young person-, and family-facing contexts (e.g., paediatrics, CAMHS, social care, safeguarding, child protection, refugee and family services)	Studies not situated within CYPF contexts
Qualitative studies, mixed-methods studies, conceptual papers, ethics-focused publications, educational papers, reflective papers, intervention-development studies, and relevant grey literature	Quantitative psychometric, scale validation, measurement, or prevalence-only studies
Publications providing substantive discussion or exploration of professional moral experiences, ethical tensions, or moral challenges	Intervention-focused studies without substantive discussion of moral experiences
Studies conducted within the United Kingdom or United States	Studies conducted outside the United Kingdom or United States
Studies examining professional experiences or perspectives	Patient-only studies without exploration of professional perspectives

Peer-reviewed and grey literature sources contributing substantively to conceptual or empirical understanding of moral experiences	Review articles, meta-analyses, conference abstracts, and opinion pieces lacking substantive conceptual or experiential content
Studies examining moral experiences within relational CYPF practice contexts	Studies focused primarily on transplantation, organ donation, genomics, artificial intelligence, digital systems, or other technology-driven ethical contexts

2.3.3 Search Strategy

A systematic search was conducted across PsycINFO, PubMed, Scopus, and ProQuest Dissertations & Theses. These databases were selected to capture an interdisciplinary evidence base spanning psychology, mental health, healthcare, and social care, while also providing access to relevant grey literature. Search terms were developed using the PCC framework and combined keywords relating to moral distress, professional roles, and CYPF contexts. Given the conceptual diversity of the field, the search strategy was intentionally broad, incorporating related constructs such as moral dilemma and ethical uncertainty where appropriate. The full search strategy and search terms are provided in Appendix A. The electronic database search was supplemented by backward citation searching of included studies, resulting in the inclusion of three additional publications.

2.3.4 Iterative Refinement

The eligibility criteria were refined iteratively during screening to improve the operationalisation of the predefined Population, Concept, and Context (PCC) framework as familiarity with the literature developed. These refinements did not alter the research question or the underlying PCC criteria but strengthened conceptual clarity regarding the moral experiences relevant to CYPF practice (Arksey & O'Malley, 2005; Levac et al., 2010; Peters et al., 2020). Initial screening identified considerable variation in terminology, with relevant studies frequently describing *moral conflict*, *moral uncertainty*, or *moral residue* alongside *moral distress* and *moral injury* (Campbell et al., 2018; Fourie, 2015; Morley et al., 2019; Rushton, 2018). Restricting eligibility to studies using the latter terms alone risked excluding substantively relevant literature. The eligibility criteria were therefore refined to include related constructs where they contributed meaningfully to understanding the moral dimensions of professional practice within CYPF services.

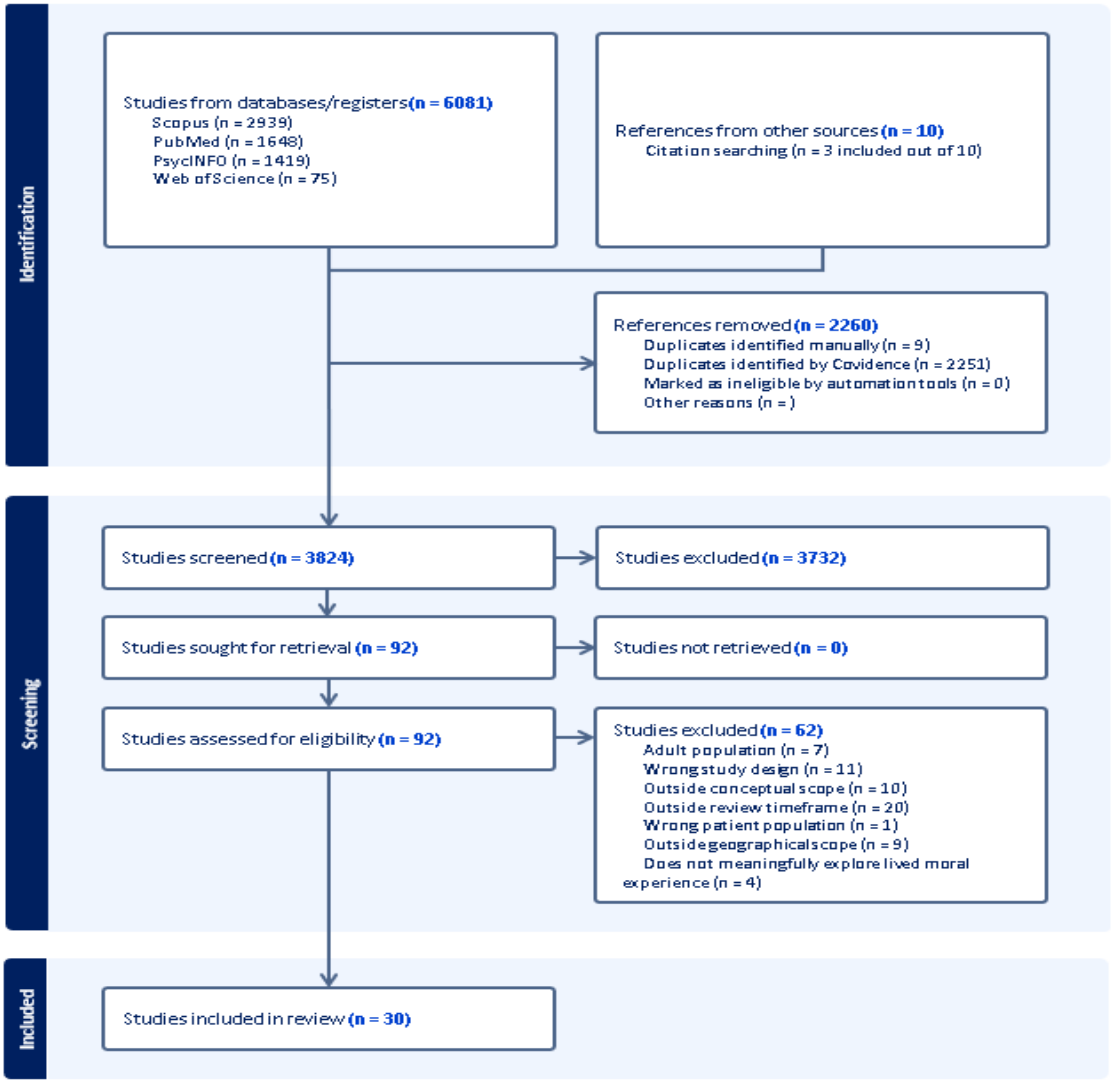
Furthermore, the review parameters were narrowed to exclude studies focused primarily on specialised procedural or technological challenges, such as organ transplantation, genomics, or artificial intelligence. While such studies often discussed ethical conflict, they were predominantly concerned with technical dilemmas rather than the relational, developmental, and safeguarding-

oriented practice that defines the scope of this inquiry. Finally, the review timeframe was refined to include studies published from 2020 onwards. This decision reflects the rapid conceptual evolution of *moral injury* following its application beyond military contexts and the substantial expansion of scholarship concerning healthcare ethics during and following the COVID-19 pandemic (Čartolovni et al., 2021; Williamson et al., 2021). Earlier foundational literature continued to inform the conceptual framing of the review but was excluded from the final synthesis to ensure a focus on the most contemporary developments in the field.

2.3.5 Study Selection

All identified records were managed using Covidence systematic review software, where duplicates were removed prior to the commencement of screening (Covidence, 2024; Tricco et al., 2018). Study selection was conducted in two stages: title and abstract screening followed by full-text assessment. All articles meeting the eligibility criteria for full-text review were successfully retrieved. To enhance methodological rigour, a second reviewer independently screened 10% of the identified records, with any discrepancies resolved through discussion and consensus. The study selection process, including the number of records identified, screened, excluded, and included at each stage, is presented in the PRISMA-ScR flow diagram (Figure 1) in accordance with PRISMA-ScR guidance (Tricco et al., 2018).

Figure 1: Prisma Diagram



2.3.6 Data Charting and Synthesis

A standardised data charting form was developed from the review aims, research question, and predefined Population, Concept, and Context (PCC) framework to support the consistent and transparent extraction of information across the heterogeneous evidence base (Arksey & O'Malley, 2005; Peters et al., 2020). Extracted data included author, year, country, study design, methodological approach, clinical or service context, conceptualisation of moral distress or related moral experiences, reported sources of moral distress or ethical tension, reported consequences, key findings, and primary contributions or implications relevant to the review aims. Consistent with scoping review methodology, the charting framework was refined iteratively as familiarity with the literature developed, enabling additional conceptual detail to be captured while remaining aligned with the review question and PCC framework (Levac et al., 2010; Peters et al., 2020).

The extracted data were synthesised using descriptive numerical analysis and qualitative content analysis. Descriptive summaries were used to map study characteristics, including country, study design, and clinical or practice context, while qualitative content analysis examined how *moral distress*, *moral injury*, and related *moral experiences* were conceptualised, described, and represented across the literature. Consistent with scoping review methodology, the purpose was not to generate a formal thematic synthesis or evaluate intervention effectiveness, but to provide a structured mapping of concepts, experiences, and ethical tensions reported across the evidence base (Pollock et al., 2023).

Concepts, practice contexts, reported sources, and reported consequences were subsequently compared across studies and organised into descriptive categories. Frequency counts were used to indicate the number of studies contributing to each category. This process produced four overarching areas for reporting: conceptualisations of *moral distress*, *moral injury*, and related *moral experiences*; clinical and practice contexts; reported sources of moral distress and ethical tension; and reported consequences.

2.3.7 Quality Appraisal

Formal critical appraisal is not typically required in scoping reviews, as the primary aim is to map the extent and nature of the literature rather than evaluate the quality of evidence (Arksey & O'Malley, 2005; Peters et al., 2020). However, critical appraisal was undertaken as part of this doctoral thesis to support critical engagement with the strengths, limitations, and credibility of the included evidence base.

The Critical Appraisal Skills Programme (CASP) qualitative checklist was selected as the most appropriate appraisal framework (CASP, 2018). Alternative appraisal tools, including the Mixed Methods Appraisal Tool (MMAT) and Joanna Briggs Institute (JBI) critical appraisal checklists, were considered. However, because the review incorporated qualitative studies, mixed-methods studies, conceptual papers, ethics-focused publications, educational papers, and reflective sources, applying multiple study-specific appraisal tools would have introduced unnecessary methodological complexity. CASP provided a flexible and consistent framework through which the methodological quality and credibility of this heterogeneous literature could be considered in relation to the exploratory aims of the review.

Appraisal was not used to generate numerical quality scores or determine study inclusion. Instead, it informed critical reflection on the methodological strengths, limitations, and credibility of the included literature. For conceptual, theoretical, ethics-focused, or reflective publications, CASP domains were interpreted cautiously in relation to the nature and purpose of each source. The

appraisal findings were therefore used descriptively to characterise the evidence base and support critical interpretation of the review findings.

2.3.8 Ethical Considerations

Ethical approval was not required for this scoping review because it involved synthesis and analysis of publicly available literature and did not involve collection of primary data from human participants.

2.4 Results

A total of 6,081 records were identified through database searching. Following removal of 2,260 duplicates, 3,824 records underwent title and abstract screening, with 3,732 records excluded. Full-text assessment was conducted for 89 articles, resulting in the exclusion of 62 studies for reasons outlined in Figure 1. Thirty studies met the inclusion criteria and were included in the final review.

The results are presented descriptively, consistent with scoping review methodology. Findings map the characteristics of the included studies, the concepts used to describe moral experiences, the reported sources of moral distress and related moral experiences, the clinical and practice contexts in which these were described, and the reported consequences for professionals. The purpose of this synthesis is to map and describe the available evidence rather than to establish causality, evaluate intervention effectiveness, or generate explanatory theory.

2.4.1 Characteristics of Included Studies

The 30 included studies reflected a methodologically diverse evidence base. Thirteen studies employed qualitative empirical methodologies, including interviews, focus groups, open-ended surveys, and thematic analyses (e.g., Beck et al., 2021; Chiumento et al., 2024; Morrison et al., 2024; Stahlschmidt et al., 2022). A substantial proportion of the literature comprised non-empirical scholarship, including conceptual ethics papers, educational papers, commentaries, and reflective papers (e.g., Anderson & McGuire, 2020; Andrews, 2021; Lawson, 2026; Nathan & Brimble, 2026). One mixed-methods study (e.g., Cenkner et al., 2025) and one intervention-development study (e.g., Shaw et al., 2025) were also included. This methodological diversity reflects the emerging and conceptually complex nature of literature concerning *moral distress*, *moral injury*, and related *moral experiences* within child-, young person-, and family-facing (CYPF) services.

The literature was geographically concentrated within the United States, which accounted for 23 of the included studies. The remaining seven studies originated from the United Kingdom. Studies were identified across a broad range of CYPF contexts within both countries.

Table 2.2: Summary Characteristics of Included Studies

Characteristic	Category	Number of Studies
Country	United States	23
	United Kingdom	7
Study Design	Qualitative empirical	13
	Conceptual ethics paper	9
	Conceptual and educational paper	4
	Commentary / reflective paper	2
	Mixed-methods	1
	Intervention-development	1
Clinical / Practice Context	Critical care / PICU	7
	End-of-life care	6
	Mental health / CAMHS	5
	Gender-affirming care	4
	Child protection / safeguarding	4
	Oncology	3
	Emergency care	2
	COVID-related disruption	2

Participants represented a diverse range of professionals working with CYPF. Most studies focused on healthcare professionals, including physicians, nurses, psychologists, psychiatrists, social workers, and multidisciplinary healthcare teams. Several studies examined specific professional groups, such as paediatric intensivists (Beck et al., 2021; Beck et al., 2023), paediatric psychiatrists (Hoffman, 2024), gender-affirming care providers (Gzesh et al., 2024; Hughes et al., 2021; Insalaco & Stamm, 2025), and child protection practitioners (Stahlschmidt et al., 2022), whilst others explored moral experiences across broader organisational or multidisciplinary contexts (Chiumento et al., 2024; Eads et al., 2024).

The settings represented within the literature were similarly diverse. Studies were situated across paediatric intensive care, end-of-life care, child and adolescent mental health services, gender-affirming care, oncology, emergency care, safeguarding, child welfare, and COVID-related contexts (e.g., Beck et al., 2021; Chiumento et al., 2024; Hoffman, 2024; Hughes et al., 2021; Humphrey & Winsor, 2025; Kotler et al., 2024; Stahlschmidt et al., 2022). Several conceptual papers were not

linked to a single clinical setting and instead explored moral distress, moral injury, and ethical tensions across paediatric or child- and family-facing practice more broadly (Anderson & McGuire, 2020; Andrews, 2021; Mabel et al., 2022). Collectively, the included evidence base reflects the wide range of professional, relational, and organisational contexts in which morally challenging situations may arise when working with children, young people, and families.

Study-level characteristics are presented in Table 2.3, providing details of the methodological approach, practice context, moral concepts examined, key findings, and primary contribution or implications of each included publication.

Table 2.3: Characteristics of Studies Included in the Scoping Review

Study	Country	Setting	Population/Profession	Design	Moral Concept(s)	Primary Contribution and Implications for Review
Anderson & McGuire (2020)	USA	Child and family mental health / LGBTQ+ care	Religious helping professionals	Conceptual ethics paper	Moral conflict; ethical tension	Value conflicts in supporting sexual and gender minority youth and families
Andrews (2020/2021)	USA	Paediatric psychology	Paediatric psychologists	Conceptual ethics paper	Ethical dilemmas; moral distress	Parent–child conflicts and ethical complexity in paediatric care
Beck et al. (2021)	USA	Paediatrics	Residents and attending physicians	Qualitative empirical	Moral distress	Recognition and mitigation of moral distress
Beck et al. (2023)	USA	Paediatric hospital medicine	Hospitalists and trainees	Qualitative empirical	Moral distress	Organisational and systemic drivers of moral distress
Cenkner et al. (2025)	USA	Child protective services	Child protection workers	Mixed methods	Moral injury	Potentially morally injurious events, betrayal and psychological outcomes
Chiumento et al. (2024)	UK	Maternity and neonatal services	Healthcare professionals	Qualitative empirical	Moral distress; ethical tension	Disruption of compassionate care following COVID-19
Eads et al. (2024)	USA	Paediatric emergency care	Social workers	Qualitative empirical	Ethical dilemmas; moral distress	Competing responsibilities, bias and advocacy challenges
Gill et al. (2025)	USA	Paediatric inpatient mental health	Paediatric clinicians	Commentary/ reflection	Moral distress; burnout	Ethical challenges arising from psychiatric boarding and system failures

		/ psychiatric boarding				
Grekov et al. (2025)	USA	PICU / End-of-life care	Paediatric intensive care clinicians	Qualitative empirical	Ethical tension; moral uncertainty	Conceptualisation of suffering in paediatric goals-of-care decisions
Gzesh et al. (2024)	USA	Gender-affirming care	Paediatric gender-affirming care providers	Conceptual ethics paper	Moral distress; institutional betrayal	Legislative and institutional barriers to ethical care provision
Heifner et al. (2025)	USA	Adolescent end-of-life care	Paediatric clinicians, adolescents and families	Conceptual ethics paper	Moral distress; ethical conflict	Tensions between adolescent preferences, parental authority and clinician duties
Hoffman (2024)	USA	Paediatric inpatient mental health / psychiatric boarding	Paediatric psychiatrist	Commentary/ reflection	Moral injury; compassion fatigue	System failure, psychiatric boarding and clinician moral injury
Hughes et al. (2021)	USA	Gender-affirming care	Physicians, nurse practitioners, and physician assistants providing gender-affirming care to transgender and gender diverse youth (n=103)	Qualitative empirical	Moral distress; ethical tension; moral conflict/dilemma	Explores provider perspectives on legislation restricting gender-affirming care, identifying ethical tensions between evidence-based practice, professional responsibilities, legal constraints, patient wellbeing, and provider distress
Humphrey & Winsor (2025)	USA	Paediatric oncology	Paediatric oncology nurses	Conceptual ethics paper	Moral distress; moral development	Impact of organisational constraints and loss of DEI structures on ethical practice
Insalaco & Stamm (2025)	USA	Gender-affirming care	Queer and queer-adjacent clinicians	Qualitative empirical	Moral distress; moral injury	Legislative threats, institutional constraints and clinician wellbeing

Kingsley et al. (2025)	USA	PICU / End-of-life care	Paediatric intensive care clinicians and families	Conceptual ethics paper	Moral distress; ethical conflict	Relational potential standard and best-interest decision making
Kotler et al. (2024)	USA	Paediatric emergency care	Emergency department clinicians	Qualitative empirical	Moral distress; moral uncertainty	Communication challenges in paediatric end-of-life care
Ladd & Henry (2025)	USA	Paediatric endocrinology	Paediatric endocrinology clinicians	Conceptual and educational paper	Ethical dilemmas; justice	Ethical issues in endocrine care, access and resource allocation
Lawson (2026)	UK	CAMHS	Child and adolescent mental health nurses	Conceptual and educational paper	Emotional labour; moral distress	Emotional labour and its relationship with burnout and moral distress
Mabel et al. (2022)	USA	Paediatric gender-affirming care	Clinicians and ethicists in gender-affirming care	Conceptual ethics paper	Moral distress; moral uncertainty; moral conflict; moral tension	Typology of moral distress in paediatric gender-affirming care
Martz et al. (2026)	USA	PICU / brain death communicatio n	Intensivists, neurologists, nurses and social workers	Qualitative empirical	Moral distress; prognostic uncertainty; ethical tension	Communication barriers and strategies in paediatric brain death cases
Morrison et al. (2024)	UK	Paediatric Critical Care	Paediatric critical care doctors and nurses (n=14)	Qualitative empirical	Moral distress; moral injury	Explores experiences of investigations following serious incidents, identifying moral injury, psychological impacts, support needs, and implications for staff wellbeing and professional practice
Nathan & Brimble (2025)	UK	Paediatric oncology / life-threatening conditions	Children's oncology nurses	Conceptual and educational paper	Emotional labour; moral distress	Emotional demands of caring for CYP with life-threatening conditions

Pountney et al. (2023)	UK	Paediatric critical care / COVID-19	Paediatric critical care nurses	Qualitative empirical	Moral distress; burnout; traumatic stress	Impact of COVID-19 on PCC nurses' wellbeing
Schneider et al. (2023)	USA	Paediatric palliative / end-of-life care	Paediatric psychologists and multidisciplinary clinicians	Conceptual ethics paper	Ethical dilemmas; moral distress	End-of-life ethical dilemmas involving prognosis, disclosure and team/family conflict
Schneider & Karfunkle (2022)	USA	Paediatric psycho-oncology	Paediatric psychologist	Conceptual ethics paper	Ethical dilemmas; moral distress	Ethical complexity in psychological care for a pregnant adolescent with cancer
Shaw et al. (2025)	UK	Paediatric critical care	Paediatric critical care staff	Intervention-development study	Moral distress; burnout; staff wellbeing	Development of evidence-based staff wellbeing interventions
Stahlschmidt et al. (2022)	USA	Child welfare services	Child welfare caseworkers	Qualitative empirical	Moral distress	Develops a dynamic theory of moral distress among child welfare caseworkers, identifying value conflicts, organisational constraints, coping strategies, psychological distress, and workforce implications
Yeter et al. (2024)	UK	Paediatric critical care	Nurses and allied health professionals	Qualitative empirical	Moral distress; burnout; compassion fatigue	Lived experiences of workplace wellbeing in paediatric critical care
Zeanah et al. (2023)	USA	Infant and early childhood mental health	Infant and early childhood mental health practitioners	Conceptual and educational paper	Ethical dilemmas; ethical tension	Need for stronger ethics guidance in infant and early childhood mental health

2.4.2 Conceptualisation of Moral Distress, Moral Injury, and Related Moral Experiences

Moral distress emerged as the predominant framework for understanding ethically challenging practice in child, young person, and family services, appearing in twenty-four of the thirty included studies. The majority of these publications utilised established conceptualisations where distress arises when professionals recognise an ethically appropriate course of action but are unable to act accordingly due to internal or external constraints (e.g. Beck et al., 2021; Chiumento et al., 2024; Stahlschmidt et al., 2022). However, a significant proportion of the literature adopted broader conceptualisations that incorporate organisational pressures, uncertainty, competing responsibilities, and barriers to providing care perceived as appropriate (e.g. Gzesh et al., 2024; Humphrey & Winsor, 2025; Lawson, 2026; Mabel et al., 2022).

A notable feature of the evidence base was the conceptual diversity and significant overlap between related moral experiences. Terms such as ethical tension, moral conflict, ethical dilemma, moral uncertainty, and moral residue appeared across both empirical and conceptual papers (e.g. Andrews, 2021; Eads et al., 2024; Gzesh et al., 2024; Mabel et al., 2022). These constructs were frequently used interchangeably to describe situations where professional duties, organisational demands, and the specific needs of children and families could not be easily reconciled. Furthermore, other concepts including emotional labour, burnout, and compassion fatigue were less consistently defined and often appeared within these broader discussions of moral distress (e.g. Beck et al., 2023; Humphrey & Winsor, 2025; Lawson, 2026; Nathan & Brimble, 2026).

Table 2.4: Distribution of Moral Concepts Across Included Studies

Moral Concept	Number of Studies Addressing Concept	Example Sources
Moral Distress	24	Beck et al. (2021); Chiumento et al. (2024); Stahlschmidt et al. (2022)
Ethical Tension	12	Andrews (2021); Eads et al. (2024); Mabel et al. (2022)
Moral Conflict / Ethical Dilemma	10	Gzesh et al. (2024); Humphrey & Winsor (2025); Nathan & Brimble (2026)
Moral Injury	4	Hoffman (2024); Insalaco & Stamm (2025); Morrison et al. (2024); Schneider & Karfunkle (2022)
Moral Uncertainty	4	Andrews (2021); Humphrey & Winsor (2025); Mabel et al. (2022)

Moral Residue	3	Beck et al. (2023); Morrison et al. (2024); Schneider et al. (2023)

While moral distress dominated the literature, moral injury was explicitly addressed in a smaller number of studies. Within these accounts, moral injury was generally conceptualised as distinct from, but related to, moral distress. It was associated with perceived violations of deeply held moral values and was characterised by more enduring psychological, professional, and relational consequences (e.g. Hoffman, 2024; Insalaco & Stamm, 2025; Morrison et al., 2024; Schneider & Karfunkle, 2022).

Ultimately, regardless of the specific terminology employed, the literature consistently located morally challenging experiences at the intersection of professional values, ethical commitments, governance, and responsibilities towards children, young people, and families. This points toward a field where experiences are widely recognised but the language used to describe them remains fluid. Several conceptual papers argued against viewing moral distress as a singular phenomenon, advocating instead for broader understandings of moral experience that incorporate moral injury, uncertainty, conflict, and ethical tension as related but conceptually distinct constructs (e.g. Anderson & McGuire, 2020; Andrews, 2021; Gzesh et al., 2024; Mabel et al., 2022)

2.4.3 Reported Sources of Moral Distress, Moral Injury, and Related Moral Experiences

Five broad categories of moral challenge were identified across the included studies (Table 2.5): conflicting responsibilities and stakeholder interests; organisational and systemic constraints; uncertainty, ambiguity, and risk; exposure to suffering and high-stakes decision making; and sociopolitical, legal, and structural constraints.

Table 2.5: Distribution of Reported Sources of Moral Distress, Moral Injury, and Ethical Tension Across Included Studies

Source Category	Number of Studies Addressing Category	Example Sources
Conflicting Responsibilities and Stakeholder Interests	26	Andrews (2021); Eads et al. (2024); Heifner et al. (2025); Mabel et al. (2022)
Organisational and Systemic Constraints	24	Beck et al. (2023); Chiumento et al. (2024); Morrison et al. (2024); Stahlschmidt et al. (2022)
Uncertainty, Ambiguity, and Risk	18	Grekov et al. (2025); Kotler et al. (2024); Mabel et al. (2022); Schneider & Karfunkle (2020)

Exposure to Suffering and High-Stakes Decision Making	17	Heifner et al. (2025); Kingsley et al. (2025); Kotler et al. (2024); Martz et al. (2026)
Sociopolitical, Legal, and Structural Constraints	13	Eads et al. (2024); Gzesh et al. (2024); Hughes et al. (2021); Insalaco & Stamm (2025)

Most studies described multiple sources of moral distress simultaneously, suggesting that moral experiences were rarely attributable to a single factor. Rather, they appeared to emerge through the interaction of relational, organisational, clinical, legal, and sociopolitical influences.

Conflicting responsibilities and stakeholder interests represented the most frequently identified source of moral distress and related moral experiences. Studies commonly described tensions arising when the needs, wishes, or perceived best interests of children and young people conflicted with those of parents, families, professionals, organisations, or wider systems. Several papers also highlighted challenges associated with balancing safeguarding responsibilities, professional duties, family preferences, and competing understandings of care (Andrews, 2021; Eads et al., 2024; Heifner et al., 2025; Mabel et al., 2022).

Organisational and systemic constraints were also prominent. These included institutional policies, professional hierarchies, service structures, resource pressures, staffing shortages, and barriers that limited professionals' ability to provide care aligned with their ethical judgement. These challenges were identified across a range of settings, suggesting that moral distress was shaped not only by clinical encounters but also by the systems within which care was delivered (Beck et al., 2023; Chiumento et al., 2024; Morrison et al., 2024; Stahlschmidt et al., 2022).

Uncertainty, ambiguity, and risk represented another recurrent source of moral challenge. Studies described difficulties associated with prognostic uncertainty, diagnostic ambiguity, safeguarding concerns, and the management of clinical risk. These experiences were often characterised by competing interpretations of available information and uncertainty regarding the potential consequences of decisions for children, young people, and families (Grekov et al., 2025; Kotler et al., 2024; Mabel et al., 2022; Schneider & Karfunkle, 2020).

Exposure to suffering and high-stakes decision making was particularly evident within critical care, oncology, and end-of-life settings. Professionals described moral distress associated with treatment futility, withdrawal of care, restrictive interventions, and witnessing the suffering of children and families (Heifner et al., 2025; Kingsley et al., 2025; Kotler et al., 2024; Martz et al., 2026).

Finally, sociopolitical, legal, and structural constraints were identified as important sources of moral distress. These included legislative restrictions, policy environments, discrimination, and structural inequities that limited professionals' ability to act in accordance with professional values or perceived best practice. Such tensions were particularly evident within literature relating to gender-affirming care and broader debates concerning children's rights, autonomy, and access to services (Gzesh et al., 2024; Hughes et al., 2021; Insalaco & Stamm, 2025).

Communication, disclosure, and relational negotiation appeared across several categories rather than as a discrete source of moral distress. Difficult conversations with children, families, colleagues, and multidisciplinary teams were frequently embedded within situations involving competing responsibilities, uncertainty, safeguarding concerns, organisational constraint, and end-of-life decision making (Beck et al., 2023; Morrison et al., 2024). Across the literature, communication appeared to shape how moral tensions were experienced, negotiated, and managed in practice, functioning as a cross-cutting feature of moral experience rather than a standalone category of challenge (Chiumento et al., 2024; Kotler et al., 2024).

This synthesis suggests that morally challenging experiences are widely described across CYPF services, whilst also drawing attention to the particular relational, developmental, and systemic contexts within which they are reported. Whether these features constitute morally distinctive aspects of CYPF practice remains an important question for consideration in the discussion that follows.

Clinical and Practice Contexts

Moral distress, moral injury, and related moral experiences were described across a wide range of CYPF settings. Critical care and paediatric intensive care were the most frequently represented contexts, followed by end-of-life care, child and adolescent mental health services (CAMHS), gender-affirming care, child protection and safeguarding, and oncology. A smaller number of studies focused on emergency care settings or examined moral experiences arising during the COVID-19 pandemic. Several conceptual papers discussed moral distress, moral injury, and ethical tensions across paediatric practice more broadly and were not linked to a single clinical setting (e.g., Anderson & McGuire, 2020; Andrews, 2021; Humphrey & Winsor, 2025; Mabel et al., 2022; Nathan & Brimble, 2026).

Table 2.6: Distribution of Clinical and Practice Contexts Across Included Studies

Clinical / Practice Context	Number of Studies Addressing Context	Studies

Critical Care / Paediatric Intensive Care	7	Grekov et al. (2025); Kingsley et al. (2025); Martz et al. (2026); Morrison et al. (2024); Pountney et al. (2023); Shaw et al. (2025); Yeter et al. (2024)
End-of-Life Care	6	Grekov et al. (2025); Heifner et al. (2025); Kingsley et al. (2025); Kotler et al. (2024); Martz et al. (2026); Schneider et al. (2023)
Mental Health / CAMHS	5	Anderson & McGuire (2020); Gill et al. (2025); Hoffman (2024); Lawson (2026); Zeanah et al. (2023)
Gender-Affirming Care	4	Gzesh et al. (2024); Hughes et al. (2021); Insalaco & Stamm (2025); Mabel et al. (2022)
Child Protection / Safeguarding	4	Andrews (2021); Cenkner et al. (2025); Eads et al. (2024); Stahlschmidt et al. (2022)
Oncology	3	Humphrey & Winsor (2025); Nathan & Brimble (2026); Schneider & Karfunkle (2022)
Emergency Care	2	Eads et al. (2024); Kotler et al. (2024)
COVID-Related Disruption	2	Chiumento et al. (2024); Pountney et al. (2023)

Critical care and end-of-life settings accounted for a substantial proportion of the literature. Studies situated within paediatric intensive care frequently described morally challenging experiences associated with life-sustaining interventions, treatment futility, end-of-life decision making, and witnessing the suffering of children and families (e.g., Beck et al., 2021; Beck et al., 2023; Heifner et al., 2025; Kingsley et al., 2025; Kotler et al., 2024).

Mental health services, including CAMHS, also featured prominently. Studies described moral challenges arising in relation to risk management, safeguarding responsibilities, service limitations, and tensions between professional judgement and organisational demands (e.g., Gill et al., 2025; Hoffman, 2024; Lawson, 2026; Zeanah et al., 2023). Similar concerns were evident within child protection and safeguarding contexts, where uncertainty, risk, and competing responsibilities frequently intersected (e.g., Eads et al., 2024; Stahlschmidt et al., 2022).

Gender-affirming care emerged as a distinct area of moral challenge. Studies described tensions associated with legislative restrictions, evolving policy environments, professional responsibilities, and competing interpretations of children's rights, autonomy, and best interests (e.g., Gzesh et al., 2024; Hughes et al., 2021; Insalaco & Stamm, 2025). These studies were notable for the extent to which broader sociopolitical debates were described as shaping professional experience.

Additional contexts included oncology, emergency care, and practice during the COVID-19 pandemic. Across these settings, studies described moral challenges associated with uncertainty, rapidly evolving circumstances, resource limitations, and exposure to suffering (e.g., Chiumento et al., 2024; Humphrey & Winsor, 2025; Kotler et al., 2024; Pountney et al., 2023; Schneider & Karfunkle, 2022).

Collectively, the findings demonstrate that moral distress, moral injury, and related moral experiences have been described across a diverse range of CYPF settings. Whilst the specific circumstances varied between contexts, morally challenging experiences were not confined to any single specialty or area of practice.

Reported Consequences of Moral Distress, Moral Injury, and Related Moral Experiences

Five broad categories of consequence were identified across the included studies: impacts on professional identity and moral integrity, burnout and exhaustion, psychological distress, compassion fatigue, and workforce impacts. Most studies described multiple consequences, suggesting that moral distress and related moral experiences affected professionals across emotional, professional, and organisational domains.

Table 2.7: Distribution of Reported Consequences Across Included Studies

Reported Consequence	Studies Addressing Consequence	Studies
Professional Identity / Integrity	17	Anderson & McGuire (2020); Andrews (2021); Beck et al. (2021); Beck et al. (2023); Chiumento et al. (2024); Heifner et al. (2025); Hoffman (2024); Hughes et al. (2021); Humphrey & Winsor (2025); Insalaco & Stamm (2025); Mabel et al. (2022); Martz et al. (2026); Morrison et al. (2024); Schneider et al. (2023); Schneider & Karfunkle (2022); Stahlschmidt et al. (2022); Zeanah et al. (2023)
Burnout / Exhaustion	15	Beck et al. (2021); Beck et al. (2023); Chiumento et al. (2024); Eads et al. (2024); Gill et al. (2025); Humphrey & Winsor (2025); Insalaco & Stamm (2025); Lawson (2026); Martz et al. (2026); Morrison et al. (2024); Nathan & Brimble (2026); Pountney et al. (2023); Shaw et al. (2025); Stahlschmidt et al. (2022); Yeter et al. (2024)
Psychological Distress	14	Cenkner et al. (2025); Chiumento et al. (2024); Gzesh et al. (2024); Hoffman (2024); Hughes et al. (2021); Insalaco & Stamm (2025); Mabel et al. (2022); Martz et al. (2026); Morrison et al. (2024); Pountney et al. (2023); Schneider et al. (2023); Schneider & Karfunkle (2022); Stahlschmidt et al. (2022); Yeter et al. (2024)
Compassion Fatigue	8	Eads et al. (2024); Gill et al. (2025); Hoffman (2024); Lawson (2026); Morrison et al. (2024); Nathan & Brimble (2026); Pountney et al. (2023); Yeter et al. (2024)
Workforce Impact	8	Gill et al. (2025); Hughes et al. (2021); Insalaco & Stamm (2025); Nathan & Brimble (2026); Pountney et al. (2023); Shaw et al. (2025); Stahlschmidt et al. (2022); Yeter et al. (2024)

Reported Consequences of Moral Distress, Moral Injury, and Related Moral Experiences

Professional identity and integrity represented the most frequently reported consequence. Studies described moral distress as challenging professionals' sense of themselves as ethical practitioners and creating tensions between personal values, professional responsibilities, and organisational demands. These experiences included feeling unable to practise in accordance with professional commitments, concerns about compromised moral integrity, and distress associated with perceived failures to provide appropriate care (e.g., Beck et al., 2023; Morrison et al., 2024; Stahlschmidt et al., 2022).

Burnout and exhaustion were also frequently reported. Studies described emotional depletion, fatigue, reduced professional satisfaction, and difficulties sustaining engagement with demanding clinical work. Such experiences were reported across a range of contexts, including critical care, mental health, safeguarding, oncology, and child welfare settings (e.g., Lawson, 2026; Nathan & Brimble, 2026; Pountney et al., 2023; Stahlschmidt et al., 2022).

Psychological distress emerged as another common consequence. Studies described emotional responses including anxiety, guilt, shame, sadness, fear, frustration, helplessness, and persistent emotional burden. These experiences were often linked to uncertainty, exposure to suffering, legal or organisational constraints, or perceived inability to provide care aligned with professional judgement (e.g., Hughes et al., 2021; Morrison et al., 2024; Schneider & Karfunkle, 2022; Stahlschmidt et al., 2022).

Compassion fatigue was reported less frequently but appeared across several emotionally intensive or trauma-exposed areas of practice, including safeguarding, mental health, oncology, critical care, and paediatric serious incident contexts. Related experiences included emotional numbing, reduced empathic capacity, and difficulties maintaining therapeutic engagement over time (e.g., Eads et al., 2024; Hoffman, 2024; Lawson, 2026; Pountney et al., 2023).

Several studies also identified workforce-related consequences, including intentions to leave clinical roles, reduced job satisfaction, recruitment and retention concerns, and difficulties sustaining long-term careers within emotionally demanding services (e.g., Hughes et al., 2021; Stahlschmidt et al., 2022; Yeter et al., 2024).

This synthesis of the literature suggests that the reported consequences of moral distress, moral injury, and related moral experiences extend beyond immediate emotional responses, encompassing professionals' sense of identity, wellbeing, capacity for care, and continued participation in CYPF work.

2.5 Discussion

2.5.1 Overview of Findings

This review sought to examine how moral distress, moral injury, and related moral experiences are conceptualised, described, and understood within literature concerning professionals working in CYPF services. Across the 30 included studies, a conceptually diverse but uneven evidence base was identified. Although the review was framed around both moral distress and moral injury, moral distress was the most present in the literature, whilst explicit discussion of moral injury remained comparatively limited. Alongside moral distress, studies frequently described ethical tension, moral conflict, moral uncertainty, and related forms of moral challenge, supporting ongoing concerns regarding the conceptual ambiguity of the field (Campbell et al., 2018; Fourie, 2015; Morley et al., 2019; Tigard, 2018).

Several findings emerged. First, moral distress remained the predominant framework through which morally challenging professional experiences were understood, despite growing interest in moral injury within broader healthcare literature. Second, competing responsibilities and conflicting priorities represented the most frequently reported source of moral distress, followed by organisational and systemic constraints, uncertainty and risk, exposure to suffering and harm, and sociopolitical and legal influences. Third, professional identity and integrity emerged as the most frequently reported consequence of moral distress, exceeding burnout, psychological distress, and workforce-related outcomes. Collectively, these findings suggest that moral experiences within CYPF services are frequently described in relation to questions of responsibility, care, and professional integrity, rather than reactions to emotionally difficult events or organisational pressures.

The review also highlighted the extent to which moral experiences within CYPF services are situated within complex relational systems. Across a range of settings, professionals described tensions involving children and young people, parents and families, multidisciplinary teams, organisations, legal frameworks, and wider social expectations. Moral challenges were therefore rarely described as arising from a single source. Instead, they were often embedded within situations requiring professionals to balance competing responsibilities, differing perspectives, uncertainty, and questions regarding what constituted appropriate care.

Taken together, the findings suggest that CYPF work may not give rise to entirely unique forms of moral distress or moral injury. However, the literature does point towards particular relational, developmental, safeguarding, and family-system contexts that appear to shape how moral experiences are encountered and understood. This was one of the central questions motivating the review. Whilst the findings do not establish that moral experiences within CYPF services are

fundamentally different from those reported elsewhere in healthcare, they do suggest that the contexts in which such experiences arise may warrant closer attention. The following sections consider these findings in relation to broader moral distress and moral injury literature before exploring their implications for understanding moral experience within CYPF services and, subsequently, the experiences of clinicians working within GIDS.

2.5.2 Moral Distress Remains the Dominant Framework

One of the clearest findings of this review was the continued prominence of moral distress as the primary framework through which morally challenging professional experiences were understood and described. Although the review was framed around both moral distress and moral injury, moral distress appeared in the majority of included studies, whilst explicit discussion of moral injury remained comparatively limited. This is notable given growing interest in moral injury across broader healthcare literature, particularly following the COVID-19 pandemic (Čartolovni et al., 2021; Williamson et al., 2020).

This may reflect the longer history of moral distress within healthcare and social care research. Since Jameton's (1984) original formulation, moral distress has become an established framework for understanding the ethical and emotional consequences of working within constrained systems of care. However, as noted by Fourie (2015), Campbell et al. (2018), and Tigard (2018), the concept has expanded considerably over time. Across the studies included in this review, experiences described as moral distress frequently overlapped with ethical tension, moral conflict, uncertainty, competing responsibilities, and perceived barriers to providing appropriate care.

Rather than revealing clear conceptual boundaries, the review identified a field characterised by substantial overlap between related forms of moral experience. In many studies, moral distress appeared to function as an umbrella term through which a range of ethically challenging situations were understood and communicated. This finding is consistent with broader critiques suggesting that there may currently be greater agreement regarding the significance of moral experiences than regarding the language used to describe them (Fourie, 2015; Morley et al., 2019; Tigard, 2018).

Comparison with broader healthcare reviews further highlights this pattern. Čartolovni et al. (2021), for example, identified increasing interest in moral injury alongside moral distress within healthcare literature. In contrast, moral injury appeared only infrequently within the CYPF literature reviewed here. This may suggest that moral injury has yet to become fully embedded within CYPF scholarship. Equally, it may indicate that professionals working within child-, young person-, and family-facing services continue to understand and communicate morally challenging experiences primarily through the language of moral distress.

For the purposes of the present review, the distinction is perhaps less important than the observation that morally challenging experiences were consistently described across the literature, regardless of the terminology employed. The findings suggest that future work may benefit from focusing not only on questions of definition, but also on how moral experiences arise, how they are understood by professionals, and how they shape clinical practice, professional identity, and relationships over time (Tigard, 2018).

2.5.3 Competing Responsibilities and Conflicting Priorities as a Central Source of Moral Challenge

The most frequently reported source of moral distress and related moral experiences across the reviewed literature was competing responsibilities and conflicting priorities. This shifts attention away from morally challenging experiences as responses to isolated ethical events and towards situations in which professionals are required to navigate competing responsibilities across children, families, organisations, and wider systems. Across studies, professionals described tensions involving responsibilities to children and young people, parents and families, colleagues, organisations, safeguarding systems, and legal or policy frameworks. In many cases, moral challenges appeared to arise not because the ethically appropriate course of action was unknown, but because multiple responsibilities could not be simultaneously fulfilled.

This finding is broadly consistent with wider moral distress literature, which has long emphasised the role of constraint in preventing professionals from acting in accordance with their values or ethical judgement (Jameton, 1984; Morley et al., 2019). However, the findings of the present review suggest that within CYPF services, constraints often arise not only from organisations and systems, but also from the need to respond to multiple stakeholders whose needs, rights, and priorities may not align. Professionals were frequently required to navigate competing understandings of care, protection, autonomy, safety, and best interests. Moral distress therefore appeared to arise not only from barriers to action, but also from the challenge of responding to multiple and sometimes incompatible ethical responsibilities.

This may represent an important emphasis within CYPF work. Unlike many healthcare contexts in which responsibility is primarily organised around a clinician–patient relationship, CYPF practice frequently involves responsibilities distributed across children, parents, carers, multidisciplinary teams, organisations, and legal systems. Professionals are therefore often required to consider how decisions made in the interests of one person may affect others, creating situations in which competing responsibilities cannot be easily reconciled.

The prominence of competing responsibilities may also reflect the developmental and safeguarding contexts within which CYPF professionals work. Across the reviewed studies, professionals described balancing protection and autonomy, present needs and future outcomes, individual wellbeing and family relationships, and therapeutic goals alongside safeguarding responsibilities (Chiumento et al., 2024; Hughes et al., 2021; Kotler et al., 2024; Morrison et al., 2024; Nathan & Brimble, 2026; Stahlschmidt et al., 2022). Such tensions are not unique to CYPF services, but they may be especially visible in work involving children and young people, where questions of dependency, developing autonomy, vulnerability, and responsibility are often central to decision-making.

What emerges from this review is that moral challenges within CYPF services are frequently associated with navigating multiple and sometimes competing responsibilities across individuals, families, organisations, and systems. Whilst this does not necessarily indicate a distinct form of moral distress, it does point towards the importance of understanding how responsibility is distributed, negotiated, and experienced within the relational, developmental, and organisational contexts of CYPF practice.

2.5.4 Organisational and Systemic Constraints

Organisational and systemic constraints emerged as one of the most frequently reported sources of moral distress across the reviewed literature. Professionals described staffing shortages, resource limitations, service pressures, administrative demands, policy restrictions, and barriers to providing care consistent with their professional values. These findings are consistent with Jameton's (1984) original conceptualisation of moral distress, which emphasised situations in which professionals recognise an ethically appropriate course of action but are constrained from acting by institutional or systemic factors.

The findings suggest that many of the structural conditions identified within early moral distress literature remain highly relevant within contemporary CYPF services. Across the reviewed studies, professionals described being unable to provide the level of care, advocacy, support, or intervention they believed children, young people, and families required because of limitations imposed by services, resources, policies, or wider organisational priorities (Austin, 2012; Morley et al., 2019; Pauly et al., 2012). Organisational constraints therefore appeared closely linked to professionals' perceptions of their ability to act in accordance with their ethical commitments and professional responsibilities.

Importantly, organisational constraints rarely operated in isolation. They frequently intersected with competing responsibilities, uncertainty, safeguarding concerns, professional obligations, and relational commitments. Similar tensions were evident across child protection, paediatric intensive

care, end-of-life care, infant mental health, and gender-affirming healthcare, where professionals described feeling caught between professional values, external constraints, and competing responsibilities (Cenkner et al., 2025; Martz et al., 2026; Schneider & Karfunkle, 2022; Schneider et al., 2023; Zeanah et al., 2023). Comparable patterns were also evident in studies examining organisational hierarchies and healthcare systems (Beck et al., 2023), politically contested areas of practice such as gender-affirming care (Gzesh et al., 2024; Insalaco & Stamm, 2025; Mabel et al., 2022), and contexts in which professionals witnessed system shortcomings affecting children, young people, and families directly (Chiumento et al., 2024; Cenkner et al., 2025).

Across the reviewed literature, organisational pressures appeared to acquire moral significance when they constrained professionals' ability to act in ways they believed were consistent with their responsibilities and values. This suggests that the experience of moral distress was linked not only to the presence of organisational difficulties, but to their perceived implications for care.

The findings also raise questions regarding where responsibility for addressing moral distress is located. Several studies highlighted the value of reflective communication, supervision, peer support, psychologically safe spaces, and opportunities to process morally challenging experiences (Morrison et al., 2024; Shaw et al., 2025; Stahlschmidt et al., 2022; Yeter et al., 2024). Whilst such approaches may provide important sources of support, the literature also suggests that individual and team-level interventions may be insufficient when moral distress is generated by wider organisational and structural conditions (Beck et al., 2023; Morrison et al., 2024). Addressing moral distress within CYPF services may therefore require attention not only to individual wellbeing, but also to the systems and structures that shape what forms of care are possible in practice.

2.5.5 Communication and Moral Experience

Communication emerged across the reviewed literature as an important process through which moral distress and related moral experiences were encountered, negotiated, and managed. Unlike other findings identified within the review, communication did not appear as a discrete source of moral distress. Rather, it cut across the evidence base, shaping how ethical tensions were expressed, understood, and responded to within professional, familial, organisational, and social contexts.

Across diverse settings, professionals described difficult conversations with children, young people, families, colleagues, and multidisciplinary teams in situations characterised by uncertainty, disagreement, vulnerability, and competing understandings of appropriate care. Communication therefore appeared not simply as a means of conveying information, but as a process through which moral tensions became visible and were worked through in practice (Heifner et al., 2025; Nathan & Brimble, 2026; Schneider & Karfunkle, 2022; Schneider et al., 2023). This was particularly evident in

literature concerning end-of-life care, safeguarding, and complex clinical decision-making, where professionals described communicating poor prognoses, managing disagreements between families and healthcare teams, balancing honesty with hope, and navigating conflicting stakeholder priorities (Heifner et al., 2025; Schneider & Karfunkle, 2022; Schneider et al., 2023).

Several studies also highlighted the importance of communication within professional systems. Morrison et al. (2024), Shaw et al. (2025), Stahlschmidt et al. (2022), and Yeter et al. (2024) emphasised psychologically safe spaces, reflective discussion, peer support, debriefing, and opportunities to process morally challenging experiences. Similarly, Nathan and Brimble (2026) highlighted the emotional labour involved in sustaining therapeutic relationships with children, young people, and families during prolonged and emotionally demanding care. Collectively, these studies suggest that opportunities to articulate, reflect upon, and share moral concerns may play an important role in how professionals make sense of ethically challenging situations.

What emerges from these findings is that communication functions as more than the exchange of information. Across the literature, moral experiences were frequently described, understood, and negotiated through dialogue with others. This resonates with broader literature suggesting that moral distress is not solely an internal response to ethical conflict, but is also shaped through professional relationships, shared reflection, and social interaction (Campbell et al., 2018; Morley et al., 2019). Where opportunities for dialogue and reflection are limited, professionals may be left carrying moral concerns in relative isolation.

The prominence of communication within the reviewed literature may therefore point towards the importance of processes through which moral experiences are expressed, shared, and made sense of over time. Whilst communication was rarely conceptualised as a source of moral distress in its own right, it appeared central to how professionals understood, negotiated, and responded to morally challenging situations across CYPF contexts.

2.5.6 Consequences of Moral Distress

Across the reviewed literature, moral distress and related moral experiences were associated with a range of emotional, psychological, and professional consequences. Frequently reported experiences included frustration, guilt, helplessness, sadness, emotional exhaustion, burnout, and reduced job satisfaction (Beck et al., 2023; Cenkner et al., 2025; Chiumento et al., 2024; Lawson, 2026). These findings are consistent with broader healthcare literature, which has repeatedly linked moral distress to emotional exhaustion, workforce attrition, diminished wellbeing, and poorer professional quality of life (Morley et al., 2019; Oh & Gastmans, 2015).

However, one of the more notable findings of this review was the prominence of professional identity and integrity as reported consequences of moral distress. Several studies described moral distress as challenging professionals' sense of themselves as ethical practitioners and creating tensions between personal values, professional responsibilities, and organisational demands (Beck et al., 2023; Heifner et al., 2025; Schneider et al., 2023). Distress often appeared to arise not simply because situations were difficult, but because professionals felt unable to provide the care, advocacy, protection, or support they believed children, young people, and families required.

These findings resonate with literature concerning moral residue, whereby unresolved ethical tensions continue to shape professionals' understanding of themselves, their work, and future decision-making (Epstein & Hamric, 2009). Although moral residue was rarely discussed explicitly within the reviewed studies, several authors described enduring impacts that persisted beyond the immediate situation, particularly where professionals experienced responsibility without corresponding authority, resources, or support (Beck et al., 2023; Cenkner et al., 2025). As with moral injury, the relative absence of specific terminology may reflect conceptual variation within the field rather than the absence of the underlying experience (Tigard, 2018).

Importantly, these consequences frequently unfolded within ongoing relationships with children, young people, and families. Professionals often remained engaged in care despite uncertainty, ethical conflict, or perceived inability to provide what they believed was needed. This may be particularly relevant within CYPF services, where therapeutic relationships, safeguarding responsibilities, and long-term involvement with families can extend the emotional and ethical significance of morally challenging experiences over time.

What emerges from these findings is that the consequences of moral distress extend beyond immediate emotional responses. Across the reviewed literature, morally challenging experiences were frequently described as affecting professionals' sense of identity, integrity, and capacity to remain engaged in care. This suggests that understanding moral distress within CYPF services requires attention not only to emotional wellbeing, but also to how professionals sustain a sense of themselves and their work in the face of ongoing ethical challenge.

2.5.7 What May Be Distinctive About Moral Experiences in CYPF Services?

One of the questions underpinning this review was whether moral distress, moral injury, and related moral experiences are described differently within CYPF services than within broader healthcare literature. The findings do not suggest that CYPF professionals encounter entirely unique forms of moral challenge. Organisational constraints, uncertainty, communication difficulties, threats to professional integrity, and exposure to suffering are all well-established features of the wider moral

distress literature (Čartolovni et al., 2021; Morley et al., 2019). However, the review does point towards several features that appeared repeatedly across CYPF contexts and may shape how moral experiences are encountered and understood.

Most notably, moral challenges were frequently described within situations involving distributed responsibility across children and young people, parents and families, professionals, organisations, and legal systems. Professionals often described balancing safeguarding responsibilities alongside therapeutic relationships (Hughes et al., 2021; Morrison et al., 2024), negotiating competing family and professional priorities (Chiumento et al., 2024; Nathan & Brimble, 2026), and managing tensions between professional judgement, organisational expectations, and child protection systems (Cenkner et al., 2025). Across the reviewed literature, responsibility was rarely experienced as residing within a single professional relationship and was more often described as negotiated across multiple individuals and systems.

The findings also suggest that moral experiences within CYPF services are frequently situated within developmental and relational contexts. Professionals were often required to consider children's developing autonomy, family relationships, future wellbeing, safeguarding responsibilities, and questions of risk and protection simultaneously. Whilst such considerations are not exclusive to CYPF practice, they appeared prominently across diverse service settings and forms of professional work.

A further observation concerns the broader meanings attached to childhood, vulnerability, protection, and responsibility. Although these issues were rarely examined explicitly within the reviewed studies, they appeared to form part of the context within which moral challenges were understood. Decisions concerning children and young people often carry particular social, professional, and legal significance, potentially shaping how responsibility is experienced and how morally challenging situations are interpreted. This remains an area that would benefit from further conceptual and empirical exploration.

Overall, the findings suggest that CYPF work may not generate entirely distinct forms of moral distress or moral injury. Rather, they point towards particular relational, developmental, safeguarding, and family-system contexts that appear to shape how moral experiences arise and are understood. Whether these features constitute morally distinctive aspects of CYPF practice remains an open question. However, the review suggests that they warrant greater attention within future research seeking to understand moral experiences in services working with CYPF.

2.5.8 Strengths, Limitations, and Future Directions

This review identified important contributions to understanding moral experiences within CYPF services, whilst also highlighting limitations within the current evidence base and opportunities for future research. The principal strengths, limitations, evidence gaps, and implications arising from the review are summarised in Table 2.7.

Table 2.7: Summary of the Scoping Review Findings and Implications

	Summary
Strengths	To the author's knowledge, this is the first scoping review to examine how moral distress, moral injury, and related moral experiences have been conceptualised within literature concerning professionals working in CYPF services. Focusing specifically on CYPF contexts highlighted patterns that may be less visible within broader healthcare literature, particularly regarding distributed responsibility, safeguarding, family relationships, and developmental considerations. The inclusion of both peer-reviewed and grey literature enabled a broad exploration of moral experiences across diverse professional and service contexts.
Limitations	The review was restricted to literature published between 2020 and 2026 and to studies conducted within the United Kingdom and United States. Whilst these boundaries supported relevance to contemporary practice and provided a clearly defined geographical scope, they may have excluded earlier conceptual developments and perspectives from other cultural and service contexts. The geographical restriction also excluded potentially relevant research from countries such as Canada and the Netherlands, which have established CYPF healthcare and research traditions and may have contributed additional perspectives. As moral experiences are situated within particular cultural, legal, organisational, and healthcare systems, inclusion of a wider range of countries may have identified different configurations of professional responsibility, constraint, and moral experience. The findings should be understood as a mapping of the literature within the defined UK and US scope rather than as an international account of moral experience across CYPF services. Considerable conceptual heterogeneity also limited comparison across studies, with moral distress, moral injury, ethical tension, moral conflict, and moral uncertainty often defined and applied inconsistently. Intersectional dimensions of moral experience were not consistently reported or explored within the included literature, limiting the extent to which the review could examine how moral distress and related experiences may differ across intersecting social and professional positions. This is important given that experiences of responsibility, constraint, authority, and capacity to act are unlikely to be distributed uniformly within professional systems. Professional role, seniority, age, and length of experience, alongside wider social positions such as gender, race, sexuality, disability, and socioeconomic position, may intersect to shape both the demands placed upon professionals and the agency available to them. These dimensions therefore remain important when interpreting the findings, particularly given the prominence of responsibility without corresponding agency across the review.
Evidence gaps	Although moral distress was well represented, relatively few studies explicitly examined moral injury despite its increasing prominence within healthcare research more broadly (Čartolovni et al., 2021; Williamson et al., 2021). Literature specific to CYPF services also remained comparatively limited. Whilst many studies documented sources and consequences of moral distress, considerably fewer

	explored how moral experiences developed over time, became integrated into professional identity, or were negotiated within ongoing professional relationships and wider organisational contexts.
Future directions	Future research would benefit from moving beyond questions of prevalence and definition towards richer exploration of how professionals understand, narrate, and carry morally challenging experiences over time. Greater attention to professional identity, organisational culture, communication, and wider sociopolitical contexts may further advance understanding of moral experiences within CYPF services. Narrative and other qualitative approaches appear particularly well suited to examining how professionals interpret morally challenging situations and how these experiences continue to shape practice, relationships, and understandings of responsibility over time.

The review provided a clear rationale for the present study. Whilst the literature identified recurring descriptions of moral distress, moral injury, and related moral experiences across CYPF services, considerably less attention had been paid to how professionals themselves understood, narrated, and integrated these experiences into their identities, relationships, and practice over time. The prominence of relational responsibility, professional identity, organisational culture, and developmental complexity across the reviewed literature pointed towards the value of narrative inquiry for exploring these processes in depth. The following chapter therefore outlines the methodological approach developed to address this gap.

2.6 Rationale for the Empirical Study

This chapter has situated the present study within a period of intensified public, political, and institutional attention toward gender identity healthcare for children and young people. While these developments centred on the Gender Identity Development Service, they reflect broader historical patterns in which marginalised communities become subject to heightened scrutiny and contestation during periods of social change and increased visibility (Butler, 2004, 2024; Faye, 2021; Foucault, 1978; Hall, 1997; Pearce et al., 2020; Weeks, 1981). Recent scholarship has further emphasised the extent to which transgender lives and healthcare have become acutely politicised within contemporary media and policy discourse (Faye, 2021; Pearce et al., 2020).

The curiosity driving this inquiry emerged from multiple narrative locations. As a queer person, I was concerned by the ways in which public debates concerning gender identity appeared to echo earlier patterns of moralised contestation directed toward minoritised groups (Faye, 2021; Weeks, 1981). I was also mindful of the potential consequences when young people's accounts of themselves are publicly questioned or invalidated within systems that hold authority over recognition and care (Fricker, 2007; Noone et al., 2025). Concurrently, my professional experience as a clinician in training

highlighted the distance between the certainty expressed within media and political narratives and the realities of clinical work: a field frequently characterised by uncertainty, relational labour, and negotiation (Ballatt & Campling, 2011; Greenhalgh & Hurwitz, 1999; Montgomery, 2006).

The scoping review reinforced the empirical rationale for the present inquiry. Across diverse child, young person, and family services, professionals encounter moral experiences associated with distributed responsibility, competing obligations, and institutional constraint. However, comparatively little attention has been paid to how these experiences are understood, carried, and integrated into professional identities over time. Together, these findings reinforced the rationale for the present inquiry and informed the research aims and guiding questions presented in Appendix M.

Since the commencement of this project, the institutional landscape has continued to evolve. The publication of the Cass Review, the formal closure of the national service, and the subsequent reconfiguration of care have fundamentally altered the environment for both clinicians and families. At the same time, substantial methodological critiques of the Cass Review have emerged within the academic literature, raising questions regarding the evidence base underpinning these structural developments (Cass, 2024; NHS England, 2022; Noone et al., 2025).

Further concerns have been raised regarding the impact of service reconfiguration on patient safety and outcomes. In 2024, an independent review concluded that available evidence did not demonstrate a causal relationship between service changes and deaths by suicide among young people referred to gender identity services (Appleby, 2024). More recently, however, newly available data published in 2026 prompted renewed concern. Analyses from the National Child Mortality Database suggested a greater number of deaths by suicide among transgender young people than had previously been reported, raising critical questions regarding how such deaths are interpreted and understood within the context of rapidly changing service provision, and the evidence and rationale behind them (Good Law Project, 2026).

Against this backdrop, it becomes essential to attend to the accounts of clinicians who worked within the service during this period. As the context continues to evolve, understanding how those delivering care experienced and made sense of these developments remains vital. By centring the narratives of those on the clinical front line, this study seeks to contribute to broader understandings of care, responsibility, and professional identity within contexts of existential threat and contested social narratives.

Chapter 3: Empirical Methodology

3.1 Introduction

Building upon the contextual, theoretical, and empirical foundations established in Chapter 1, this chapter outlines the methodological approach adopted for the present study. Given the study's focus on meaning-making, experience, and narrative, a qualitative methodology was adopted. The research is informed by a critical realist ontology and a moderate social constructionist epistemology, with narrative inquiry providing the overarching methodological framework.

The chapter outlines the philosophical and methodological foundations of the study before describing participant recruitment, data generation, analysis, ethical considerations, and approaches to research quality..

Together, these sections provide an account of how knowledge was generated within the study and the methodological decisions that shaped the interpretation of participants' narratives.

3.2 The Research Encounter: Reflexivity and the Adjacent Witness

Reflexivity was employed throughout this study not as a means of eliminating subjectivity, but as an ongoing ethical and methodological practice of examining how my positioning shaped the research process and the meanings co-constructed within it. While the personal and professional origins of this inquiry were established in Chapter 1, this section analyses how those locations actively influenced the generation and interpretation of the data.

Reflexive box: Shortly after completing the interviews, I visited a retrospective exhibition of Lucian Freud's work, intending it to be a break from the emotional intensity of the research. Instead, it became unexpectedly reflexive.

As a clinical psychologist, I was struck by returning to the Freud name through a very different medium. Standing in the exhibition, I found myself thinking not only about Lucian Freud's paintings, but also about interpretation itself. His portraits, particularly of young men, prompted reflections on vulnerability, embodiment, and the ways gendered meanings become attached to bodies. I found myself wondering how Freud's own biography, historical context, relationships, and cultural assumptions had shaped the people he chose to paint and the way he painted them. Critics have long remarked on his distinctive portrayal of the eyes, and I noticed how readily I found myself interpreting them through the conversations I had spent months immersed in. Whether these readings reflected Freud's intentions became less important than recognising that they reflected my own.

It was during this visit that I encountered Freud's reflection, *"Everything is autobiographical, and everything is a self-portrait."* The quotation immediately resonated with the epistemological position underpinning this inquiry. It captured something I had come to appreciate through the research process: that researchers, participants, clinicians, artists, policymakers, and readers alike do not approach the world from nowhere. Every act of observation, interpretation, and meaning-making is shaped by the lives we have lived, the histories we inherit, the relationships we have known, and the cultural contexts in which we are situated.

The exhibition reminded me that reflexivity is not simply about acknowledging personal bias. It is about recognising that interpretation is always situated. Just as Freud's paintings were inevitably shaped by the person who created them, my engagement with participants' stories was shaped by the person listening. The aim of this inquiry was therefore not to eliminate the influence of the researcher, but to make visible some of the lenses through which I came to understand these narratives. In this sense, the quotation that introduces this chapter came to represent not only Freud's philosophy of portraiture, but the methodological and epistemological position that underpins this thesis: that every inquiry is, inevitably, also a self-portrait.

3.2.1 Social Order and the Lens of Moral Regulation

My interest in this research is informed by a personal history that has sensitised me to the ways institutions utilise moral language in the organisation of social life. Growing up within the continuing legacy of Section 28 and the cultural reverberations of the AIDS crisis[1], I became aware of how particular groups can become subject to heightened scrutiny, regulation, and exclusion through appeals to protection, common sense, and social order. These experiences informed my sensitivity to questions of legitimacy and authority, resonating with critical perspectives that understand institutional frameworks not as neutral systems, but as arrangements that may reproduce particular forms of power whilst marginalising others (Crenshaw, 1989; Foucault, 1980; Kairys, 1998).

Reflexive Impact: This attunement to moral regulation directly impacted the research encounter by shaping my listening. I was hyper-aware of when the rhetoric of protection appeared in participants' accounts, not as a neutral clinical goal, but as a potential site of professional and ethical constraint. It allowed me to probe the binary of protection from a place of shared historical understanding. However, this carried a reflexive risk: my predisposition towards narratives of exclusion required constant monitoring to ensure I did not project a story of injustice onto participants who may have been narrating their experience through different frames.

3.2.2 Navigating Anticipated Wariness: Relational Accountability and the Research Collective

The generation of data took place within a context of unprecedented professional risk. Many prospective participants had been subject to escalating public scrutiny and felt uniquely visible yet silenced within public discourse. Consequently, there was an anticipated and understandable wariness among participants, several of whom expressed concerns about having been previously misrepresented in the media or feeling unsupported by institutional structures.

To address this and ensure the study remained grounded in the material and ethical realities of the service, the research team was deliberately composed of individuals with direct GIDS experience. This included a second supervisor and a field consultant, representing different professional roles within the service during the relevant period. Their involvement served as an ethical safeguard to

[1] Growing up in Britain in the decades following Section 28 and the AIDS crisis, these histories have shaped my understanding of LGBTQ+ lives and the ways in which silence, stigma, and public narratives influence individual and collective experience. For me, Section 28 represents not only a piece of legislation, but its enduring cultural legacy of silence, invisibility, and internalised stigma surrounding LGBTQ+ identities. Similarly, the AIDS crisis represents both the devastating loss of a generation of predominantly gay men and the absence of many of the voices, relationships, mentors, and collective memories that might have shaped those who followed. History has informed my sensitivity to participants' descriptions of politicisation, misrecognition, and the marginalisation of clinical and community voices. This is not intended to suggest that these historical contexts are equivalent to contemporary experiences of trans communities, but rather to acknowledge the historical lens through which I approached this inquiry.

ensure the research did not inadvertently replicate the harms of decontextualised or hostile narratives (Andrews et al., 2008; Riessman, 2008).

Reflexive Impact: The presence of these insider perspectives significantly shaped the research encounter, signalling to participants that their professional world was understood from within. This helped establish the trust necessary for participants to move beyond carefully managed or professionally guarded accounts (Berger, 2015; Dwyer & Buckle, 2009). This was not a strategy of persuasion, but a commitment to eliminating harm by ensuring that both the interview process and analytic interpretations were subject to reflexive scrutiny by those who understood the professional and emotional stakes of the work.

Furthermore, collaboration with an Expert by Experience (EbE) consultant, a trans-identifying academic researcher, provided a critical counterbalance to this internal clinical expertise. This reflexive appraisal ensured the study remained attentive to how professional narratives are situated within wider systems of power and institutional legitimacy (Butler, 2004; Crenshaw, 1989; Kairys, 1998). The EbE's role was central in reducing the possibility that the study might inadvertently reproduce the deficit-based understandings that trans and non-binary (TNB) communities have often described as harmful.

3.2.3 The 'Inspected' Identity: Trainee and Clinician

I use the term *inspected identity* to describe the ways professionals may come to understand themselves and their work within systems characterised by ongoing audit, surveillance, accountability, and external scrutiny (Ball, 2003; Power, 1997). My professional formation as a trainee clinical psychologist occurred within a healthcare system increasingly shaped by governance, audit, and public accountability (Power, 1997; Strathern, 2000). This status created a powerful parallel with the participants, whose own service had been rated Inadequate by the Care Quality Commission (CQC) and was subject to constant review. Notably, the CQC's rating coexisted with findings that staff demonstrated high levels of commitment and that care was experienced as compassionate (Care Quality Commission [CQC], 2021).

Reflexive Impact: This shared inspected identity facilitated a professional shorthand where participants felt they did not have to explain the weight of administrative pressure or the relational labour of care. However, sitting as a researcher within these stories required significant emotional regulation. During interviews where participants became tearful while recounting the service's closure or a sense of professional betrayal, I had to balance my clinical instinct to contain their distress with my research goal to allow the narrative rupture to speak. My role was to remain an adjacent witness: someone professionally invested in the provision of care while remaining outside the immediate professional risks they had endured.

3.2.4 Analytic Integrity and the Co-Constructed Narrative

Within this thesis, co-construction refers specifically to the relational production of meaning within the research encounter. Participants brought their experiences and interpretations to the interview, while my questions, responses, positioning, and the developing interaction shaped how those experiences were narrated within that particular context (Andrews et al., 2008; Riessman, 2008). Co-construction does not imply that participants or the Expert by Experience (EbE) were involved in analysing the data or producing the final interpretations; responsibility for these remained mine as the researcher.

Reflexivity was embedded throughout data generation and analysis through reflective journalling and supervision, allowing me to attend to how my positioning shaped both the interview encounter and my subsequent interpretation of participants' narratives. My role was not to adjudicate a singular truth regarding the service's closure, but to attend to how these clinicians made sense of their ethical commitments during a period of existential threat. Through this reflexive awareness, I sought to honour the complexity of participants' experiences while acknowledging the specific interpretive frameworks, shaped by my queer history, trainee status, and clinical ethics, through which I heard and represented them (Andrews et al., 2008; Finlay, 2002; Riessman, 2008).

3.3 Ontological and Epistemological Positioning

This study is grounded in a critical realist ontology and a moderate social constructionist epistemology. While these positions are occasionally viewed as being in tension, their integration is essential for a narrative inquiry situated within the highly regulated and materially consequential environment of the NHS (Bhaskar, 1978; Berger & Luckmann, 1966; Maxwell, 2012). This section outlines the philosophical architecture through which clinicians' accounts are approached, allowing them to be understood as situated interpretations of experiences that are simultaneously socially mediated and materially consequential.

To support reflexive transparency, each subsection concludes with a brief "Positioning in Action" commentary. Following calls for reflexivity as an ongoing ethical and methodological practice rather than a static biographical statement (Finlay, 2002; Tracy, 2010; Yardley, 2000), these commentaries make explicit how philosophical commitments informed analytic attention, interpretation, and methodological decision-making throughout the study. In doing so, reflexivity is treated not as an additional procedural step but as an active analytic practice of "negotiating the swamp" of research and interpretation (Finlay, 2002).

3.3.1 Critical Realism: Acknowledging Material Energy

Critical realism provides the ontological assumption that social and institutional structures exist independently of individual perception and exert real, material effects on people's lives (Bhaskar, 1978; Sayer, 2000). Within this framework, institutions such as healthcare systems, regulatory bodies, and governance arrangements are understood as enduring and consequential: they shape the conditions under which professional practice occurs, even as they are experienced and interpreted in varied ways.

This positioning was significant to the design of the present study. It allowed clinicians' accounts to be approached as situated interpretations of experience without reducing the organisational conditions in which those experiences occurred to matters of discourse alone. The research questions attended both to how clinicians understood and made sense of their experiences and to how organisational, political, and sociocultural conditions shaped the possibilities and constraints of providing care. This orientation similarly informed the interview schedule, which invited participants to move between their lived experiences and the organisational, professional, and wider contexts through which they understood them. Analytically, it supported attention to the relationship between individual meaning-making and the material conditions of practice, while recognising that the same conditions could be experienced and interpreted differently.

Reflexive Impact: This ontological stance ensures the analysis does not collapse participants' experiences into pure discourse. It allows the researcher to treat the "inspected identity" and "administrative pressure" as real, external constraints that produced visceral effects on clinicians, rather than viewing them as optional narrative choices. By recognising the material force of structural events, such as the 2021 CQC rating or the 2024 service closure, the analysis can explore how these real-world conditions functioned as the existential threat identified in the study's title.

3.3.2 Moderate Social Constructionism: The Mediation of Meaning

Epistemologically, the study adopts a moderate social constructionist orientation. This recognises that while institutional structures have material force, our knowledge of them is always mediated through language, discourse, relationships, and historically situated forms of understanding (Berger & Luckmann, 1966; Burr, 2015). Meaning is therefore approached not as a direct reflection of events, but as a product of social interaction and narrative practice (Andrews et al., 2008; Riessman, 2008).

Reflexive Impact: This epistemology informs the use of the "phantasmatic" as an analytic lens. It allows the researcher to examine how circulating public narratives constitute a social reality that clinicians must navigate. Rather than seeking a "factual" account of the service's history, the analysis focuses on how participants utilised available cultural and institutional resources to make sense of their ethical commitments, the work itself and professional identities.

3.3.3 The Intersection: Navigating Structural Determinism and Discourse

The integration of a critical realist ontology and a moderate social constructionist epistemology provide the philosophical architecture necessary to navigate the polarised narratives surrounding the closure of GIDS. This combined stance avoids reducing clinician's experiences either to structural determinism, where clinicians are viewed as passive objects of policy, or to radical constructionism, which might treat material institutional changes as purely discursive events without tangible consequences.

By adopting this integrated position, the study acknowledges that the organisational conditions of the service, including the Care Quality Commission (CQC) ratings and the formal closure, were consequential structures that exerted material force on clinicians. However, it simultaneously recognises that these seemingly systematic processes were mediated through phantasmatic constructions: socially and culturally mediated imaginaries that shape what becomes recognised as credible, threatening, or worthy of protection long before a clinical encounter occurs. This allowed for a context in which institutional audits, while appearing objective and systematic in their focus on risk and safety, could themselves be understood within wider contested narratives regarding the nature of gender identity healthcare and the legitimacy of trans identities.

Reflexive Impact: This dual focus is critical in the analysis of moral distress and moral injury. Critical realism acknowledges the real, structural barriers to care, such as resource limitations, legal shifts, resulting from the Bell v Tavistock judgment, and the subsequent reconfiguration of service provision. Concurrently, social constructionism foregrounds how these material barriers were interpreted by clinicians as violations of deeply held moral values and professional commitments.

In practice, this means the visceral weight of the institutional audit is not seen as determining a professional's story, but as the material ground upon which their story was built. By maintaining this reflexive intersection, the study can examine how clinicians negotiated their professional identities within a field where the "systematic" look of governance often obscured the underlying phantasmatic narratives of moral panic and contestation. This approach ensures that knowledge remains situated and contingent, honouring the partiality of individual accounts while remaining critically attentive to the broader systems of power and meaning through which those accounts were produced.

3.3.4 Partiality, Contingency, and Analytic Integrity

Ultimately, knowledge within this framework is understood as partial, situated, and contingent (Haraway, 1988). Multiple accounts of the same institutional context are therefore expected: they are viewed not as competing claims to a singular truth, but as reflections of different positionalities and narrative locations (Andrews et al., 2008).

Reflexive Impact: This orientation requires treating contradiction and ambivalence as analytically meaningful rather than as problems to be resolved. In the analytic phase, this meant that when a participant's story was interrupted by tearfulness or a sense of professional betrayal, these moments were handled not as deviations from a factual record, but as sites where the material force of the service closure collided with the narrative negotiation of identity. This orientation aligns closely with the study's interest in moral distress and moral injury, phenomena that emerge in contexts where professional values, institutional demands, and public narratives come into tension and cannot easily be reconciled (Čartolovni et al., 2021; Rushton, 2018).

3.4 The Phantasmatic and the Narrative Hinge

"For myth is alive at once and in all its parts, and dies before it can be dissected."

"The incarnate mind, the tongue, and the tale are in our world coeval." - J.R.R. Tolkien (1983)

From this positioning, meaning is understood as something that comes into being not only through lived experience, but through its telling, retelling, and wider circulation (Bruner, 1990; Riessman, 2008). The quotes above highlight the inseparable nature of experience, speech, and story: the "incarnate mind" of the clinician, the "tongue" that speaks of care, and the "tale" that is told in public discourse are born together and cannot be easily untethered. In this sense, language does not merely describe the clinical world, but participates in shaping what becomes possible within it, particularly when it is spoken with institutional authority and amplified through repetition (Austin, 1962; Butler, 1997; Foucault, 1980).

In contemporary healthcare contexts, these dynamics operate through policy discourse, media reporting, and political debate, where partial or decontextualised narratives can acquire a state of moral certainty through circulation (Foucault, 1980; Hall, 1997). As discussed in Section 3.3.3, this creates a context in which institutional processes, such as audits or reviews, may appear systematic and objective, yet are propelled forward by phantasmatic constructions and dogmatic assertions regarding the nature of gender identity and the legitimacy of care. Like the "myth" described by Tolkien, these phantasmatic narratives function as living, coherent wholes that resist simple dissection by the data of the clinical room.

From a queer theoretical perspective, these processes are not neutral. Normative frameworks govern which forms of knowledge are authorised, whose accounts are rendered credible, and which stories are repeatedly amplified or silenced (Ahmed, 2017; Butler, 2004). As dominant narratives take hold, the quieter, relational stories of care and ethical labour are frequently crowded out, despite their fundamental significance to lived practice. This is particularly evident where marginalised voices, or those providing care for them, are positioned as less credible within dominant systems of knowledge (Andrews et al., 2008; Dotson, 2011; Frank, 2013).

This study attends to those narratives that have remained largely unheard within these processes. By centring the "tongue" of the clinician, the research approaches these accounts as situated responses to lived conditions. These are stories through which professional identity, responsibility, and ethical commitment were negotiated over time, held at the intersection of the material reality of the service and the phantasmatic imaginaries of the public sphere (Clandinin & Connelly, 2000; Riessman, 2008).

3.5 Narrative Inquiry: Framework and Rationale

The narrative landscape described thus far, characterised by competing public myths and a profound dissonance between institutional accounts and clinical realities, leads to a necessary and obvious alignment with narrative inquiry. Given the study's focus on how meaning is co-constructed, narrative inquiry (NI) provides the most robust framework for attending to the storied nature of human experience. Rather than treating accounts as neutral reports of events, NI operates from the assumption that meaning is actively produced through narrative practices situated within specific social, institutional, and historical contexts (Bruner, 1990; Riessman, 2008).

In the context of the Gender Identity Development Service (GIDS), this approach is uniquely suited to examining moral distress and moral injury, phenomena often defined by ethical ambiguity, unresolved tension, and systemic constraint (Čartolovni et al., 2021; Litz et al., 2009; Shay, 2014). Narrative inquiry allows for an exploration of how participants narrate responsibility, conflict, loss, and care without reducing these experiences to static categories or singular explanatory frames (Andrews et al., 2008; Riessman, 2008). By centring the clinician's story, the research honours the complexity of practice during a period in which the very legitimacy of that work was being publicly and politically redefined (Andrews et al., 2008; Bruner, 1990; Hall, 1997).

A strength of this methodology is its explicit attention to temporality, which is essential for capturing staff experiences across a period of organisational transition, including anticipation, rupture, and aftermath (Clandinin & Connelly, 2000; Polkinghorne, 1988). Narrative approaches attend to how individuals locate experiences within past, present, and anticipated futures, allowing for an analysis of how professional identities and moral positions were reshaped as the service moved toward closure (Clandinin & Connelly, 2000; Riessman, 2008). This orientation aligns with the study's critical realist foundation by acknowledging participants' stories as situated responses to real institutional constraints and moral demands while retaining a focus on the interpretative mediation of those events (Bhaskar, 1978; Sayer, 2000; Willig, 2011).

Narrative inquiry was selected in preference to other qualitative methodologies because it preserves the complexity and integrity of participants' accounts (Andrews et al., 2008; Riessman, 2008). While reflexive thematic analysis prioritises patterns across a dataset and risks decontextualising experiences from their relational frameworks, narrative inquiry maintains the coherence of the individual story (Braun & Clarke, 2021; Riessman, 2008). Similarly, while Interpretative Phenomenological Analysis (IPA) offers rich idiographic detail, NI is better positioned to attend to the broader systemic and discursive forces shaping the narrative, as its focus extends beyond individual sense-making to narrative positioning within wider contexts (Riessman, 2008; Smith et al., 2009).

Ultimately, this framework provides a methodological container capable of holding contradiction, multiplicity, and partiality, ensuring that the clinicians' accounts are taken seriously as situated forms of knowledge (Andrews et al., 2008; Polkinghorne, 1988).

3.6 Participant Selection and Sampling Strategy

The methodology for participant selection was designed to move beyond the decontextualised narratives found in public discourse by centring the situated knowledge of those on the clinical front line. This section outlines the purposive strategy and recruitment procedures used to generate the study's sample.

3.6.1 Purposive Sampling Strategy

Participants were recruited using a purposive sampling strategy, which is consistent with qualitative designs that prioritise depth, relevance, and contextual experience over statistical representativeness (Braun & Clarke, 2021; Patton, 2015). The strategy targeted former clinical staff with direct experience of working at GIDS during the critical period leading up to and including the service's closure. This approach ensured that the storytellers were uniquely positioned to provide narrative accounts of the existential threat and institutional rupture under study (Clandinin & Connelly, 2000; Riessman, 2008).

3.6.2 Recruitment

Recruitment was facilitated through a professional peer network, specifically a private messaging group for former GIDS staff, with written consent from the group's Administrator. A recruitment poster was shared within this space, inviting individuals to express interest voluntarily via a secure university platform.

As established in Section 3.2.2, the anticipated and understandable wariness of this cohort required a recruitment process grounded in relational accountability. The involvement of GIDS-experienced members in the research team acted as an essential bridge, providing the necessary credibility to facilitate access. This was not an attempt at persuasion, but a commitment to creating the relational conditions of trust required for narrative storytelling to become possible (Andrews et al., 2008; Riessman, 2008).

3.6.3 Inclusion and Exclusion Criteria

The criteria for participation were designed to ensure that the sample consisted of individuals with direct clinical experience of the service during its period of existential threat, whilst maintaining an ethical commitment to participant agency. This meant avoiding unnecessary exclusion criteria beyond participants' capacity to provide informed consent, recognising their autonomy to decide

whether participation was appropriate for them and what aspects of their experiences they wished to share.

Inclusion Criteria: Participants were eligible to take part if they met the following requirements:

- Aged 18 years or older.
- Employed in a clinical capacity at GIDS during the relevant period (2020–2024).
- Able to provide informed consent.
- Proficient in English for the purposes of an in-depth narrative interview.

Exclusion Criteria and Ethical Nuance: Beyond the requirement for informed consent, no additional exclusion criteria were applied. This was a deliberate methodological choice, reflecting the study's commitment to respecting participants' autonomy in deciding whether to participate and how they wished to narrate their experiences, rather than the researcher making assumptions about who should or should not contribute.

Reflexive box: this approach sought to navigate the tension between respecting participants' autonomy and the researcher's ethical responsibility to minimise harm. While the study did not formally exclude individuals based on mental health status, particular care was taken when prospective participants indicated they were experiencing significant distress or were uncertain about taking part. In such instances, they were encouraged to consider whether involvement felt appropriate for them at that time, rather than being subject to a paternalistic exclusion. This shift from rigid exclusion to reflective encouragement ensured that participation remained entirely voluntary and supported individuals in making autonomous decisions about their own narrative safety.

3.6.4 Anonymity and Deductive Disclosure

Given the small and highly specialised nature of the participant cohort, deductive disclosure presented a particular ethical concern: participants could potentially become identifiable through combinations of otherwise non-identifying details (Kaiser, 2009). Protecting anonymity therefore required attention not only to direct identifiers, but to how professional, demographic, and narrative information might become identifying when presented together. The following strategies were employed while seeking to preserve the integrity of participants' accounts:

- **Pseudonymity:** Participants selected their own pseudonyms, retaining some agency over how they were represented within the thesis.
- **Selective Reporting:** Potentially identifying details, including specific professional roles, service locations, and exact timelines, were removed or generalised where necessary.
- **Decoupling Data:** Demographic information was collected to provide contextual understanding but was stored and considered separately from participants' narrative accounts and was not linked to individual extracts in the presentation of findings.
- **Linguistic Neutrality:** Transcripts did not report accents, speech patterns, or specific language backgrounds where these might contribute to identification.

These decisions involved a methodological trade-off. Participants differed in age, professional role, career stage, length of experience within GIDS, and wider social and professional positioning, all of which could be relevant to how responsibility, organisational authority, agency, and change were experienced. However, systematically linking these characteristics to individual narratives would have increased the possibility of deductive disclosure within an already identifiable professional population. Demographic information therefore informed contextual understanding without being used to construct demographic comparisons between participants.

This necessarily limited the extent to which intersectional patterns could be examined across the dataset. The study was not designed as an intersectional analysis, and social or professional characteristics were not treated as deterministic explanations for participants' experiences. Where aspects of participants' positioning became meaningful within their narratives, these were attended to interpretively. Nevertheless, the deliberate decoupling of demographic information from individual narratives limits the claims that can be made about how intersecting social and professional positions shaped experience.

3.6.5 Sample Size and Narrative Depth

The final sample size was determined by the requirement for narrative depth, rather than the pursuit of thematic saturation. In narrative inquiry, the aim is not to reach a point where no "new" information is generated or to produce a unifying model, but to preserve the complexity and integrity of individual stories (Andrews et al., 2008; Polkinghorne, 1988; Riessman, 2008). Consequently, the study prioritised a smaller, focused cohort to allow for meticulous attention to the temporality, relationality, and contextual positioning of each participant’s account (Clandinin &

Connelly, 2000; Polkinghorne, 1988). The sample size also reflects the practical scope and requirements of a doctoral thesis project.

A total of eight participants were recruited, representing the maximum number of individuals from the specific professional peer network who felt able or motivated to participate within the study's timeframe. Participation was facilitated by a trusting and psychologically safe interview environment, which supported participants to reflect upon and narrate their experiences openly. Given the small and highly specialised nature of the GIDS clinical cohort during the service's final years, this sample size is consistent with narrative inquiry's emphasis on idiographic depth and rich case-based understanding (Kaiser, 2009; Riessman, 2008). Rather than seeking statistical generalisability, the study aimed to generate a contextually grounded understanding of clinicians' experiences within GIDS (Haraway, 1988).

3.6.6 Participant Withdrawal and Ongoing Consent

Participants were informed that they could withdraw from the study without providing a reason for up to two weeks following the completion of their interview. This specific timeframe was selected to ensure that participants retained meaningful control over their contributions while acknowledging the practical constraints of the narrative analytic process. Given that narrative inquiry involves a time-intensive sequence of verbatim transcription, meticulous anonymisation, and the iterative integration of narrative material into the interpretive phase, a defined withdrawal period was necessary to protect the integrity of the project once analysis had commenced (Riessman, 2008).

Consistent with the study's commitment to relational accountability, informed consent was approached as an ongoing process rather than a single procedural event. Participants were reminded at the start of the interview that their involvement remained entirely voluntary and that they could decline to answer specific questions, request breaks, or terminate the conversation at any point without penalty.

This approach sought to honour the clinicians' agency, given the unsolicited visible nature of their previous professional roles. By providing a clear pathway for withdrawal and encouraging reflective participation, the study sought to ensure that participants felt safe to share their accounts on their own terms, while maintaining the rigour required for a doctoral-level inquiry (Andrews et al., 2008; Clandinin & Connelly, 2000; Riessman, 2008).

3.6.7 Data Generation

The Narrative Interview: Data were generated through narrative-style, semi-structured interviews conducted remotely via Microsoft Teams. This format was selected to prioritise participants' own

storytelling practices, providing the space necessary for individuals to construct extended accounts of their experiences while situating them within broader social and institutional contexts (Clandinin & Connelly, 2000; Riessman, 2008). By employing open-ended prompts, the interviews encouraged participants to reflect on their professional journeys at GIDS, including significant moments of transition and the impact of the service's closure. Consistent with the study's critical realist orientation, participants were invited to move between their lived experiences and the organisational, professional, and sociopolitical conditions they understood as enabling or constraining practice.

The Interview Process and Topic Guide: Interviews typically lasted between 60 and 120 minutes, with breaks offered at the one-hour mark to manage the emotional intensity of the discussion. The interaction was guided by a topic guide used as a flexible orienting device rather than a prescriptive schedule, enabling participant-led storytelling while ensuring that areas relevant to the research aims were addressed (Riessman, 2008; Andrews et al., 2008). As detailed in Section 3.2.2, this guide was refined through consultation with an Expert by Experience (EbE) to ensure that the language and framing remained sensitive to the sociopolitical complexities of gender identity healthcare. The full topic guide is provided in Appendix H.

Clinical Monitoring and Narrative Safety: Consistent with the trauma-informed principles established in Section 1.3.3, I utilised my clinical training to monitor participants' emotional wellbeing throughout the encounter. I remained attentive to signs of distress, reminding participants they could pause, decline to answer, or stop the interview at any point without explanation. In instances where the narrative was interrupted by emotion, space was provided for emotional expression without intervention, allowing the participant to regulate the pace and tone of their account. Supporting this emotional regulation was considered a core relational and ethical responsibility of the interviewer.

Transcription and Participant Review: All interviews were video- and audio-recorded with informed consent and transcribed verbatim using Microsoft Teams before being checked against the original recordings for accuracy. Participants were not asked to review or amend interview transcripts. Consistent with the study's moderate social constructionist epistemology and narrative inquiry methodology, transcripts were understood as records of a co-constructed research encounter rather than objective accounts requiring participant verification (Riessman, 2008). Consequently, member checking was not considered an appropriate strategy for establishing analytic validity, as the inquiry sought to understand how participants made meaning within the interview context rather than produce a definitive account of experience (Birt et al., 2016; Braun & Clarke, 2013).

Reflexive Documentation: Reflexivity was integrated throughout the inquiry through the maintenance of a reflexive journal. Following each interview, I documented emotional responses, assumptions, emerging interpretations, and observations regarding the relational dynamics of the encounter. This practice supported ongoing critical reflection on how my positioning shaped the co-construction and interpretation of participants' narratives, helping ensure that the analysis remained attentive to the specific context in which the stories were told (Finlay, 2002).

Excerpts from the reflexive journal are provided in Appendix G to demonstrate how reflexive thinking developed across the research process. Where relevant, reflexive commentaries are also incorporated throughout the thesis in highlighted text boxes, providing transparency regarding the interpretive decisions, responses, and methodological considerations that informed the evolving analysis.

3.7 Ethical Considerations

Ethical considerations informed the design and conduct of this inquiry from its inception and are integrated throughout this chapter. Ethical approval was obtained from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee (Protocol No. 1215 2025 Oct HSET). Participants received a detailed Participant Information Sheet (Appendix C) and provided written informed consent (Appendix B), recognising consent as an ongoing process rather than a single event.

The principal ethical considerations underpinning the inquiry are summarised in Table 3.1, with detailed discussion provided in the referenced sections.

Table 3.1: Ethical considerations

Ethical consideration	Summary	Location
Relational access and trust	Recruitment was developed through trusted professional relationships following ethical approval, recognising the relational conditions required to access a professionally vulnerable community.	Sections 3.2.2 and 3.6.2
Participant agency and autonomy	Procedures relating to informed consent, inclusion and exclusion criteria, voluntary participation, and participant withdrawal are described in Sections 3.6.3 and 3.6.6.	Sections 3.6.3 and 3.6.6

Confidentiality, anonymisation, and data management	Enhanced measures were adopted to minimise deductive disclosure within a small, specialised participant group. Identifiable information was stored separately from interview data on secure University of Hertfordshire servers with access restricted to the research team. In accordance with the approved data management plan, identifiable information was securely deleted following completion of the project by the first supervisor, Dr Rebecca Adlington.	Section 3.6.4
Participant wellbeing and narrative safety	Interviews were conducted with ongoing attention to participants' emotional wellbeing, including clinical monitoring, opportunities to pause or discontinue participation, and appropriate signposting where required.	Section 3.6.7
Researcher reflexivity	Reflexive practice, supervision, and documentation supported ongoing consideration of researcher positioning, ethical decision-making, and interpretation throughout the inquiry. Reflexive journal excerpts are provided in Appendix G, with selected reflexive commentaries incorporated throughout the thesis.	Section 3.X; Appendix G

3.7.1 Expert by Experience Consultation

The involvement of an Expert by Experience (EbE) consultant reflected a commitment to relational accountability and qualitative rigour. The consultant, an academic researcher who identifies as trans and whose work explores the mental health of marginalised communities, provided critical reflexive feedback on the study's conceptual development, interview topic guide, and the wider sociopolitical context surrounding gender identity healthcare. Their feedback informed the language, tone, and framing of interview questions, helping to minimise deficit-based assumptions and strengthen the sensitivity of the interview design while ensuring clinician narratives remained situated within their broader social and political contexts.

Reflexive Process: The impact of this reflexive consultation is evidenced by several key modifications to the research instrument. Following the consultant's invitation to reflect on the decision to focus on clinicians rather than service users, prompts in the topic guide were refined to ensure that professional accounts remained explicitly situated within the context of the structural marginalisation experienced by trans communities.

For example, where initial questions focused on institutional risk management, the guide was adjusted to explore how clinicians navigated the phantasmatic imaginaries that frequently framed their work as inherently threatening or controversial. This shift ensured that the interviews did not treat clinicians as neutral observers but as actors whose narratives were co-constructed alongside the lived realities of those for whom they provided care. By refining the phrasing and scope of these questions, the study remained attentive to power and social regulation, ensuring that the clinicians' ethical labour was analysed without marginalising the community at the heart of the service.

The role of the EbE was consultative rather than co-analytic. Their involvement informed the conceptual framing and development of research materials, but did not extend to data generation or analysis, for which responsibility remained mine as the researcher. This distinction was maintained deliberately to avoid positioning a single individual as representative of a broader community and to ensure that accountability for analytic decisions remained clearly located within the doctoral research process (Brett et al., 2014). This collaboration ensured the research remained attentive to the ethical responsibilities inherent in conducting inquiry within a politically contested social field.

3.8 Analytic Strategy

The data were analysed using an interpretive narrative approach grounded in the work of Riessman (2008) and Andrews, Squire, and Tamboukou (2008). This framework informed an analytic focus on narrative content, structure, and performance, supporting an exploration of how participants constructed meaning and negotiated professional identities over time (Andrews et al., 2008; Riessman, 2008). The study's critical realist orientation additionally supported attention to the material and institutional conditions within which these narratives were situated. Consistent with narrative inquiry principles, the analysis unfolded through iterative and overlapping phases rather than a linear or procedural sequence (Clandinin & Connelly, 2000; Riessman, 2008).

3.8.1 Phase 1: Narrative Immersion and Reflexive Engagement

Analysis commenced with an immersive phase in which each transcript was engaged as a coherent whole prior to any fragmentation of the data (Andrews et al., 2008; Polkinghorne, 1988). This involved reading each transcript fully at least three times to attend to the overall narrative arc, tone, and stakes of the account (Riessman, 2008). During this stage, short narrative summaries were written to capture the central moral tensions and turning points within each participant's story. This process was supported by reflexive memo-writing to document emerging interpretive questions, emotional responses, and the assumptions I carried as an adjacent witness (Braun & Clarke, 2021; Finlay, 2002). This immersion ensured a deep familiarity with the integrity of each narrative, protecting against the risk of premature fragmentation.

> "I am not arguing that my third reading is 'truer' than my first or second; they are, simply, different. Although I think the thrice-told tale illuminates a layered complexity rather well, I am sure readings from other historical and dispositional standpoints can illuminate the material in other ways. There is never a single authorised meaning." *(Riessman, 2004)*

3.8.2 Phase 2: Case-Level Mapping and Structural Analysis

Following immersion, analysis proceeded to case-level interpretive mapping of each transcript. MAXQDA Analytics Pro (Version 26) was used to support the structural and interpretive organisation of narrative dimensions rather than traditional thematic coding (VERBI Software, 2026). This approach draws on narrative portraiture, which seeks to bridge individual clinicians' accounts with the broader social and institutional narratives they inhabit (Rodríguez-Dorans & Jacobs, 2020).

Five narrative dimensions were identified to support the construction of each portrait:

- **Temporality (Blue):** Locating past positioning, turning points, moments of rupture, and anticipation of the future (Riessman, 2008).
- **Identity and Positioning (Green):** Identifying professional identity claims, moral self-descriptions, and "we" versus "they" language (Bamberg, 2004; Riessman, 2008).
- **Moral Tension and Ethical Stakes (Orange):** Identifying expressions of conflict, responsibility, and tensions between care and governance (Litz et al., 2009; Rushton, 2024).
- **Institutional and Sociopolitical Discourses (Purple):** Identifying references to media, policy, and broader institutional or systemic discourse (Andrews et al., 2008; Foucault, 1980).

- **Interactional Features (Yellow):** Attending to the dialogic performance of the interview, including hesitations, laughter, and relational appeals (Riessman, 2008).

Together, these dimensions preserved case coherence while enabling a systematic examination of how concepts such as *moral distress* and *phantasmatic narratives* intersected within individual stories. Appendix J provides an example of the coding framework alongside an excerpt from an annotated transcript to illustrate this analytic process.

3.8.3 The Liminal Space and Phase 3: Constructing Narrative Portraits

Between the structural mapping of Phase 2 and the construction of narrative portraits, a deliberate period of analytic distance was maintained. This pause created space to sit with the clinicians' stories before progressing to the final interpretive synthesis, helping to avoid premature fragmentation while honouring the emotional weight of the research encounter.

In Phase 3, the mapped narrative dimensions were synthesised into narrative portraits, drawing on the framework of Rodríguez-Dorans and Jacobs (2020). Narrative portraiture seeks to preserve participants' voices while situating individual accounts within the wider social, cultural, and institutional contexts that shape them. Consistent with this approach, clinicians were treated as experts in their own lived and professional experiences, with interpretation directed towards understanding rather than reduction.

Constructing each portrait involved careful editorial judgement. Rather than reproducing transcripts verbatim or reducing accounts to themes, the portraits sought to retain the coherence, complexity, and emotional texture of participants' stories while recognising that narratives were co-constructed within the interview encounter. Interpretation remained closely grounded in the interview data while acknowledging the researcher's role in shaping the final narrative representation (Rodríguez-Dorans & Jacobs, 2020).

The resulting portraits situated clinicians' experiences within the organisational, institutional, and sociopolitical narratives through which they became meaningful, providing a systematic interpretive framework that connected individual experiences with the broader contexts in which they were lived.

3.8.4 Phase 4: Cross-Narrative Dialogue and Synthesis

The final phase involved placing the eight narrative portraits in dialogue with one another to explore areas of resonance and divergence. Rather than seeking thematic saturation, this cross-narrative

interpretation identified recurring moral tensions and shared narrative configurations while preserving the specificity and partiality of each account (Andrews et al., 2008; Riessman, 2008). This stage was conducted by laying the case summaries side by side to identify where clinical experiences echoed one another and where they remained distinct, ensuring the analysis did not collapse individual stories into abstract categories.

Consistent with the decolonial aims of narrative portraiture, this process was not used to "cleanse" the data into neat findings, but to build a bridge between individual experiences and the broader social narratives of gender identity healthcare (Rodríguez-Dorans & Jacobs, 2020). The synthesis remained critically attentive to the broader systems of power and meaning, examining how phantasmatic sociopolitical narratives entered the individual stories and how structural forces were personified or resisted (Andrews et al., 2008; Riessman, 2008). Ultimately, this process allowed for a synthesis of the cohort's experiences that honoured the participants as experts on their own lives while situating their ethical labour within the material reality of the service's closure (Bhaskar, 1978; Rodríguez-Dorans & Jacobs, 2020).

Chapter Four: Individual Narrative Portraits and Reflexive Accounts

In this chapter, I present the findings from the study using narrative inquiry as a methodological tool. First, I present interpretive individual narrative portraits of each participant, followed by the collective storylines developed through the cross-narrative analysis.

Accompanying each portrait is a reflexive box containing excerpts from contemporaneous reflexive writing. These boxes make visible aspects of my positioning, emotional responses, and experiences of the interview encounter, consistent with narrative inquiry's commitment to reflexivity, relationality, and the co-construction of meaning (Andrews et al., 2008; Rodríguez-Dorans & Jacobs, 2020). Rather than offering additional analysis of participants' accounts, they invite the reader into the relational space in which the narratives were told and heard, highlighting how researcher and participant shaped the interview encounter.

Reflexive Box: The construction of these portraits did not occur in a vacuum. As the analysis progressed, the legacy of institutional rupture described in this thesis continued to manifest through an escalating series of real-world events. Throughout the project and while I sat with transcripts, the news was punctuated by reports of the Supreme Court ruling on the definition of a woman and frequent radio broadcasts detailing an increase in queer and transphobic attacks and the continued politicisation of gender identity healthcare (Butler, 2024; Noone et al., 2025), reminding me of the harm being done to a community with each decision announced.

Working within what I came to understand as a rupture in time necessitated constant, and at times anxious, reflexive monitoring of my role as an adjacent witness. I felt a profound responsibility to ensure that I did not misrepresent participants' accounts or project my own sociopolitical concerns onto their professional stories. At the same time, I recognised that narrative inquiry inevitably involves editorial judgement to produce a coherent and accessible account. These tensions remained an ongoing focus of reflexive consideration throughout the analysis (Berger, 2015; Riessman, 2008).

4.1 JP

JP entered the interview with warmth, pace, humour, and caution. Before we began, they chose to blur rather than replace the background behind them, partially obscuring their home while allowing its presence to remain visible. I experienced this as a cautious invitation into the conversation, while simultaneously signalling the need for privacy and protection. This tension became explicit almost immediately. "I take our home security very seriously," JP explained, adding that they did not want the "Daily Mail outside" while walking the dogs. The humour was lively and disarming but carried vigilance too. From the outset, JP's account was shaped by the sense that being seen, or quoted, could have consequences.

JP came to GIDS with both professional commitment and personal proximity to the work. Having worked across adult and child mental health and education, they described themselves as coming from a "northern working-class town" and being "first generation to go to university". Their move into GIDS was narrated as values-driven work with communities to which they felt connected, including TNB and LGBTQ+ communities.

JP repeatedly described GIDS as "a very psychologically safe place to work", with "really good, robust line management, clinical supervision, reflective spaces" and opportunities for "processing the psychological emotional experience of the work". They later described relationships with families as "precious" and "respectful", and these remained the aspects of the work of which they were "most proud".

Yet this experience gradually became a story of rupture. JP described an increasing separation between GIDS and the wider Trust: "there really was a separation between GIDS and the Tavi". The language of leadership became "alien", accompanied by "the corporate face" and an implicit message to "smile, put up and shut up and get through this". Staff had repeatedly been led to believe they would transfer to the new services, only to be told "two weeks before Christmas" that "we would not be transferred to the new services" and that "we were not told that we were not going to have jobs". For JP, this was "taking away somebody's professional identity".

A central concern in JP's account was safety. Public and institutional language repeatedly referred to safe closure and safe transfer, but JP's own formulation was blunt: "it wasn't safe". They described the loss of clinical time, the absence of meaningful transition, continuing reporting demands, and the impact on children and families who had already waited years. JP spoke of the "weight of their journey", including families who had lost relationships because they affirmed their child's identity and young people devastated that care would not move at the pace they had hoped.

JP also described experiencing a loss of professional authority. Attempts to share evidence, contact professional bodies, and advocate through appropriate channels left them feeling "ignored", "gaslit", and "stonewalled". "Don't piss up my back and tell me it's raining," they reflected, capturing their anger at what they experienced as appeasing but inauthentic engagement. JP described speaking openly as carrying the threat of professional consequences, while online forums and discussion spaces were experienced as increasingly hostile and, in their view, "infiltrated".

A haunting dimension of JP's account was the depiction of transphobia as "an infection". Drawing on their healthcare background, they moved between "infection control" and "psychological harm", explaining that while clinicians can take the "gloves off", the "pinny [pinafore] off", or the "mask off", they "can't do that for psychological harm". The metaphor conveyed something pervasive and contaminating that could not be contained by ordinary professional boundaries.

This "infection" followed JP beyond the clinic. It manifested as "hyper vigilance", extending into ordinary moments and relationships: "Do I hold my partner's hand here?". The same fear that accompanied "walking my dogs in my wellies" and worrying about the "Daily Mail" being "outside [my] door" was also present in professional spaces that felt "infiltrated". The repeated invocation of safety appeared to carry a dual meaning, expressing concern for young people whilst also hinting at a sense of professional and personal unsafety that threaded through this period.

JP's account is not organised around resolution but around pride held alongside betrayal. Despite the "emotional, psychological gymnastics", they remained proudest of the "precious" and "respectful" relationships built with families. Their narrative became one of sustained care under conditions of public hostility, institutional rupture, and professional silencing, in which the work remained meaningful even as the systems around it became increasingly difficult to trust.

Reflexive Box: I remember feeling immediately comfortable with JP. I found myself laughing with them early in the interview and, although I shared little about myself, the interaction quickly felt familiar and easy. Given that so much of JP's account later centred on safety and unsafety, I was struck by the contrast between the content of the narrative and the relational atmosphere of the interview itself. I wondered whether humour became a way of establishing sufficient safety for difficult experiences to be approached.

Throughout the interview, I became increasingly curious about what the humour was accomplishing relationally. At times, it seemed to create connection and shared recognition. At others, it appeared to allow fear, betrayal and vulnerability to be approached indirectly. By laughing with JP and responding warmly, I may have communicated that this way of narrating experience was welcome within the interview. What became tellable appeared shaped not only by what JP brought, but also by the relational space we created together.

I also noticed moments when I wanted to slow the conversation. Brief references to "increased self-harm and some suicides, kids" carried considerable emotional weight and I experienced a pull to remain there and invite elaboration. At the same time, I was aware of wanting JP to determine where meaning was expanded and where it remained only briefly touched. I was left wondering whether the brevity of these statements itself communicated something important about experiences that resist sustained narration.

Reflecting afterwards, I was struck by how often the interview seemed to move towards and away from painful experiences in quick succession. Humour, metaphor and vigilance appeared to regulate proximity to emotionally live material, allowing difficult experiences to be approached without becoming overwhelming. I was left with a heightened awareness that bearing witness within narrative inquiry sometimes involves tolerating what remains partially spoken and resisting the impulse to move closer than the participant wishes to go.

4.2 Alice

Alice entered the interview in motion. They described themselves as "hyperkinetic". Even before speaking about GIDS, their account was characterised by pace, metaphor, and multiplicity. The interview began with practical adjustments: checking technology, making coffee, and gently laughing at the chaos of daily work life.

Alice situated themselves as "Gen X", as someone who had "sat outside gender norms, but without much language around that". Reflecting on their own journey, Alice explained that, for people of their generation, "we are very grateful to those who came after us for giving us language to talk about this". They spoke of having "not felt wholly comfortable", positioning their work with transgender, queer, and polyamorous communities within a longer personal and professional story. Having worked across multiple settings, they had been seeking a "more clinical space". Working in youth gender services became "an act of resistance" and one of the roles of which they felt most "proud".

Alice repeatedly returned to "whole family work", describing how "a lot of the time we were able to offer something that was helpful in people's lives". This extended beyond pathways into medical intervention. Instead, they described therapy offered in "whole family ways around communication", helping families "talk together about difference" and reflect on "CIS privilege in parents where we never thought about gender". They recalled facilitating these conversations and being able to "see the difference that made over time".

Time itself was repeatedly foregrounded in Alice's account. They reflected that "we're kind of there for years" and joked that "it takes years to get off the wait list, but once you do, we're never going to let you go". Relationships often extended beyond formal episodes of care. "You're kind of with us", Alice explained, before describing young people and families who later found them in private practice because they did not want to begin again elsewhere. One young woman was "turning 20 this year" and Alice had known her "since she was 14". Reflecting on this continuity, they simply concluded, "that kind of work is incredible".

Moments of grief repeatedly interrupted the momentum of Alice's narrative. Speaking about the Judicial Review, they recalled being pulled back into a room and hearing the outcome. "And then bump, literally, it's like a curtain came down." Becoming tearful, they said, "Oh my goodness ... I just got really emotional" and patted their eyes with open hands. They remarked that they had "had therapy since then" and thought they had "worked through this". Nevertheless, the event remained "clinically shocking". It "really, literally rocked me to the core."

A similar interruption occurred when speaking about young people who remained on waiting lists. Alice described them as "languishing", waiting without support or intervention. Pausing, they said quietly, "I possibly can't really think about that very much actually". Throughout the interview, movement and reflection repeatedly gave way to moments that seemed difficult to hold in language.

Yet each interruption was followed by movement. Alice's narrative continually returned to systems, timelines, and practical action. The period surrounding the closure was described through vivid metaphor. At one point, they likened it to one of those "joke Saturday afternoon TV shows" in which they had to "run over the spinning log", "dodge the balls", and "run up the slippery slope". Elsewhere, reflecting on the service closure, they remarked, "This was business unusual... the band played well, the Titanic sank". Even in loss, their account remained organised around movement, work, and responsibility.

Alice described the wider institution with disappointment and betrayal. They felt the "upper echelon" had failed to "have our back", opting instead for the "Tavistock silent thing" while clinicians continued to absorb hostility and uncertainty. Yet care itself increasingly became an "act of resistance". Staff worked "so so hard", completing transitions, letters, and endings with families, continuing "right up to the end". Returning after the service had closed, Alice found that GIDS had already been "scrubbed out". The "bubbly balloons" had been painted over. Elsewhere they reflected, "Olympus has fallen".

Asked what they remained proudest of, their answer was simple: "Being there". Their account became one of sustained care and enduring attachment, in which movement, humour, and action coexisted alongside grief that remained only partially resolved. Although the service had disappeared physically, the relationships and meanings attached to it continued to be carried within their narrative.

Reflexive Box: Alice's energy was striking on entry and I initially experienced it as disorientating. Their self-description as "hyperkinetic" felt partially congruent with their presentation. The interview carried a strong sense of movement, although I experienced this less as physical acceleration and more through rapid shifts between topics, metaphors, and timelines. I found myself repeatedly orientating and re-orientating within the conversation, trying to keep pace whilst resisting an urge to slow it down too quickly. The interaction felt warm and engaging, but there was also a strong sense of presence and authority. Although I could gently use the topic guide, I largely found myself following Alice's lead. Rather than directing the interview, I experienced myself as accompanying the movement of their narrative and became curious about what this continual forward motion was accomplishing.

Watching the recording back, I noticed myself becoming calmer and more still. My questions became slower and I felt an impulse to provide a steady and containing presence. In retrospect, I wondered whether our interaction involved a negotiation around pace. Alice repeatedly moved forwards through stories, metaphors, and practical descriptions, while I found myself introducing pauses and invitations to reflect. At times, it felt as though we were negotiating not only pace but also proximity: how quickly we moved and how long we remained with difficult experiences before moving on.

The atmosphere shifted when Alice became tearful whilst discussing the Judicial Review. They appeared surprised by their own response and I felt momentarily caught by the suddenness of the change. I noticed myself becoming more internally still and felt an impulse to remain with what had emerged. Instead, Alice gradually moved the conversation forwards and I followed their lead. A similar moment occurred when they spoke about young people "languishing" without support before quietly saying, "I possibly can't really think about that very much actually". The silence that followed felt unusually full and I became aware of the tension between wanting to stay with what had appeared and respecting the participant's way of managing proximity to painful experiences. I also became aware that the sense of presence and authority I experienced in Alice may have contributed to my willingness to trust the rhythm they established for approaching difficult material.

Reflecting afterwards, I found myself wondering what this continual movement was accomplishing within Alice's narrative. The rapid shifts between stories, metaphors, and timelines seemed to sustain momentum while also regulating proximity to emotionally difficult experiences. Moments of grief emerged with striking intensity but were rarely dwelt upon for long, giving way instead to humour, action, or practical reflection. I was left wondering whether these shifts functioned not as distractions from difficult experiences, but as part of how those experiences could be narrated and carried.

Looking back, I came to think that the interaction itself mirrored the account Alice was telling. Both moved through humour, metaphor, and action, punctuated by brief moments in which grief became unexpectedly present before receding again. Rather than interruptions, these shifts came to feel like the organising rhythm of the narrative itself, allowing continuity, responsibility, and care to remain at the centre of Alice's story.

4.3 Grayson

Grayson presented for the interview sitting on an "office chair", wearing glasses and a dark, soft-looking sweater. They expressed flexibility in their time, introducing a relaxed energy. Their speech was thoughtful and measured, often punctuated with phrases such as "sort of" and "you know". They required little prompting to explore complex ideas and remained reflective and deliberate throughout the interview.

Grayson positioned their arrival at GIDS as a natural progression of personal and professional interests. They moved through roles and found GIDS to be "a really great place to learn". They valued opportunities to think alongside colleagues from different professional backgrounds and described the service as offering the "unique experience" of accompanying a young person throughout their "journey", sometimes from the ages of "12 or 13" until transfer to adult services. Remaining alongside young people over such a significant period of their lives was experienced as "really special" and "so rare".

Clinical work was repeatedly described through the language of relationship and context. At the centre of practice were "holistic assessments" aimed at understanding the "whole person in all their contexts". Grayson carefully described a process that unfolded over time and involved thinking with young people and families about developmental histories, mental health, relationships, school experiences, and broader social contexts. The service "really tailor[ed] conversations to where young people were at". This was particularly important when discussing "more complex topics" such as fertility, sexuality, and future relationships. Such conversations were always "based on a consent basis". Grayson described creating sufficient space to think collaboratively about uncertain futures rather than seeking immediate solutions.

This commitment to complexity also shaped Grayson's understanding of gender. They described it as "a slightly ephemeral construct" that shifts "across time, across cultures" whilst simultaneously carrying "real implications" and "lived realities for people". Everyone, they suggested, has "a relationship to the construct", whether gender feels "rooted all the way through their being", more contingent, or not especially salient.

Grayson repeatedly described public narratives about GIDS as "black and white and clean cut", collapsing complexity into certainty. In their account, the service was accused of doing precisely what it worked hard to avoid. Public discussions suggested that young people were being told who they were, whereas clinicians sought to create "an open minded and non-judgemental space" in which young people could "find their way through it". They described aspects of this discourse as "Orwellian" and later as "dystopian".

As Grayson narrated the increasing intensity of external scrutiny, they increasingly described experiences of "constant moral injury". They recalled "fighting for every small bit of care" available to young people and advocating for pathways that became progressively more difficult to access. Additional reviews and procedural barriers shifted practice towards anxiety and process, whilst clinicians remained unable to answer families' most basic questions about future care.

The closure itself came as "a massive shock". Messages that the service should continue "business as usual" while simultaneously preparing to close felt contradictory. The decommissioning process was described as a period of "complete uncertainty" and being systematically "gaslit by NHS England".

More broadly, Grayson came to view the closure as a "targeted beginning of an attack on overall gender care".

A striking feature of Grayson's account was the contrast between the relational realities of clinical work and the increasingly abstract systems through which that work was judged. Within clinical encounters there was space to "open up" conversations and think together with young people and families. Beyond the consulting room, however, decisions increasingly appeared to rest with an "external multidisciplinary review team" conducting "paper review[s] of every single child" they had never met. Grayson described clinicians being positioned publicly as either "dangerous", "stupid", or "ideologically captured". Using the metaphor of a "small animal being patted on the head", they conveyed a sense of diminishment and misrecognition. Institutional responses were experienced as a "purposeful, willing misunderstanding" of the work.

Yet despite these experiences, Grayson's account ended with pride in what remained possible within the clinic room. Reflecting on "the power of witnessing", they hoped that young people and families had left feeling "seen and heard and hopefully understood a bit". In a story marked by simplification, uncertainty, and institutional rupture, they repeatedly returned to the possibility that another person might feel understood.

Reflexive Box: Watching the interview back, I was struck by how little prompting Grayson required. They appeared comfortable thinking aloud, moving fluidly between describing events, reflecting on their experiences, and considering their wider implications. Rather than presenting settled conclusions, they seemed to reason through ideas as the interview unfolded. I found myself adopting a more conversational and less directive stance. There was a sense of intellectual familiarity to the interaction, and I noticed myself relaxing into the interview and becoming less active in shaping its direction, trusting Grayson to lead the thinking.

I was mindful of Grayson's use of they/them pronouns and of the possible significance of their own relationship to gender within an interview concerned with gender identity care. However, I did not assume that this necessarily shaped their account in a particular way where Grayson did not themselves make that relationship explicit. Consistent with the wider narrative approach, I therefore sought to remain attentive to identity as part of the context in which the story was told without treating it as a predetermined explanation for the story itself.

I was particularly aware of how closely the form of Grayson's account mirrored the values they described. Their explanations of holistic assessment moved carefully through developmental histories, family relationships, mental health, school experiences, and future possibilities. Throughout the interview, they repeatedly qualified, revisited, and refined their own ideas, acknowledging uncertainty and resisting simple conclusions. I found myself wondering whether this was not only a way of explaining the work, but also of modelling the epistemic integrity they believed had characterised the service. Rather than defending GIDS as flawless, Grayson openly acknowledged its imperfections while carefully distinguishing these from what they experienced as external misrepresentations. In doing so, the account itself seemed to resist the simplification and binary narratives that Grayson repeatedly described as shaping public discourse.

I noticed a shift in my own emotional responses when Grayson spoke about paper reviews being conducted by people who had never met the young people concerned. Their voice appeared quieter and heavier, and I experienced a sense of discomfort and powerlessness. I found myself imagining what it might be like to hold responsibility for young people over many years whilst seeing decisions increasingly relocated elsewhere. The phrase "constant moral injury" ceased to feel abstract and became something I sensed emotionally within the interaction.

Perhaps what stayed with me most was the coexistence of distrust and hope. After describing experiences of institutional betrayal, Grayson nevertheless continued to speak about the NHS as a "brilliant" institution founded on principles they still valued. I noticed myself expecting the interview to resolve into a position of complete disillusionment, yet it never did. Instead, I found myself resisting an impulse to reconcile these tensions into a single, coherent conclusion. Looking back, I wondered whether this capacity to hold disappointment alongside commitment reflected something central to Grayson's account: that in this account moral injury did not extinguish professional values, and that maintaining epistemic integrity sometimes requires resisting the certainty and simplification that characterised the very public narratives they were describing.

4.4 Kathryn

Kathryn entered the interview from her bedroom, apologetically explaining that her dog had "commandeered the lounge". She initially appeared "panicked" about whether her status as a trainee clinician made her eligible to participate. The anxiety quickly passed and gave way to a candid and politically engaged account. On her training course, she had been the person who was "always banging on about trans rights". She had actively pursued the GIDS placement because it offered a "unique way of working". It was not simply another placement but a specialist service she had sought out and imagined would exemplify affirming care.

The reality proved more complicated. Kathryn described arriving at what she had anticipated would be "an affirmative service" and instead encountering a system that felt "ridiculously bureaucratic and hoop jumpy". She recalled being encouraged to hold things "a little bit less black and white", while working alongside colleagues she experienced as thoughtful, reflective, and often "really queer". She repeatedly returned to a sense of "cognitive dissonance" as she attempted to reconcile her political commitments with the clinical realities she encountered.

Kathryn described the multidisciplinary nature of the service as valuable, offering opportunities to think deeply and collaboratively about young people's experiences. Yet she remained struck by the procedural complexity surrounding access to medical pathways. Although more senior clinicians held responsibility for endocrine decisions, Kathryn described becoming increasingly aware of her participation within processes that sat uneasily alongside her hopes for affirming care.

The waiting list repeatedly returned as a source of concern. One of the "most depressing things" was beginning appointments by saying, "I'm sorry you've been waiting three years for this appointment". She reflected that "you wouldn't do that anywhere else". Alongside these waits came the responsibility of telephoning young people who were approaching adulthood without ever having been seen, simply to ask, "Hi, are you okay?" while knowing they would likely age out of the service. For Kathryn, "that's not good care".

The trainee room appeared to function as a space in which these tensions could be thought about collectively. As someone still developing her professional identity, Kathryn described joining other trainees in making sense of waiting lists, bureaucracy, and the realities of caring within systems that often seemed unable to meet need. Rather than distancing herself from these challenges, her trainee position seemed to heighten her awareness of becoming part of a system she was simultaneously learning to question. Yet the wider sociopolitical context remained ever present. She described a "wave of transphobia" that was "coming" and a constant "spectre" of scrutiny surrounding the service. Clinicians wanted to support young people and "give them what they want", while simultaneously feeling that "if we don't do everything exactly right, we're going to get in trouble".

Kathryn repeatedly described assessments as organised around external anxieties rather than lived realities. She contrasted public narratives about "kids" getting "surgeries" with what she encountered: "worried families" and young people who often had "very little outside influence", some of whom "weren't on social media" or lived in "really rural parts of the world". Questions sometimes felt aligned with an "external kind of negative voice", as though public suspicion had entered the clinical room. She recalled asking about trans role models and young people responding, "I don't have any trans icons, I'm just me". Others responded to questions about not transitioning by

saying, "why would I? I'm already trans, I've been waiting three years, I am transitioned". In contrast to public abstractions, Kathryn described the reality as "lovely kids" and "slightly worried parents". Looking back, she described GIDS as a "Frankenstein's monster of all the transphobia that's in the world", the "best the goodies can come up with after the baddies have said what should happen".

The Cass Review and subsequent closure were narrated less as singular events than as confirmation of something already "in the air". She described the review process as a "whole load of nothing" that seemed to involve little "meaningful input" from staff or service users. The closure reinforced her sense that care had not improved but had instead "gotten worse".

Kathryn's account became one of repositioning rather than departure. She did not relinquish work with trans young people. Instead, she moved towards forms of practice that felt more ethically congruent, offering "low cost therapy" and assessments that approached trans identities as a "baseline".

Reflexive Box: I found myself connecting strongly with Kathryn's position as a trainee within a highly specialised service. Like her, I am aware that training placements carry symbolic weight. They are places where professional identities are formed and where we hope to encounter versions of practice we might one day wish to embody. I recognised something of myself in her description of entering GIDS with strong values and expectations, only to encounter bureaucracy, competing responsibilities, and ethical uncertainty. I gave this attention throughout the interview.

Kathryn's trainee status appeared to shape the interaction in important ways. There was a sense of speaking with someone who occupied a familiar professional position while also having travelled slightly further into experiences I could readily imagine but had not personally lived. At times, I felt a pull towards solidarity and found myself understanding the language of formulations, supervision, professional responsibility, and tension without requiring further explanation. I wonder whether this shared professional location contributed to the openness and candour of her account.

She described having to make many phone calls to young people to check if they're ok and it feeling redundant. I found myself imagining the weight of being a trainee tasked with contacting young people who had waited years for care, only to explain that they would likely age out of the service. The responsibility felt disproportionate to the authority available to act differently. In that moment, gatekeeping ceased to feel like an abstract political critique and instead became a lived experience of holding distress whilst simultaneously representing a system unable to meet need.

Kathryn described feeling that "this wave of transphobia was... coming" and that clinicians "had to do everything exactly right". I found myself wondering whether clinicians had become intermediaries for a wider social anxiety, standing between vulnerable young people and a public discourse increasingly organised around fear, risk, and blame. Although it was the identities of trans young people that were being publicly debated and attacked, much of the manifested hostility appeared to settle upon the clinicians tasked with caring for them.

What remained with me most was Kathryn's repeated return to contradiction. She described thoughtful colleagues and meaningful work whilst simultaneously feeling "part of the problem" by not always being able to work affirmatively. Looking back, I came to understand this less as disillusionment than as professional identity work. Kathryn occupied an unusual position: sufficiently embedded within the service to feel morally implicated in its practices, yet without the authority to shape many of the decisions that troubled her. This left her negotiating not only tensions within the service, but also the kind of clinician she wished to become. Her eventual repositioning outside GIDS therefore felt less like a rejection of the work than an attempt to restore congruence between her values and her practice.

4.5 Silvie

Silvie entered the interview smiling warmly and making tea in a mug she joked was "as big as my head". The interaction began lightly and with ease. Almost immediately, her account became layered. She joined GIDS ”before the Keira Bell case verdict was delivered", and described what followed simply as "shitstorm after shitstorm". Throughout the interview, she repeatedly returned to trying to "make this make sense", suggesting experiences that remained active rather than fully resolved.

Silvie arrived at GIDS from inpatient CAMHS and other specialist services, having previously worked with gender-diverse young people and those with "marginalised experience". She described the role as both a "perfect storm" and "my perfect job really". Rather than signalling contradiction, these descriptions reflected the kind of work she was seeking: highly specialised, psychologically complex, and situated within the "lots of grey stuff" that she "loved". It was not the crisis that appealed to Silvie, but the opportunity to work thoughtfully within complexity and uncertainty. She explained that the role "ticked every single box", while emphasising that she "only knew this service in crisis".

Paradoxically, beginning during a period of upheaval felt "weirdly okay". Silvie positioned herself as arriving with "fresh eyes", explaining that, unlike longer-serving colleagues, she had not yet become "morally injured and professionally injured" by the Bell judgment. The team welcomed her ideas and there appeared to be "loads of opportunities to support". Describing herself as stepping into "a crisis situation", she recalled thinking, "right, how can I be helpful?"

Silvie repeatedly returned to the waiting list as a central concern. She remembered saying, "I am not having people dying on that waiting list, like on my watch". The waiting list represented "untold unknown harms". Young people with increasingly complex needs were "languishing", while referrals to GIDS often meant other services stepped back. By the time many reached the top of the waiting list, additional difficulties had emerged and "they couldn't do the work that we needed them to do". She described this situation as fundamentally unsafe.

When the CQC rating and transformation project arrived, Silvie initially narrated these developments as opportunities for change. There was a "huge amount of energy" directed towards making the service safer and better. She advocated for radical change, suggesting that the service should "just stop, pause, revamp and go again". She imagined possibilities that might "make ourselves obsolete as a service", with wider systems holding more of this work and specialist care becoming smaller and more focused.

Early meetings with Cass were described similarly. She recalled feeling that "she gets it". Cass appeared "really validating", "a brilliant communicator", and someone who could acknowledge that clinicians were "being asked to do an impossible thing". For a time, she described feeling hopeful.

This hope gradually gave way to bewilderment. NHS England funded work to make safer a service that was simultaneously being dismantled. She later discovered that "one and a half million" had been spent on external consultants and described this period as "madness".

Silvie repeatedly described the greatest tension as continuing to see new families and refer young people for treatment despite the service's impending closure. This "felt like a lie to families". Relationships that clinicians had carefully developed with young people and parents became, in her words, "weaponised". Although NHS England declined repeated requests to communicate these decisions directly to families, arguing that clinicians held the relationships, Silvie described feeling "coerced into delivering messages containing distress, because we cared". Looking back, she experienced this process as one in which clinicians' relationships with families were used to communicate decisions they had neither made nor controlled, something that, by the end, "felt abusive".

Alongside anger and powerlessness, Silvie consistently positioned herself as active and resistant. She spoke about an open letter to NHS England because staff felt "so voiceless and so powerless". She complained to the ombudsman about the lack of family engagement and raised concerns with the CQC because "there was no internal mechanism for reporting". She described herself as possessing a "natural rebelliousness" and being unwilling "to just do what I'm told if I think this is wrong". This allowed her to become "a thorn in leadership's side".

Silvie's account of the service's ending was characterised by exhaustion and depletion. Staff had wanted "a big party", yet "we never had it because we were so done". Instead, "the removal van came". Families were handed to services where clinicians had never been met and pathways could not be explained. Final letters to GPs effectively stated: "we're closing", "I can't tell you what's going to happen", and "keep an extra eye on them".

Silvie's account ultimately returned to the recognition that "political stuff trumps clinical stuff". She described remaining on "high alert" and wanting to retain a "healthy scepticism" about systems and intentions. Despite profound disillusionment, her narrative remained organised around action, resistance, and an enduring commitment to speaking when something feels wrong.

Reflexive Box: Watching back, I was struck by how quickly humour and familiarity became established between us. We joked about the large mug that repeatedly appeared in and out of frame and the interaction felt warm and easy. Yet this ease sat alongside an account that repeatedly returned to "shitstorm after shitstorm" and to trying to "make this make sense". I noticed myself becoming curious about this process of sense-making and, at times, felt drawn into it. Rather than hearing a settled narrative, I experienced myself alongside someone who was still thinking through experiences that remained active and difficult to reconcile.

Silvie often positioned herself as active and responsive, repeatedly asking, "how can I be helpful?" and describing complaints, letters and challenges to organisational decisions. I found myself struck by this continued orientation towards action, even when discussing situations that felt impossible or unsafe. At times, I noticed feelings of sadness and anger emerging in me as I listened to descriptions of relationships becoming "weaponised" and clinicians being "coerced into delivering messages containing distress, because we cared". The atmosphere of the interview seemed to shift during these moments, becoming heavier and more emotionally charged.

As my fifth interview, I became increasingly aware that I was carrying previous participants' accounts into this encounter. Listening to further descriptions of unsafe endings, unknown harms and institutional contradictions produced a cumulative sense of weight. The image that remained with me afterwards was not one of dramatic closure but of "the removal van" arriving when everyone was "so done" and "so depleted". I found myself wondering whether this emotional incongruity was partly what made the ending feel so difficult to hold. A service repeatedly described as highly specialised and deeply meaningful appeared to end not with recognition, but with exhaustion or possibly burnout.

I was left with a sense that the interview itself mirrored this unfinished quality. We moved between humour, bewilderment and critique, repeatedly returning to questions that neither of us could fully answer. Rather than arriving at coherence, the interaction left me with a heightened awareness that some endings remain difficult to narrate because they continue to ask for meaning after the events themselves have passed.

4.6 Alex

Despite apologising for the remnants of a recent "cold and flu", Alex spoke with urgency and precision, carefully locating events in time and distinguishing between people, systems, and decisions. Having met prior to the interview, there was a sense of cautiously established trust. Her account was highly structured, often moving from chronology to evidence and then to clinical and moral implications. Even when discussing painful experiences, she remained thoughtful and deliberate.

Alex joined GIDS on a temporary basis, prior to 2020, initially intending to "dip my toe in". By this point she was "quite a way into" her career. Despite almost "30 years" of lived familiarity with the community, she reflected that she had "never really worked with the trans community before". The work became something more. She "really enjoyed the work", finding it "really kind of interesting". She recalled "we were doing some really good work at the time", that "the team was really nice", and that some of the young people and families were "just great, absolutely fantastic". When the six months ended and she was offered a permanent post, she simply thought, "yeah, I'll stay and just kind of work from there.".

Initially, Alex was "not out as a trans person" within the service. However, clinical encounters increasingly demanded a different position. She described experiences that had "an impact on me as a trans person" and realised that she "need[ed] to be discussing some of this in clinical supervision". This eventually led to a process of selective disclosure. The decision became more pressing from "2016, 2017 onwards" as a small "gender critical cohort" emerged within the service. She recalled hearing opinions that she believed were "not respectful of the lived experience of young trans people" and recognised that colleagues perceived her as "a white, middle class, CIS gender woman responding" to these discussions. She ultimately concluded that this was "doing a bit of a disservice to the trans community" and that it would be "more powerful to kind of hear the voice of a trans woman responding to these points".

The work itself remained deeply meaningful. Alex repeatedly returned to the rationale underpinning early intervention, describing young people arriving in profound distress and explaining that clinicians sought to prevent "damaging pubertal changes" that young people and their families "quite clearly state that they don't want and will cause emotional harm". Yet the work also carried personal vulnerability. She recalled a father who, after hearing statistics about suicidality amongst trans young people, "shrugged his shoulders" and said that suicide "might not be a bad option" in relation to his own child. Alex described this as "probably the most shocking thing" she had heard in ten years of

practice. As someone with lived experience, she found herself wondering, "if he values his own child's life so lightly, so little, what would the thoughts be if he knew that I was a trans person?"

Alex's account increasingly became one of conflict. She described "many [kind of] disagreements" and reflected that, in the period following the Bell judgment, the wider Trust became "not always particularly respectful" of trans staff and trans lives. At the same time, she distinguished this from her experience of GIDS leadership, for whom she retained "great respect". Reflecting on the Trust's response after Bell, she felt it had "basically threw up their arms and just went with what government said and what NHS England said" and had "done nothing to protect the staff group or to protect the patient group".

For Alex, Bell represented "the biggest turning point in trans healthcare in this country". Within "24 hours", the Trust implemented "a moratorium on hormone blockers and hormone treatments for young people". She recalled telephoning young people who had been due to attend endocrine appointments "that very week" and telling them "that wasn't happening". She experienced this as a "hard stop". She repeatedly stated that clinicians, including herself, had warned that the moratorium was "clinically dangerous". In her account, the service "never recovered fully. Never recovered." The repetition appeared to communicate the finality of this moment for Alex. Looking back on the period between December 2020 and December 2023, she described "a huge increase in deaths related to the GIDS service", which she attributed "directly" to decisions to stop provision of blocker treatment. Contrasting this with her knowledge of one suicide in almost seven years before the moratorium and "approximately 16 deaths related to the service" in the following three years, she reflected, "I don't think that's a coincidence." She described raising these concerns "in various forums in the NHS", only to feel that "people just don't want to know", that the issues had been "brushed under the carpet", and that there had been "a complete whitewash of those issues ever since. Awful."

During this period, Alex increasingly narrated herself as someone who was "raising alarm bells" and repeatedly "brought this up in various forums in the NHS", despite feeling that "people just don't want to know". After contributing to an open letter expressing concerns, she recalled feeling that she had "a target on my chest". She described being "threatened with disciplinary action", overlooked for promotion, and repeatedly unsupported when raising concerns. Yet she remained clear about the position from which she was speaking. She reflected that "any debate that does not begin from a position of respect for trans identities does not meet that threshold to warrant discussion and debate". Hearing colleagues express views that were "disrespectful of trans people's identities", she found herself asking, "Why are we here? Why are we discussing this?" Although she was often labelled "an extremist in that respect", she stated, "asking for basic respect for trans people is not an

extremist point of view. It's actually what the starting point should be for any discussion around trans lives."

Alex narrated the final years of GIDS as a period of extraordinary demands. Holding one of the largest caseloads in the service, she described working "14, 15 hour shifts every day" to support young people whom she described as "desperate to access endocrine treatment". These accounts conveyed a growing tension between the urgency of responding to young people's needs and the increasing demands of the systems surrounding their care. The bureaucracy associated with referrals had become "extraordinary", with submissions extending to "100 pages plus" and requiring "literally a week" to complete. Alex understood these barriers as "a deliberate ploy to limit access to trans healthcare".

Reflexive Box: Interviewing Alex carried a different weight from the outset. She was the only participant who had wanted to speak beforehand and I became aware of this as an act of caution, but also one of trust. Throughout the interview, I felt a heightened sense of responsibility to receive her account carefully and represent it faithfully. Alex occupied a dual position within the interview. She spoke as a highly accomplished clinician and academic, but also from lived experience. Her voice felt central to the research, and I was acutely aware of the courage involved in revisiting experiences that had, in her account, repeatedly been misunderstood and misrepresented.

The contrast between Alex's narrative and many of the external accounts that had initially drawn me to this research was striking. She firmly rejected the notion of a service deeply divided by ideology, describing the "gender critical" staff group as something that "could be counted on hands". Sitting with this account, I became aware of some of my own assumptions being unsettled. Rather than hearing a story of pervasive internal conflict, I encountered a narrative organised around care, professional disagreement, and increasing institutional rupture. The interview became an important reminder that public narratives and lived accounts do not map neatly onto one another.

Alex's account unfolded with the qualities of testimony. She moved carefully between chronology, evidence, and ethical implications, returning repeatedly to events that she felt required witnessing and remembering. By this stage of interviewing, I was already carrying stories of moral injury, unsafe closure, and experiences of silencing. Hearing these themes again, but through Alex's distinct positioning as both clinician and person with lived experience, gave them additional weight. Narrative inquiry suggests that stories accumulate and begin to shape the listener's understanding as much as they reveal the participant's. I became increasingly aware that I was no longer encountering isolated accounts but an emerging collective story.

As I write this portrait, I remain aware of a strong desire to "get it right". This feels partly methodological and partly ethical. Alex's seniority and clarity were reassuring and containing during the interview, not intimidating. What stayed with me most, however, was where she chose to end her account. Asked what she remained proudest of, her answer was immediate: "It's a legacy of the young people that we kind of worked with." She described interventions as "life changing" and recalled families contacting her after leaving GIDS to say so. After an interview that traversed institutional conflict, moral injury, and service closure, Alex returned not to the controversy but to young people and the possibilities of "affirmative health care". I came to understand this return not simply as a conclusion, but as the organising moral centre of her narrative. It was this, above all else, that I felt responsible for carrying forward into the thesis.

4.7 N

N began by asking whether the project had “any kind of hypotheses”, before later checking whether biographical details made her “quite identifiable”. The account unfolded from a position in which telling the story required caution.

Coming from CAMHS, N described an interest in identity and “minority stress” and was “quite interested in working in gender identity development because of those links”. She emphasised that understanding people “in their context” and working “from their voice and their point of view” did not constitute an ideology. “I don’t believe that is indicative of some sort of ideological bias in me,” she said, “although that’s a very common belief about the work that my colleagues and I did in the service.”

The early GIDS that N narrated was demanding but thoughtful. The work “surpassed my expectations”. It was “very thorough” and “the culture was very reflective”. GIDS brought together people with “a genuine interest in doing the thinking around the work in order to do the work in the best way”. The work “necessitated holding constant uncertainty and ethical dilemmas alongside a young person and their family or their carers, social workers, and the people in their network and in the systems around them.” Gender work involved “a temporal sort of tension about permanence, impermanence, longevity”, extending through family relationships and wider social and political contexts.

The account turned when N described the closure process. Between 2022 and 2024 there was “a lot of anxiety and grieving and concern held in the system”, alongside “a lot of care and hard work for the young people and families”. From 2021, clinicians were required to write “hundred plus page documents” to justify decisions to panels who “had never worked in gender services”. Patient-facing work reduced and the service became increasingly organised around assumptions that it was “the trans kids service”, which, N said, “it wasn’t”.

The phrase that structured this period was “business as usual”. Staff were repeatedly told this while trying to understand “how are we going to safely transfer them?” N recalled asking what should be communicated to patients and families and how risk and complexity should be handed over. Instead, she described an HR presentation in which staff were told: “we will take disciplinary action against you, we will report you to your governing bodies, you won’t be able to work here, you won’t be able to work anywhere, we’ll end your careers and we’ll sue you”.

At the same time, “we had the system was saying, be silent”, while families were asking “what was going to happen to them” and children were asking, “what’s going to happen to me?” N described

“seen and unseen risk”, including young people “saying that they would end their lives”. She recalled feeling unable to rely on organisational assurances. “I need to be active. I cannot rely on the system to be responsible.” The image she used for this work was simple: “I don’t know when I have to send them off and I don’t know where I have to send them off to... but I’ll, I will, you know, pack their bag as best I can before I send them off.”

The account became most emotionally charged when N spoke about colleagues. She described “a lot” of colleagues as “quite acutely suicidal at points”, adding, “I spent a lot of time on the phone trying to prevent my colleagues from ending their lives”. She also recalled that “some young people did end their lives during all of that and some of their clinicians haven’t done so well since”. Speaking about these events remained difficult because, she said, “my words get twisted” into narratives of clinicians as “evil gatekeepers”, “groomers”, or “naive kind of progressives”.

The account ended through physical acts of closure. N described shredding confidential documents, preserving photographs and artwork, cleaning offices and putting the keys through the letterbox. “The ceremony of it helped to close it and say goodbye to it for me.” She remained in gender work, which she described elsewhere in the interview as “a real honour”. Yet the final position from which she narrated these experiences rested less on institutional assurances than on action itself: “the broader their claims about care, the less I’ll believe them. I only believe action.”

Reflexive Box: N's opening questions about my hypotheses and concerns about identifiability introduced an immediate sense of caution into the interview. I noticed myself becoming aware that I, as researcher, may not have been positioned as neutral but as someone who potentially represented the institutions and forms of knowledge production that N was critiquing. I found myself wanting to communicate openness and trustworthiness while recognising that trust could not be assumed and may need to be earned based on their assumed experiences.

As the interview progressed, I remained aware of N's repeated anticipation that her words could be misunderstood or "twisted". I found myself listening with particular attention to these moments. Rather than hearing them as interruptions to the narrative, I wondered about what it might be like to tell a story that felt vulnerable to misrepresentation. I noticed a sense of responsibility in my role as listener and writer of the portrait, particularly given the ethical tensions inherent in selecting, arranging and representing another person's account.

The emotional atmosphere shifted when N spoke about colleagues who had become suicidal and continued to live with what she described as ‘moral injury’. I became tearful and experiencing feelings of sadness and anger. I was struck that the interview became most emotionally charged when discussing colleagues rather than political decisions or service closure itself and the ramifications for the community it served. I wondered whether I was hearing not only an account of organisational change but also an attempt to bear witness to forms of suffering that occurred.

By this stage of data collection, I was also aware that I was no longer encountering this account in isolation. I was carrying other clinicians' stories of grief, uncertainty, fear and institutional rupture into the interview. Hearing further descriptions of suicidality, risk and loss produced a cumulative sense of weight. I became increasingly conscious that narrative inquiry asks the researcher to remain present to these stories rather than move too quickly towards explanation. I was left with a lingering sense of sadness and a heightened awareness of my responsibility to represent N's account carefully, preserving both its complexity and caution.

4.8 Blue

Reflecting on what happened to GIDS, Blue described struggling to make sense of events until reading a book about fascism. "I thought, oh, we're fighting fascism. Okay. That's what was going on." This appeared to provide a way of understanding changes that had otherwise been difficult to reconcile.

Blue worked in GIDS around 10 years, holding a range of clinical roles and contributing to service development over time. Looking back, the early years were "really exciting". They described "lots of innovation", "lots of kind of networking and interagency working", and a "holistic approach". Clinicians travelled to schools and CAMHS teams, advocated for young people and families, and tried to help local systems think about how best to support transgender young people.

Blue had arrived at GIDS with an interest in gender and identity and described personal resonances with the work, describing it as "a special interest of mine". Their approach developed through working with "a few hundred, if not over thousand or something like that" young people and families over many years. Seeing some young people's gender remain "consistent" and others become "more fluid" reinforced the importance of remaining open to different possibilities. They described wanting to "be accepting of the young person's identity but also hold uncertainty, bring your psychological developmental knowledge and kind of be tuned into all kind of different possibilities". Throughout the interview, Blue repeatedly returned to "the young person's voice and experience and families and caregivers" as being "really central". This continual return appeared to position careful psychological thinking and openness to uncertainty as the organising principles of their clinical practice.

As the public and political climate changed, Blue described increasing tensions between this way of working and external demands placed upon the service. Through involvement in high-level meetings, they recalled meeting new professionals who "have no idea about gender but talked as if it was their expertise". Looking back, these encounters became moments where they "started to clock, okay, there's big changes are coming". They described an increasing sense that gender expertise had become devalued and portrayed as "ideologically driven rather than actually clinical expertise".

Blue described the period following the Bell case and the Cass Review as one of anxiety and uncertainty. Staff were "really anxious, really angry, really upset". Promises that expertise would be wanted in future services became, in Blue's words, "complete gaslighting". Working at GIDS came to feel like "you were contaminated by working at GIDS, really".

Alongside these changes, clinical work became increasingly constrained. Blue described "bureaucratic authoritarianism" and "so many barriers put in place for families to be able to access medical interventions". Processes became "very bureaucratised and over regulated" and practice became "very defensive". They recalled feeling as though they were becoming "an agent of the state". Although they explained the new requirements to families, they also tried to make clear that "this wouldn't have been my choice" and that "it's not something we used to do". These explanations appeared to position Blue alongside families rather than the organisational decisions they were required to enact, distinguishing their own clinical values from the systems in which they were working. In narrative terms, this repeated positioning communicated an effort to maintain moral alignment with families while navigating a situation experienced as increasingly morally injurious.

Blue repeatedly returned to the impact on young people and families. They described people becoming "hugely anxious" and "powerless". Some young people "felt like they couldn't be really honest anymore because they felt like they had to tick a box". In response to what Blue described as a "massive erasure", they recalled making "an extra effort to, you know, be present, to acknowledge and hear them, to think with them, how they can claim some agency". It became "therapeutically even more important to engender some agency that, you know, they could have over their lives".

Towards the end of the interview, Blue reflected on what remained significant from their time at GIDS. They described working with "some of the most thoughtful, creative, compassionate, passionate clinicians and intellectually curious". These were "really skilled clinicians who made a real difference, I think, to many of the young people they worked with". Although the account contained descriptions of loss and disillusionment, it returned to people: young people who had been overshadowed and colleagues whose care and expertise in Blue's account, continued to matter and to help them "claim some agency" within systems that had increasingly rendered them voiceless.

Reflexive Box: I experienced Blue as measured and clear. From the beginning of the interview, there was a coherence to the account and I noticed myself relaxing into the conversation. Blue's responses felt considered, creating what I internally experienced as a safe pair of hands. I became aware that this response may also have reflected my perception of Blue's clinical demeanour. The interview carried a sense that difficult experiences could be thought about, named and held in mind.

At times, the account felt highly organised. I became curious about whether I was hearing a story that had been repeatedly narrated because it had needed to be explained and defended, particularly within contexts where expertise had repeatedly been described as "devalued" and portrayed as "ideologically driven" across this and previous interviews. At the same time, I remained aware that this was my interpretation. Later in the interview, Blue described having previously "really struggled to make sense of what happened" and finding an explanatory framework that appeared to make events more understandable. This led me to reconsider my initial assumption that the coherence of the account necessarily reflected resolution. I noticed my own tendency, perhaps shaped by my clinical background, to search for signs of ongoing emotional work beneath narration.

I was struck by the contrast between the political language used throughout the interview and the relative absence of visible emotional intensity. I wondered whether the reflective quality of the account also functioned as a way of containing experiences that may have been profoundly challenging to live through. I was mindful not to reduce this to a psychological explanation or to assume that coherence indicated resolution.

As the final interview, I was aware that I was not encountering Blue's story in isolation. I carried with me the accumulated accounts of grief, uncertainty, vigilance and institutional rupture described by previous participants. Blue's framing of events, including the metaphor of "fighting fascism", appeared to offer one possible way of organising themes that had recurred across earlier interviews. I was left not with a sense of closure, but with an awareness that people construct different narrative resources to make difficult experiences thinkable and communicable.

Chapter Five: Cross-Narrative Dialogue and Collective Storylines

5.1 Entering Cross-Narrative Dialogue

Narrative researchers may present findings and discussion either together or as separate chapters, depending on the nature of the inquiry and the form of knowledge being produced (Wengraf, 2001, 2004). In this thesis, the chapters are presented separately to distinguish two complementary levels of interpretation. Chapter Four presents the narrative portraits, which constitute the primary findings of the study. As Rodríguez-Dorans and Jacobs (2020) argue, within narrative portraiture the person's story is itself a research finding and a valuable research output in its own right. The portraits therefore represent the first stage of interpretation, preserving the coherence, temporality, and situated meanings of each clinician's account while foregrounding participants' voices within their broader social and institutional contexts (Riessman, 2008; Rodríguez-Dorans & Jacobs, 2020).

Chapter Five builds upon these findings through a second level of interpretation. Rather than treating the portraits as isolated accounts, it examines the shared narrative patterns, tensions, and moral meanings that emerge across participants' stories, bringing these into dialogue with one another and with the wider empirical, theoretical, and sociopolitical literature. This movement from individual narratives to cross-narrative interpretation reflects the epistemological assumptions of narrative inquiry, in which interpretation is present throughout the analytic process but operates at different levels. The discussion therefore extends, rather than replaces, the interpretive work undertaken in Chapter Four (Andrews et al., 2008; Riessman, 2008).

To undertake the cross-narrative interpretation, I returned repeatedly to the original transcripts, completed narrative portraits, and accompanying reflexive writing, reading them alongside one another. Consistent with narrative inquiry, the analysis did not seek thematic saturation or decontextualised categories. Instead, it attended to how narratives were organised, how meaning was constructed, and how individual accounts were situated within wider social, political, and institutional narratives (Andrews et al., 2008; Riessman, 2008). Specifically, the analysis attended to the organising tensions around which participants structured their accounts, the wider social and institutional narratives entering those accounts, and the narrative resources through which meaning was constructed, including repetition, metaphor, positioning, and narrative endings (Riessman, 2008). Organising tensions refer to the central conflicts, uncertainties, or moral concerns to which participants repeatedly returned as they made sense of their experiences. During the construction of each portrait, I also retained a small collection of quotations that captured these organising tensions. Returning repeatedly to these quotations alongside the completed portraits and original transcripts ensured that the developing cross-narrative interpretation remained grounded in participants' own

words while allowing dialogue to develop across accounts. Through this iterative process, several collective storylines and shared narrative trajectories gradually emerged. Appendix K presents an example of this analytic process through a Cross-Narrative Dialogue Matrix (Appendix K).

I refer to this process as *cross-narrative dialogue*. By this I mean placing narratives in conversation with one another whilst preserving their specificity, partiality, and capacity to remain contradictory (Andrews et al., 2008; Riessman, 2008). The collective storylines presented in this chapter are therefore not objective themes residing within the data. Rather, they are interpretive constructions developed through sustained engagement with participants' narratives and the relational contexts in which they were elicited and understood (Rodríguez-Dorans & Jacobs, 2020). They represent one way of understanding how participants made sense of the decommissioning and closure of GIDS, and how broader societal narratives entered, were negotiated, and were resisted within their accounts.

Although participants narrated the closure of the same service, they did not tell the same story. Instead, multiple, overlapping narratives emerged, organised around recurring moral and narrative tensions that remained unresolved both within and across accounts. Table 5.1 provides an overview of the collective storylines developed through this cross-narrative dialogue. Together, these storylines illuminate how participants negotiated care, complexity, institutional power, moral experience, and professional life following the closure of GIDS.

Table 5.1. Overview of the collective storylines developed through cross-narrative dialogue

Section	Collective storyline	Focus of the cross-narrative dialogue
5.2	**Resisting Simplification**	How participants collectively resisted binary and reductive accounts of gender identity healthcare, emphasising uncertainty, complexity, and relational ways of knowing.
5.3	**Caring Under Untenable Conditions**	How clinicians described sustaining care while working within increasingly restrictive organisational, political, and institutional conditions.
5.4	**Moral Injury and Ethical Distress**	How sustained care under conditions of constraint, perceived institutional failure, and ethical conflict shaped participants' emotional, professional, and moral experience.
5.5	**Witnessing and Narrative Resistance**	How participants used storytelling to bear witness, preserve professional knowledge, and resist dominant public narratives about GIDS.

5.6	**Narrative Endings: Living Beyond Closure**	How participants narrated endings, loss, identity, and the continuation of professional and ethical commitments following the closure of GIDS.

5.2 Resisting Simplification

Across the portraits, participants thought of gender identity work as complex, relational, and deeply contextual. Discussions of clinical practice returned to uncertainty, developmental thinking, family relationships, and the importance of understanding young people within their broader social worlds. Complexity was not narrated as an obstacle, but as an ordinary feature of clinical care.

This understanding appeared across accounts in different ways. Alice repeatedly returned to "whole family work" and helping families "talk together about difference". Grayson described "holistic assessments" that sought to understand the "whole person in all their contexts", whilst conversations about fertility, sexuality, and future relationships unfolded over time and remained "based on a consent basis". Silvie described being drawn to work involving "lots of grey stuff that [she] loved", N reflected that "uncertainty is uncomfortable" and that people are often tempted by "offers of certainty", and Blue described the importance of remaining "accepting of the young person's identity" whilst also being able to "hold uncertainty". Collectively, these accounts portrayed care as relational, developmental, and resistant to simple conclusions.

Despite this, participants described their work becoming publicly flattened within wider institutional and societal narratives. Grayson reflected that external accounts had become "black and white and clean cut", whilst clinicians were portrayed as doing precisely the opposite of what they understood themselves to be doing. JP described organisational language becoming "alien", Alex repeatedly described "well-argued critiques" being ignored within what she experienced as "institutional group think" at the level of government and NHS England, and Silvie described a public "picture that was so far removed from the reality" of a "highly specialised" service engaged in "gnarly grey clinical work".

Placed alongside one another, these accounts suggest that uncertainty, relational work, and psychological formulation were narrated as ordinary features of good clinical practice with gender-diverse children, young people, and families. Participants' distress appeared to arise not from this complexity itself, but from their experience of its replacement by simplified public, political, and institutional narratives. What appeared harmful was the sense that nuanced, psychologically informed care had become reduced to accounts participants experienced as inaccurate and disconnected from their lived practice. As these narratives became embedded within institutional responses, participants described them as shaping not only public understandings of GIDS, but also

the conditions under which care was organised, understood, and delivered. In this sense, participants were not simply defending a model of care, but the relational, psychological, and organisational conditions they believed made ethically responsible care possible.

Andrews et al. (2008) argue that public narratives provide culturally available ways of making sense of complex social and moral issues. Read alongside one another, the portraits suggest that participants experienced these dominant narratives as obscuring rather than illuminating their work. Their repeated return to "whole family work" (Alice), "holistic assessments" (Grayson), "lots of grey stuff" (Silvie), and the need to "hold uncertainty" (Blue) can therefore be understood as resisting this reduction. In doing so, their accounts functioned as counter-narratives that sought to preserve forms of clinical knowledge participants experienced as marginalised or misunderstood (Riessman, 2008). Rather than defending complexity as an end in itself, participants positioned it as the means through which careful psychological thinking, relational practice, and ethical responsibility towards young people and families became possible.

These accounts can also be understood through the lens of epistemic injustice, which draws attention to inequalities in whose knowledge is recognised as credible and whose interpretive resources are afforded legitimacy (Fricker, 2007). Participants did not describe an absence of clinical knowledge, but a perceived displacement or devaluation of specialist, relational, and contextual ways of knowing by accounts they experienced as increasingly reductive. This interpretation requires caution: as healthcare professionals, participants themselves occupied positions of epistemic authority, including in relation to young people and families, and their accounts cannot therefore be straightforwardly positioned as those of epistemically marginalised subjects. Nevertheless, within the particular institutional and sociopolitical context surrounding GIDS, participants described their professional knowledge as becoming increasingly difficult to articulate, defend, or have recognised within decisions affecting care. This reflects the broader relationship between knowledge and power, whereby some accounts become authorised as credible while others are obscured or excluded (Foucault, 1980; Dotson, 2011). Read alongside the literature on moral distress (Jameton, 1984; Fourie, 2015; Morley et al., 2019), this suggests that epistemic authority may be important to clinicians' capacity for moral agency: where clinicians experience responsibility for care while the knowledge through which they understand and justify that care is simultaneously discounted or displaced, moral constraint may arise not only from being unable to act, but from being unable to establish the legitimacy of the knowledge upon which action is based.

5.3 Caring Under Untenable Conditions

Participants narrated their work differently, but all eight accounts remained organised around relationships and being in service to young people and families. Participants repeatedly returned to long-standing therapeutic relationships, enduring attachments, and forms of care described as "precious" and "respectful" (JP), "really special" (Grayson), and simply "being there" (Alice). Blue similarly described "the young person's voice and experience and families and caregivers" as "really central". Rather than functioning as background to participants' work, these relationships became the lens through which organisational change, uncertainty, and service closure were understood and experienced.

Yet participants also described this care as occurring within conditions that increasingly felt difficult to sustain. A recurring tension across narratives concerned the growing incompatibility between the responsibilities participants felt towards children, young people, and families and the conditions under which they were expected to practise. Alice described young people "languishing" on waiting lists, Grayson spoke of "fighting for every small bit of care", Kathryn experienced practice becoming "ridiculously bureaucratic and hoop jumpy", Blue described "so many barriers put in place for families to be able to access medical interventions", and JP reflected that organisational language had become "alien". These accounts suggest that clinicians remained deeply committed to young people and families whilst describing conditions that increasingly constrained their ability to provide the forms of care they believed were needed. Importantly, participants did not narrate themselves as withdrawing from care. Rather, they repeatedly described continuing to care under conditions that increasingly undermined their ability to enact care in ways that felt clinically coherent, ethically defensible, or emotionally sustainable.

“the band played well, the Titanic sank” *Alice*

The waiting list occupied a particularly significant place across several narratives. Alice reflected on "the abandonment they must have been feeling" whilst families waited for support, JP spoke of the "weight of their journey", and Silvie repeatedly returned to the "untold unknown harms" associated with prolonged waiting, insisting, "I am not having people dying on that waiting list, like on my watch." Across participant accounts suggest that participants' care extended beyond the clinic room to encompass young people they had not yet met. Their narratives conveyed an ongoing sense of responsibility for imagined futures, anticipated harms, and the consequences of waiting beyond their immediate clinical reach. This extended the moral field of care beyond established therapeutic relationships. Participants narrated responsibility not only for young people already known to them,

but for those they anticipated might experience harm while waiting for care. Responsibility was prospective as well as relational, encompassing consequences participants could foresee but had limited capacity to prevent.

As decommissioning progressed, these tensions intensified. Participants described continuing to assess young people, develop therapeutic relationships, and refer for treatment whilst increasingly being unable to answer families' most pressing questions about what would happen next. Grayson recalled periods of "complete uncertainty", JP stated simply that closure "wasn't safe", and Silvie described continuing to see new families despite feeling that this "felt like a lie to families", later reflecting that conversations increasingly became, "We're closing... I can't tell you what's going to happen." These accounts suggest that participants were asked to sustain ordinary therapeutic relationships whilst the conditions that ordinarily make such relationships possible, had become profoundly disrupted.

> “We’re closing, I’ve had my last session with the family, I can’t tell you what’s going to happen. So if you can just keep an extra eye on them, that would be great. Like, that was our ending.” *Silvie*

The inability to answer questions that young people and families understandably asked appeared to create circumstances that several participants experienced as clinically unsafe and fundamentally at odds with their understandings of good care.

Participants also repeatedly narrated a sense that institutions were retreating from relationships that clinicians continued to inhabit. Decisions were often experienced as distant, politically determined, and difficult to influence, yet their relational consequences remained within the clinic room. Clinicians repeatedly described becoming the people who had to hold uncertainty, absorb distress, and communicate decisions that they had neither made nor fully understood.

Read alongside other accounts, this quote suggests that care itself increasingly became the mechanism through which uncertainty and institutional decisions were delivered. The very relationships that participants regarded as central to good clinical work appeared, at times, to intensify experiences of responsibility and distress.

Building on the experiences of epistemic and institutional misrecognition identified in Section 5.2, a further tension concerned how these experiences intersected with participants' continuing responsibility for care. Participants repeatedly described themselves as working hard to preserve relationships, advocate for young people, and continue providing care despite increasingly difficult and uncertain circumstances. Grayson described clinicians being portrayed as "dangerous", "stupid",

or "ideologically captured", whilst experiencing institutional responses as a "purposeful, willing misunderstanding" of the work. Alex described repeatedly raising "well-argued critiques" and "alarm bells" that she experienced as being ignored, and Blue reflected on expertise becoming increasingly "devalued" and portrayed as "ideologically driven". Together, these accounts suggest that participants experienced not only the erosion of conditions necessary for care, but also a failure of recognition regarding their continued efforts to mitigate harms, advocate for young people, and preserve forms of care they regarded as ethically important. Within these accounts, responsibility appeared to persist despite participants experiencing diminishing recognition of both their expertise and their capacity to influence the systems within which care was delivered.

These accounts resonate with literature conceptualising moral distress as arising where clinicians experience constraints on acting in accordance with their ethical judgement or commitments (Jameton, 1984; Fourie, 2015; Morley et al., 2019). The narratives suggest that moral constraint was not confined to discrete clinical decisions or encounters, but extended across existing therapeutic relationships, young people waiting beyond participants' immediate clinical reach, anticipated future harms, and families whose continuity of care participants could no longer confidently predict. The GIDS context illuminates an important asymmetry in how responsibility and authority were experienced: clinicians remained relationally and professionally accountable for the consequences of care, while authority to alter the conditions shaping that care was experienced as increasingly located elsewhere. Participants could therefore experience themselves as carrying responsibility for perceived failures in care without possessing commensurate authority to address the conditions producing them. In this sense, care exceeded clinical interventions or measurable service activity; participants' accounts encompassed relational continuity, emotional containment, anticipation of harm, advocacy, and responsibility towards young people and families whose futures they could not necessarily determine. Crucially, these responsibilities were negotiated within a wider context in which gender-diverse young people, the legitimacy of their healthcare, and the expertise of those providing it were themselves subject to intense sociopolitical contestation. As discussed in Chapter 1, phantasmatic constructions can shape what becomes recognised as credible, threatening, or worthy of protection before the clinical encounter itself (Butler, 2004, 2024; Pearce et al., 2020). GIDS therefore makes visible how moral distress may be produced across interacting levels of care: not only through constraints within the clinical encounter, but through organisational, regulatory, legal, and political processes that participants experienced as entering and reshaping the conditions under which care could be provided. Continued caring could therefore itself become morally burdensome: participants remained answerable within relationships for consequences they experienced themselves as increasingly unable to influence.

Narrative inquiry directs attention towards the social and relational conditions in which experiences become meaningful and tellable (Andrews et al., 2008). Across these accounts, care was narrated as both deeply meaningful and increasingly untenable. Participants did not describe becoming less committed to young people and families. Rather, they described continuing to care whilst the conditions that ordinarily made such care possible appeared progressively eroded. They spoke of caring without answers, caring without authority, caring under public scrutiny, and caring within systems that increasingly felt politically rather than clinically organised. Across the portraits, sustaining care under these conditions carried significant emotional and ethical consequences.. Participants spoke of feeling "rocked... to the core" (Alice), experiencing "constant moral injury" (Grayson), engaging in "emotional, psychological gymnastics" (JP), and becoming "morally injured and professionally injured" (Silvie). Collectively, these accounts suggest that it was participants' continued commitment to relationships, rather than a withdrawal from them, that rendered these circumstances so psychologically and ethically difficult to bear. This provides important context for understanding the experiences of moral injury and ethical distress explored in the following section.

5.4 Consequences of Caring Under Untenable Conditions

The preceding sections have shown how participants resisted simplified accounts of their work whilst continuing to sustain care under increasingly untenable conditions. Across the portraits, these experiences were not narrated as emotionally or morally neutral. Rather than constituting a distinct cross-narrative storyline, participants described profound emotional, ethical, and professional consequences arising from sustained efforts to provide psychologically informed care within systems they increasingly experienced as politically, organisationally, and morally difficult to inhabit. Although only Grayson explicitly described experiencing "constant moral injury", Silvie similarly reflected that longer-serving colleagues had become "morally injured and professionally injured". Elsewhere, participants spoke through the language of betrayal, coercion, abuse, vigilance, preventable harm, and loss. Read together, these accounts suggest that distress did not arise solely from difficult clinical work or service closure itself. Rather, it emerged where participants' ethical commitments to young people and families came into repeated conflict with the conditions in which care was delivered.

Across the portraits, participants repeatedly described witnessing foreseeable harms whilst remaining responsible for relationships they increasingly felt unable to protect. Alice reached a point where she quietly acknowledged, "I possibly can't really think about that very much actually", as she reflected on young people waiting without support. Silvie worried about the "untold unknown harms" associated with prolonged waiting and stated, "I am not having people dying on that waiting

list, like on my watch". JP briefly referred to "increased self-harm and some suicides, kids", whilst Alex described having "raised alarm bells even before the judgement was given". At the same time, participants described remaining relationally close to young people and families whilst experiencing diminishing influence over decisions that profoundly shaped care. JP reflected that closure "wasn't safe", Silvie described continuing to deliver messages that "felt like a lie to families", and Grayson recalled periods of "complete uncertainty" in which clinicians could not answer families' most pressing questions about future care. Considered alongside one another, these accounts suggest that participants experienced moral distress not simply through witnessing suffering, but through witnessing foreseeable harms whilst remaining unable to enact the forms of care they believed were ethically required.

The moral significance of these accounts lies not simply in the presence of constraint, but in what participants experienced themselves as being constrained from doing and the commitments placed at stake. Moral distress literature has long located such experiences in tensions between ethical judgement and the capacity to act upon it (Jameton, 1984; Fourie, 2015; Morley et al., 2019). Yet constraint alone does not fully account for these narratives. Moral injury provides a related but distinct lens where experiences involve perceived moral violation, transgression, or betrayal, particularly where their consequences endure beyond the immediate event (Litz et al., 2009; Čartolovni et al., 2021). Across these accounts, participants described not only being constrained from providing care as they believed they should, but experiences of betrayal, coercion, and institutional failure that appeared to persist in their professional identities, relationships with institutions, and sense of moral safety.

Participants also described these experiences as shaped by perceived institutional failures of recognition, protection, and shared responsibility. They spoke of feeling "ignored", "gaslit", "stonewalled", and "devalued" (JP; Blue), whilst Alex reflected that institutions had "done nothing to protect the staff group or to protect the patient group". Silvie described being "coerced into delivering messages containing distress because we cared", reflecting that "the care that we had for patients was kind of weaponised" and that the process "felt abusive by the end". Blue similarly described professional expertise becoming increasingly "devalued" and portrayed as "ideologically driven". Read together, these accounts suggest that distress arose not only from exposure to suffering, but from experiencing responsibility without corresponding authority, recognition, or organisational protection.

Silvie's description of care being "weaponised" is particularly revealing. The relational commitment that sustained clinicians' work could also leave them carrying and communicating institutional

decisions they experienced as harmful. Moral burden was therefore narrated not only as an inability to act, but as being required to remain ethically present within relationships while implementing, containing, or witnessing consequences produced beyond participants' authority.

The consequences described by participants extended beyond ethical conflict alone. Alice spoke of feeling "rocked to the core", whilst participants described remaining on "high alert" (Silvie), becoming "hyper vigilant" (JP), and continuing to carry these experiences long after the service had closed. N's account was particularly striking. Reflecting on colleagues who had left the service, they recalled that some had been "very, very badly impacted themselves" and that they were "not sure they'd still be around now if they hadn't have" left the service. Yet N also reflected, "I felt that I had to stay and do whatever I could do, however limited that was, for the families that I was working with". Across the portraits, emotional consequences appeared inseparable from participants' continuing ethical commitments to young people, families, and colleagues.

These accounts suggest that participants occupied a dual position as both witnesses to suffering and recipients of institutional and moral harms. They described witnessing the distress of young people, families, and colleagues whilst simultaneously experiencing organisational betrayal, public misrecognition, and enduring psychological consequences themselves. Moral distress therefore appeared to emerge not simply through exposure to suffering, but through sustained efforts to respond to it whilst experiencing diminishing authority, recognition, and protection. The distinction between witness and recipient consequently became difficult to sustain: remaining close enough to care also meant remaining exposed to the consequences of decisions participants felt unable to alter.

These findings extend those of the scoping review presented in Chapter Two, which suggested that moral experiences in child and adolescent mental healthcare frequently arise through competing responsibilities, organisational constraints, and tensions between what clinicians believe is needed and what systems permit. The present narratives offer a more relational and temporally situated account of these processes. Rather than describing isolated ethical dilemmas or singular moments of conflict, participants narrated moral distress as an accumulative process that unfolded through sustained attempts to care whilst witnessing foreseeable harms, carrying responsibilities that could not be fully enacted, and remaining committed to relationships under conditions they increasingly experienced as untenable. These findings extend this understanding by showing how moral constraint operated simultaneously across clinical, organisational, regulatory, legal, and sociopolitical domains. Responsibility for young people and families remained relationally immediate, while authority over the conditions shaping their care was experienced as increasingly located elsewhere.

This occurred within a field in which gender-diverse young people, the legitimacy of their healthcare, and the expertise of those providing it were themselves subject to intense sociopolitical contestation (Butler, 2004, 2024; Noone et al., 2024; Pearce et al., 2020). Moral distress therefore emerged as relational, cumulative, and systemically produced, while accounts of betrayal, coercion, and enduring disruption point towards moral injury where participants experienced these conditions as violating deeply held ethical commitments (Litz et al., 2009; Čartolovni et al., 2021).

Importantly, these consequences did not conclude with the closure of the service itself. Participants continued to describe "high alert" (Silvie), "hyper vigilance" (JP), and ongoing efforts to make sense of what had happened (Blue). Elsewhere, they continued to carry concerns about young people, families, colleagues, and wider systems of care. Institutional closure did not produce moral closure. Ethical commitments and unresolved questions persisted beyond the life of the organisation, including participants' reflections on how institutions had responded to harms affecting both the communities they served and the clinicians themselves. The quotation that follows captures how, for Alex, these unresolved questions became entwined with experiences of institutional protection, recognition, and belonging.

> We're not the only trans people who work in GIDS... this was extremely upsetting to all members of staff really, that the Trust just blankly refused to publish a statement of condolence [to Brianna Ghey's parents]. They had done so the previous year for George Floyd, so there was precedence for that type of thing. But when it was happening to a community that we directly work with, they refused to do it, which I thought was shocking... Basically they didn't protect us." *Alex*

5.5 Witnessing and Narrative Resistance

This final section shares important parallels with *Resisting Simplification*, as participants again resisted dominant public and institutional accounts of GIDS. During the analysis, I considered whether these accounts represented the same storyline. Returning to the completed portraits, however, suggested they operated at different narrative levels. Whereas *Resisting Simplification* concerned participants' efforts to preserve the complexity of psychologically informed practice, the narratives presented here were oriented towards preserving the meaning and legacy of that work. Participants repeatedly resisted allowing the closure of GIDS to become the definitive ending of their stories.

Across the portraits, participants repeatedly positioned themselves not only as clinicians but as witnesses. They bore witness to young people's lives, to colleagues' distress, and to forms of practice that they believed had become increasingly obscured within wider public, political, and institutional narratives. Together, their accounts appeared to do more than recount professional experiences. They repeatedly sought to preserve understandings of GIDS that they felt had become difficult to articulate, recognise, or legitimise elsewhere.

As outlined in earlier sections of this chapter, participants repeatedly returned to descriptions of clinical work that emphasised reflection, relationships, and context. Alice described "whole family work"; Grayson spoke of understanding the "whole person in all their contexts"; JP recalled a service characterised by reflective practice and psychological safety; Silvie described the "gnarly grey clinical work" that had drawn her to GIDS; and Blue reflected on remaining accepting whilst holding uncertainty. Here, however, these descriptions take on an additional narrative function. Rather than simply recalling clinical practice, participants appeared to place on record ways of working that they believed had become increasingly absent from wider public narratives.

Alongside these descriptions sat another recurring narrative. Participants described public and institutional accounts that appeared increasingly detached from their lived clinical realities. Grayson spoke of a "purposeful, willing misunderstanding"; Silvie reflected on a public "picture that was so far removed from the reality"; Blue described expertise becoming "devalued" and portrayed as "ideologically driven"; and Alex located these developments within broader political shifts and culture wars. These accounts indicate that participants experienced themselves not simply as responding to criticism, but as attempting to speak into narratives whose meanings had largely been established before their own voices were heard.

The concept of phantasmatic construction illuminates the wider discursive field participants were navigating, in which GIDS, gender-diverse young people, clinical expertise, risk, and protection had already acquired powerful social and political meanings (Butler, 2004, 2024). Narrative resistance therefore involved more than correcting factual misunderstanding; it contested the terms through which the service and its work had become intelligible. Their repeated return to complexity, context, and relational practice sought to preserve forms of meaning displaced by more reductive and affectively charged narratives.

"...it was just layer after layer of it, wave after wave of it... there was obviously an aim to scapegoat the service... The narrative had to be that GIDS was some kind of a grooming, disgusting, bizarre, secretive... clinic... and everything that happened around it... had to fit that narrative no matter what the reality was. And the people who were loudest about caring about the children obviously didn't care about the clinical risk to the children... because the people at the coal face who did care, who tried to communicate that upward, were silenced and told not to speak about it." *N*

For some, this extended beyond public misunderstanding to a sense that clinical expertise, dissent, and professional critique were no longer meaningfully received within institutional decision-making. Alex's account captures this experience particularly clearly.

"There was an institutional group think happening at the level of government and NHS England... it completely ignored the multitudes of valid and well-argued critiques... From my own experience of meeting Hilary Cass four or five times, I was unimpressed by her knowledge of trans issues and her ability to answer critical questions... She was not an expert in the field and it shows... I saw her as a political appointee, and the idea that she was politically neutral did not stand up to scrutiny." *Alex*

Alex's account brings expertise, institutional authority, and political context into direct relationship. Her concern was not simply disagreement with the decisions being made, but that clinically informed and well-argued critiques were raised and not meaningfully received within the processes through which those decisions acquired authority. Her repeated return to these moments positions institutional non-receptivity as part of the event itself. Being unheard was not separate from what happened, but integral to how she experienced and now narrates it. Across the portraits, this tension recurred as professional and experiential knowledge was voiced yet failed to acquire corresponding institutional authority.

Across several interviews, I became aware that participants were not just recounting, but entrusting aspects of those experiences to the interview as testimony. They paused to contextualise events, revisit moments they felt had been misunderstood, and explain aspects of clinical work they believed had become obscured within wider public discourse. Read this way, the interview became more than a site of data generation. It became a relational space in which participants could bear witness to experiences they understood as overlooked, simplified, or silenced. This resonates with Frank's (2013) understanding of testimony as an ethical act that asks another person to receive a story, and

with Andrews et al.'s (2008) conception of narrative as co-constructed within particular historical and relational contexts.

Testimony also carried an epistemic dimension. To bear witness was not only to recount experience, but to seek recognition for forms of knowledge participants understood as having been discounted, or rendered difficult to articulate (Fricker, 2007). Read alongside the epistemic tensions identified in *5.2*, the interview therefore became a space in which participants could reassert the intelligibility of clinical knowledge and experience they perceived as having lost authority elsewhere.

Alex's reflection exemplifies this narrative work, returning to warnings she believed had been voiced, ignored, and entrusted to the interview as part of the story she wanted preserved.

"I think the changing social zeitgeist and the politicisation of young people's lives and work itself... the culture wars have not happened by accident... something that's been driven by discriminatory beliefs around trans people. And we saw this within GIDS itself... I raised alarm bells even before the judgement was given... we're going to lose this case because they don't know how to argue in a coherent way around trans issues and they don't want to listen... Their arrogance was unbelievable and they ignored." *Alex*

Placed alongside the wider portraits, Alex's account situates institutional non-receptivity within the sociopolitical conditions surrounding the service. Across the narratives, questions of gender diversity, legitimacy, expertise, risk, and protection moved across clinical, institutional, and political domains rather than remaining confined to any one of them. Wider narratives were therefore not simply background to participants' experiences. They entered the conditions through which care could be practised, professional knowledge recognised, and ethical responsibility exercised (Butler, 2024; Noone et al., 2024; Pearce et al., 2020).

Together, the portraits suggest that participants were engaged not only in caring for young people but also in preserving an account of that care. The interviews became spaces in which experiences that had become difficult to voice elsewhere could be explained, contextualised, and witnessed. Rather than offering a single authoritative account of GIDS, these narratives preserve experiences and forms of knowledge that participants understood as increasingly absent from the public and institutional accounts through which the service had come to be known. In doing so, they resist allowing decommissioning to become the definitive ending of the story.

Witnessing acquired significance within the study. Participants could not alter institutional decisions that had shaped care, but through testimony they could preserve clinical knowledge, ethical

commitments, and experiences that might otherwise become obscured alongside the service itself. Narrative resistance did not recover a single authoritative truth about GIDS. It kept open what could be known and remembered about the work, refusing to allow dominant institutional and sociopolitical narratives to exhaust its meaning.

5.6 Narrative Endings: Living Beyond Closure

None of the participants narrated closure as resolution. Although GIDS closed as an organisation, participants' stories rarely concluded with finality. Administrative closure did not coincide with narrative closure. Instead, participants repeatedly ended their accounts by returning to relationships, ethical commitments, unanswered questions, and ongoing attempts to make sense of what had happened. For many, these unfinished narratives continued to shape their professional identities, relationships with institutions, emotional lives, and understandings of care. The institution had ceased to exist, yet its meanings remained active within participants' lives and stories.

Alice concluded simply by remaining proud of "being there", locating the meaning of her work not in the survival of the organisation but in the relationships she had shared with young people and families. Grayson ended not with certainty but with the hope that young people had left feeling "seen and heard and hopefully understood a bit". JP continued to speak of the "precious" relationships built with families despite experiences of institutional betrayal elsewhere. Blue reflected that they were still making sense of what had happened, whilst Alex's account remained characterised by continued advocacy and political engagement. Even where participants described profound anger, grief, or disillusionment, their narratives repeatedly returned to people rather than institutions.

Silvie captured this unfinished quality vividly:

> “It was such a not okay clinically ending. It wasn't like, okay, we've made the best of a bad situation and we've wrapped up this service. It was like, ‘Oh my God, what is going to happen to all of our families?’... We all just left and said goodbye to our families and they were like, ‘What is going to happen?’... We would have to summarise this in letters to GPs, saying, ‘We're closing... I can't tell you what's going to happen. So if you can just keep an extra eye on them.’ That was our ending. We didn't have the energy for a party... we just couldn't have celebrated that kind of ending.” *Silvie*

These endings suggest that participants continued to carry relationships, responsibilities, and ethical questions beyond the life of the organisation itself. The unfinishedness was therefore more than

narrative. Closure ended the organisational setting in which responsibility had been held, but did not necessarily resolve participants' sense of responsibility towards young people and families, or the moral consequences of care they experienced as left incomplete. In this respect, their accounts complicate understandings of moral distress centred on constraints upon ethical action (Jameton, 1984; Fourie, 2015; Morley et al., 2019). Moral experience persisted beyond the immediate conditions of constraint through remembered relationships, unresolved responsibility, and the continuing professional meanings participants made of what had occurred, while the enduring consequences of experiences understood through betrayal or moral violation also resonate with accounts of moral injury (Litz et al., 2009; Čartolovni et al., 2021).

Rather than narrating closure as a completed event, they located themselves within continuing stories of care, grief, advocacy, teaching, and reflection. These narrative endings appeared to serve an important function. By returning to valued relationships, enduring commitments, and moments of pride alongside experiences of loss and uncertainty, participants resisted allowing decommissioning to become the defining meaning of their work. Narrative inquiry recognises that endings are rarely absolute but remain open to reinterpretation as lives continue (Andrews et al., 2008). Read in this way, the closure of GIDS represented the end of an institution, but not the end of the stories, identities, and values that participants continued to carry forward.

This continuing sense of unfinishedness was perhaps most visible in the ways participants described how the closure continued to shape their thinking and practice. Reflecting on her teaching, Silvie explained:

> “I've just given a lecture on gender... the last time it was about how gender diverse children and young people present... this time it was almost entirely about the context... the role of the clinical psychologist... and social justice. The angle has really shifted... Afterwards, trainees asked, ‘If the government's so worried about safety, why are they implementing practices that reduce safety?’... We would raise, ‘If you do this, the consequence will be...’... It almost felt like there was this naïve, transphobic hope that restricting services would reduce the number of trans and gender diverse kids... But that's not how identity works.” *Silvie*

Silvie's account shows how these experiences travelled into subsequent professional practice. What she carried forward was not only knowledge about gender-diverse young people, but a changed understanding of the clinical psychologist's role within the organisational, political, and social conditions surrounding care. Her teaching had shifted accordingly, from clinical presentation alone towards questions of context, safety, social justice, and professional responsibility. Across the

portraits, this suggests that the significance of moral distress and injury extends beyond the consequences for individual clinicians. Such experiences may also shape how clinicians subsequently understand, teach, supervise, and enact ethical practice.

Importantly, these narratives continue to resonate beyond the interviews themselves. Since these accounts were collected, debates surrounding the evidence informing service transformation, critiques of the Cass Review (e.g., Noone, 2025), and continuing discussion regarding the adequacy and outcomes of replacement services suggest that many of the questions participants grappled with remain active rather than historically settled. Read alongside these developments, the portraits appear less as retrospective accounts of a completed chapter in healthcare and more as contributions to an ongoing conversation about gender identity care, institutional responsibility, and ethical practice.

This continuing relevance is particularly significant in a service that was formally decommissioned and replaced. Closure redistributed structures of care and institutional authority, but did not necessarily resolve the questions participants raised about responsibility, expertise, safety, continuity, and the conditions required for ethical practice. GIDS therefore provides a distinctive lens on moral distress and injury because it allows these experiences to be traced through institutional rupture itself, showing how organisational change can formally relocate responsibility while its moral and relational consequences continue to be carried by clinicians and through the systems and practices that follow.

What remains across the portraits is not consensus or resolution, but relationships remembered, ethical commitments carried forward, and questions that continue to be asked. Although GIDS closed as an organisation, participants' stories continued through clinical practice, teaching, advocacy, reflection, and everyday encounters with young people and families. Closure marked an institutional endpoint without resolving the moral, relational, and professional consequences through which participants continued to understand and carry their work.

5.7 Conclusions

5.7.1 Revisiting the Research Aims

This study set out to explore how clinicians made sense of the decommissioning and closure of the Gender Identity Development Service (GIDS), with particular attention to potential moral distress. Through narrative inquiry, it found that participants rarely organised their accounts around isolated ethical dilemmas or singular organisational events. Instead, their stories were structured around preserving the complexity of psychologically informed practice, sustaining care under increasingly untenable conditions, negotiating the emotional and moral consequences of those conditions, and

constructing narrative endings that preserved professional identities and ethical commitments beyond the life of the organisation.

These findings answer the research question by demonstrating that clinicians understood the closure of GIDS not simply as the ending of a service, but as a prolonged moral, relational, and narrative process. Participants described continuing to care for young people and families whilst experiencing increasing organisational constraint, public scrutiny, and uncertainty. Moral distress emerged not as the central organising feature of participants' accounts, but as one expression of sustained efforts to provide ethically committed care within organisational, political, and societal conditions that they increasingly experienced as untenable.

These findings build directly upon the scoping review presented in Chapter Two. Whilst the review identified moral distress as arising through competing responsibilities, organisational constraints, and tensions between professional values and institutional demands, the present inquiry demonstrates how these experiences accumulated over time and became embedded within relationships, institutional narratives, and clinicians' evolving professional identities. Narrative inquiry made it possible to understand not only what participants experienced, but how they organised those experiences into meaningful stories and what those stories accomplished. In doing so, the study extends understandings of moral distress beyond discrete ethical dilemmas by identifying an asymmetry between responsibility and authority across participants' accounts. Clinicians remained relationally responsible to young people and families while experiencing diminishing authority over the conditions shaping their care. This asymmetry was also epistemic, as participants described clinical and experiential knowledge as increasingly difficult to establish as legitimate within decisions affecting care. Moral constraint concerned not only clinicians' capacity to act upon ethical judgement, but whether the knowledge through which that judgement was formed and justified could itself be recognised.

5.7.2 Contribution to Knowledge

This study makes three principal contributions to knowledge. First, it contributes to the growing literature on moral distress by demonstrating how clinicians narrated moral experience as cumulative, relational, and embedded within organisational and sociopolitical contexts, rather than arising solely from discrete ethical dilemmas. Existing conceptualisations describe moral distress as emerging when clinicians are constrained from acting in accordance with their ethical commitments (Jameton, 1984; Fourie, 2015; Rushton, 2018). Whilst participants' accounts were consistent with these understandings, they also extended them. Moral distress was rarely narrated as a singular event. Instead, it accumulated through sustained attempts to care whilst witnessing foreseeable

harms, carrying responsibilities that could not be fully enacted, negotiating competing public and institutional narratives, and experiencing diminishing authority, recognition, and organisational protection. Across these accounts, responsibility, authority, and recognition became unevenly distributed: participants remained answerable within relationships for consequences they experienced themselves as increasingly unable to influence, while the knowledge through which they understood and justified care was itself contested or devalued. The study extends existing accounts of moral constraint by identifying epistemic authority as one condition through which moral agency may be enabled or constrained. Accounts of betrayal, coercion, institutional failure, and enduring disruption further suggest the relevance of moral injury where participants experienced these conditions as violating deeply held ethical commitments (Litz et al., 2009; Čartolovni et al., 2021).

Second, the study demonstrates the value of narrative inquiry for understanding moral experience within healthcare. Rather than fragmenting participants' accounts into decontextualised themes, narrative portraiture preserved the temporal, relational, and contextual integrity of individual stories before bringing them into cross-narrative dialogue. This approach illuminated aspects of clinicians' experiences that may have been less visible through thematic approaches, including the ways participants constructed professional identities, bore witness to experiences they believed had become obscured, and used narrative endings to preserve relationships, values, and meanings beyond organisational closure. The study therefore contributes methodologically by illustrating how narrative portraiture can generate nuanced understandings of moral experience, organisational change, and professional identity within contested areas of healthcare.

Third, the study provides an original empirical account of clinicians' experiences during the decommissioning and closure of GIDS. The inquiry foregrounded how participants themselves made sense of these events, without attempting to reconcile other accounts. In doing so, it documents an important account of a significant period in the history of gender identity healthcare in England whilst highlighting the organisational and ethical complexities that accompanied service transformation. The significance of GIDS extends beyond its status as the setting in which these experiences occurred. Its decommissioning brought clinical responsibility, professional expertise, institutional authority, continuity of care, public scrutiny, and sociopolitical contestation into close and consequential relationship. GIDS therefore provides a revealing lens through which to examine moral distress and moral injury across interacting levels of a healthcare system. Its closure made visible how responsibility for young people and families could remain relationally immediate while authority over the conditions shaping their care became increasingly located elsewhere, and how organisational transformation could redistribute formal structures and decision-making without

resolving the moral and relational consequences of care. Nor did institutional closure resolve the contested meanings through which GIDS, gender-diverse young people, clinical expertise, risk, and protection had become understood. These meanings continued to circulate through evolving policy, public discourse, and participants' own efforts to make sense of what had occurred. Moral experience was not confined to the period preceding closure, but could remain active as the service and its legacy continued to be narrated and reinterpreted. The study therefore contributes an empirically grounded account of moral experience during institutional rupture, showing how ethical responsibility, epistemic authority, and the conditions of care were contested across intersecting clinical, organisational, regulatory, legal, and sociopolitical domains.

5.7.3 Strengths and Limitations

Quality of the Research: The quality of the present study may be considered in relation to Tracy's (2010) Big-Tent criteria for excellent qualitative research. Although these criteria are intended as guiding principles rather than a prescriptive checklist, they provide a useful reflexive framework for considering how methodological rigour was enacted and where the study's principal strengths lie. Table 5.2 summarises this appraisal. The key methodological limitations and considerations are then discussed separately (Table 5.3).

Table 5.2 Application of Tracy's (2010) 'Big-Tent' qualitative quality criteria to the empirical study

Tracy Criterion (2010)	**Application to the Present Inquiry**
Worthy topic	This study addressed a timely and clinically significant question: how clinicians made sense of the decommissioning and closure of the Gender Identity Development Service (GIDS), with particular attention to experiences of moral distress. Given the ongoing transformation of gender identity healthcare in England and the limited qualitative literature exploring clinicians' perspectives, the study addresses an important gap in understanding the relational, organisational, and ethical consequences of service closure.
Rich rigour	Rigour was supported through in-depth narrative interviews, iterative engagement with transcripts, construction of narrative portraits, cross-narrative dialogue, reflexive writing, and sustained movement between individual accounts and cross-narrative interpretation. Rather than seeking thematic saturation, the analysis prioritised depth, contextual richness, and preservation of narrative coherence. The study is nevertheless limited by its relatively small, self-selecting sample and its focus on a single specialist service.
Sincerity	Sincerity was supported through reflexive journalling, supervision, iterative memo writing, and the inclusion of reflexive boxes throughout the narrative

	portraits and discussion. Attention was given to my own assumptions, emotional responses, and evolving interpretations. Knowledge generated through the interview encounter was understood as relationally and interpretively co-constructed, while responsibility for subsequent portrait construction, cross-narrative analysis, and interpretation remained with the researcher.
Credibility	Credibility was strengthened through close engagement with participants' narratives, extensive use of verbatim quotations, construction of individual portraits prior to cross-narrative interpretation, and repeated movement between transcripts, portraits, reflexive writing, and developing analyses. Interpretations sought to remain grounded in participants' stories whilst acknowledging narrative inquiry as an interpretive rather than representational methodology.
Resonance	Resonance was supported through narrative portraiture, participant-near language, extended quotations, and reflexive writing that sought to preserve the emotional, relational, and temporal qualities of participants' accounts. The findings aim to resonate with clinicians, researchers, educators, and policy-makers by illuminating experiences of moral distress and organisational change that extend beyond the specific context of GIDS.
Significant contribution	The study extends existing conceptualisations of moral distress by demonstrating how moral experience was narrated as cumulative and relational, and by identifying the relationship between responsibility, authority, epistemic recognition, and moral agency. It further identifies the relevance of moral injury within accounts of betrayal, coercion, institutional failure, and enduring disruption. GIDS provides a revealing empirical context in which these processes could be examined across interacting clinical, organisational, regulatory, legal, and sociopolitical domains, including through the institutional rupture of decommissioning and closure. Methodologically, it illustrates the value of narrative portraiture for understanding moral experience and preserving accounts of contested healthcare services.
Ethics	Ethical practice was supported through university ethical approval, informed consent, careful attention to participant wellbeing during emotionally demanding interviews, anonymisation, and reflexive consideration of representation. Attention was paid to preserving participants' voices whilst avoiding overclaiming or positioning any single narrative as authoritative.
Meaningful coherence	The study demonstrates coherence through alignment between its social constructionist narrative epistemology, narrative inquiry methodology, portrait-based analysis, reflexive practice, and cross-narrative interpretation. Rather than asking whether clinicians' accounts were objectively accurate, the study explored how participants constructed meaning around service closure and moral distress. The analytic movement from individual portraits to collective storylines,

	emotional consequences, and narrative endings reflects this methodological and theoretical coherence throughout the thesis.

This appraisal demonstrates that the study's strengths lie not only in its methodological rigour, but also in the coherence between its social constructionist epistemology, narrative inquiry methodology, portrait-based analysis, reflexive practice, and interpretive claims. Rather than seeking objectivity or consensus, the inquiry prioritised preserving the integrity, contextual richness, and relational meaning of participants' narratives whilst maintaining transparency throughout the analytic process.

Considerations: The appraisal presented above should be considered alongside several methodological considerations that inform the interpretation and transferability of the findings. Rather than diminishing the inquiry, these reflect the epistemological assumptions of narrative inquiry and clarify the scope within which its findings should be understood. Table 5.3 summarises these considerations.

Table 5.3: Methodological Considerations and Limitations of the Present Inquiry

Methodological consideration	**Implications for the study**
Single service context	This inquiry explored clinicians' narratives within one specialist NHS service during a unique period of decommissioning. The findings are therefore not intended to be statistically generalisable but offer analytic transferability to other healthcare settings experiencing organisational change, moral complexity, or contested practice.
Self-selecting sample	Participants volunteered to take part and may have been particularly motivated to revisit their experiences. The portraits therefore represent the situated accounts of eight clinicians rather than all staff who worked within GIDS. The findings should therefore be understood as illuminating one set of richly contextualised experiences rather than reflecting the full diversity of perspectives across the former staff group.
Retrospective narrative accounts	Interviews were conducted after the closure of GIDS and reflect participants' ongoing processes of meaning-making rather than objective reconstructions of events. Within narrative inquiry, these evolving interpretations are

	understood as central to the phenomenon under investigation rather than simply a methodological limitation.
Single stakeholder perspective	The study foregrounds clinicians' narratives and does not include the perspectives of young people, families, organisational leaders, policymakers, or other stakeholders. These perspectives may generate different understandings of the service's closure and represent important directions for future research.
Researcher interpretation	Narrative portraits and cross-narrative dialogue represent one reflexively developed interpretation of participants' stories. Rather than seeking a singular or definitive account, the study prioritised methodological transparency, reflexive engagement, and close attention to participants' words to support credibility and trustworthiness, recognising that alternative interpretations remain possible.

The two tables demonstrate both the strengths of the inquiry and the methodological boundaries within which its findings should be interpreted. This balanced appraisal supports the contribution of the present inquiry whilst recognising that narrative knowledge is necessarily situated, relational, and interpretive.

5.7.4 Clinical and Organisational Implications

Although grounded in the specific context of GIDS, the findings have implications that extend beyond a single service. The present inquiry suggests that moral distress cannot be understood solely as an individual psychological experience but is shaped by the organisational, relational, and sociopolitical conditions within which care is delivered (Fourie, 2015; Morley et al., 2019; Rushton, 2018). Supporting clinicians therefore requires attention not only to individual wellbeing but also to the organisational conditions that enable ethically coherent practice. Approaches that focus exclusively on resilience or coping risk overlooking the systemic and relational contexts within which moral distress emerges and is sustained. This includes whether clinicians have sufficient authority, organisational support, and epistemic recognition to enact the responsibilities they are expected to hold. Understanding moral distress in these terms matters clinically because its consequences may extend beyond individual wellbeing to professional identity, relationships with institutions, and how clinicians subsequently understand and enact ethical practice.

A second implication concerns organisational change. The inquiry highlights the ethical significance of staff voice during periods of service transformation and uncertainty. Organisational responses to change may have consequences that extend beyond operational delivery, shaping clinicians' professional identities, wellbeing, and capacity to sustain relationships of care. Transparent communication, opportunities for meaningful dialogue, and recognition of clinicians' expertise may therefore represent important components of ethically informed organisational leadership, particularly within services experiencing public scrutiny, policy reform, or contested practice. The findings also draw attention to how responsibility is transferred during service transformation. Closure or restructuring may relocate formal accountability without resolving existing relational responsibilities towards patients and families. Transition planning should therefore attend not only to operational handover, but to continuity of care, clarity about responsibility for foreseeable risks, mechanisms through which clinical concerns can inform decision-making, and support for staff required to communicate or enact decisions over which they have limited authority.

These implications extend beyond clinicians and provider organisations. Participants' accounts located moral experience within relationships involving young people and families, clinical teams, organisational leadership, and wider regulatory, legal, and policy processes. GIDS illustrates how decisions made across a healthcare system can enter the clinical relationship through changes to access, continuity, communication, and the possibilities for care, while their relational consequences may be carried most immediately by young people, families, and frontline clinicians. Ethical service transformation therefore requires attention to how responsibility, authority, knowledge, and consequences are distributed across stakeholders and systems, rather than locating moral distress within individual practitioners.

The inquiry also demonstrates the value of narrative approaches for understanding organisational change within healthcare. By attending to how clinicians made sense of their experiences over time, narrative inquiry illuminated forms of moral experience, professional identity, and organisational meaning-making that may be less visible through approaches that privilege decontextualised themes or discrete ethical events (Andrews et al., 2008; Riessman, 2008). Narrative methods may therefore offer a valuable means of informing organisational learning, service development, and workforce support during periods of significant change.

More broadly, this inquiry highlights the importance of creating spaces in which clinicians can tell and contextualise their own stories, particularly during periods of organisational change and public scrutiny. Where participants experienced their work as increasingly narrated by others, opportunities to articulate their own understandings may contribute to organisational learning, ethical reflection,

and workforce wellbeing. Yet the findings also suggest that voice alone is insufficient if the knowledge expressed cannot be heard, recognised, or meaningfully engaged with echoing wider concerns regarding epistemic recognition and authority (Fricker, 2007). Organisational listening therefore requires more than opportunities for expression; it requires structures capable of receiving, considering, and responding to clinical and experiential knowledge. Such spaces may also help preserve forms of professional knowledge and relational experience that might otherwise become obscured within dominant institutional or public narratives.

5.7.5 Future Research

The findings of this inquiry suggest that clinicians made sense of the closure of GIDS not as a singular organisational event, but as a prolonged relational, ethical, and narrative process. Across the collective storylines, participants described resisting simplified accounts of their work, sustaining care under increasingly untenable conditions, experiencing profound emotional and moral consequences, and continuing to carry relationships and ethical commitments beyond the closure of the service. Whilst this inquiry has illuminated how clinicians narrated these experiences, it also raises important questions that extend beyond its scope.

Future research would benefit from placing these narratives into dialogue with those of young people, families, organisational leaders, policymakers, and clinicians working within the replacement services. Rather than seeking a single account of GIDS, such work could explore how different groups construct, negotiate, and contest meanings surrounding the same organisational events, and how these differing narratives shape experiences of care, organisational change, and service development. This could further illuminate how responsibility, authority, and knowledge are differently experienced and distributed across stakeholders, including where their accounts converge, conflict, or remain difficult to reconcile.

The inquiry also points towards the value of longitudinal narrative research. Participants' stories demonstrated that the meanings attached to the closure of GIDS continued to evolve long after the organisation itself had ceased to exist. Future work could therefore explore how clinicians, organisations, and healthcare systems continue to make sense of these events as policy, practice, and public discourse develop over time. Such research could examine whether and how the moral significance of institutional rupture changes as events are subsequently narrated, contested, legitimised, and remembered, including whether moral distress or experiences associated with moral injury persist, diminish, or acquire different meanings over time.

The present inquiry also raises important questions about the continuing transformation of gender identity healthcare in England. Participants repeatedly expressed concern that psychologically

informed, relational approaches to care, alongside forms of clinical expertise they valued, were becoming increasingly marginalised during the decommissioning of GIDS. As replacement services continue to develop, future research should critically examine whether and how these concerns have been addressed in practice. This includes exploring how young people, families, and clinicians experience the evolving model of care; whether opportunities for psychologically informed, relational work have been preserved; how competing understandings of evidence and expertise shape clinical practice; and whose voices come to influence service development and evaluation. Given the continuing legal challenges, critiques of the evidence underpinning service transformation, and ongoing public and professional debate surrounding gender identity healthcare, there is also a pressing need for independent longitudinal evaluation of the replacement services. Such research should examine not only clinical outcomes, but also experiences of care, access, continuity, therapeutic relationships, workforce expertise, and whether the aspirations underpinning service transformation are being realised for the young people and families these services are intended to support. In a field where the production and legitimisation of knowledge remain contested, sustained empirical evaluation will be essential to informing future policy and practice.

Finally, this inquiry suggests that narrative approaches have an important contribution to make to future research on moral distress and organisational change. By attending to how experiences are constructed, negotiated, and carried forward over time, narrative inquiry offers opportunities to examine not only how clinicians experience ethically complex work, but also how institutional and public narratives shape professional identities, organisational memory, and the knowledge that comes to inform future healthcare practice. Future research could examine more directly the relationship between epistemic authority and moral agency, including how clinicians, young people, and families experience responsibility for care where their knowledge, authority, or capacity to influence decisions is constrained. This would enable the relationship identified within the present narratives to be examined across different stakeholder positions and healthcare contexts

5.8 What Remains: Closing Reflections

When I began this inquiry, I thought I was studying the closure of a service. What participants entrusted to me was something far more human: stories of care, uncertainty, responsibility, grief, and the enduring consequences of trying to do ethically committed work within increasingly difficult circumstances. As I listened, I became increasingly aware that many participants were not simply recounting events. They were reclaiming stories they felt had become obscured within wider institutional, political, and public narratives.

Perhaps this is where the contribution of narrative inquiry lies. Rather than determining which account should prevail, it creates space for the quieter, everyday stories of clinical work, ethical labour, and human relationships that often remain obscured within dominant public narratives. In doing so, it allows lived experiences that unfolded within consulting rooms, supervision spaces, team discussions, and conversations with families to sit alongside the more visible political and media narratives through which GIDS has largely come to be understood.

If these portraits leave the reader with anything, I hope it is curiosity: a willingness to notice when prevailing narratives appear complete, to remain open to alternative accounts, and to continue asking whose stories are being heard, whose are being overlooked, and what may be lost when complexity gives way to certainty.

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APPENDICES

Appendix A: Full Database Search Strategies

Database	Key Search Concepts	Search Strategy
PsycINFO	Moral distress, moral injury, ethical challenges; child- and family-facing contexts; professional groups	("moral distress" OR "moral injury" OR "moral stress" OR "ethical dilemma*" OR "moral dilemma*" OR "ethical conflict" OR "moral conflict" OR "ethical challenge*" OR "value conflict*") AND (child* OR adolescen* OR youth OR "young people" OR family OR families OR parent* OR paediatric* OR pediatric* OR CAMHS OR CYPMHS OR safeguarding OR "child protection") AND (clinician* OR psychologist* OR psychiatrist* OR therapist* OR nurse* OR "social worker*" OR practitioner* OR "health professional*" OR "mental health professional*" OR staff OR worker*)
PubMed	Moral distress, moral injury, ethical challenges; child- and family-facing contexts; professional groups	(("moral distress"[Title/Abstract] OR "moral injury"[Title/Abstract] OR "moral stress"[Title/Abstract] OR "ethical dilemma*"[Title/Abstract] OR "moral dilemma*"[Title/Abstract] OR "ethical conflict"[Title/Abstract] OR "moral conflict"[Title/Abstract] OR "ethical challenge*"[Title/Abstract] OR "value conflict*"[Title/Abstract])) AND ((child*[Title/Abstract] OR adolescen*[Title/Abstract] OR youth[Title/Abstract] OR "young people"[Title/Abstract] OR family[Title/Abstract] OR families[Title/Abstract] OR parent*[Title/Abstract] OR paediatric*[Title/Abstract] OR pediatric*[Title/Abstract] OR CAMHS[Title/Abstract] OR safeguarding[Title/Abstract] OR "child protection"[Title/Abstract])) AND ((clinician*[Title/Abstract] OR psychologist*[Title/Abstract] OR psychiatrist*[Title/Abstract] OR therapist*[Title/Abstract] OR nurse*[Title/Abstract] OR "social worker*"[Title/Abstract] OR practitioner*[Title/Abstract]

		OR "health professional*"[Title/Abstract] OR "mental health professional*"[Title/Abstract] OR staff[Title/Abstract] OR worker*[Title/Abstract]))
Scopus	Moral distress, moral injury, ethical challenges; child- and family-facing contexts; professional groups	("moral distress" OR "moral injury" OR "moral stress" OR "ethical dilemma*" OR "moral dilemma*" OR "ethical conflict" OR "moral conflict" OR "ethical challenge*" OR "value conflict*") AND (child* OR adolescen* OR youth OR "young people" OR family OR families OR parent* OR paediatric* OR pediatric* OR CAMHS OR safeguarding OR "child protection") AND (clinician* OR psychologist* OR psychiatrist* OR therapist* OR nurse* OR "social worker*" OR practitioner* OR "health professional*" OR "mental health professional*" OR staff OR worker*)
ProQuest Dissertations & Theses	Moral distress, moral injury, ethical challenges; child- and family-facing contexts; professional groups	("moral distress" OR "moral injury" OR "moral stress" OR "ethical dilemma*" OR "moral dilemma*" OR "ethical conflict" OR "moral conflict" OR "ethical challenge*" OR "value conflict*") AND (child* OR adolescen* OR youth OR "young people" OR family OR families OR parent* OR paediatric* OR pediatric* OR CAMHS OR safeguarding OR "child protection") AND (clinician* OR psychologist* OR psychiatrist* OR therapist* OR nurse* OR "social worker*" OR practitioner* OR "health professional*" OR "mental health professional*" OR staff OR worker*)

Appendix B: Participant Consent Form

Participant pseudonym:

University of Hertfordshire UH Ethics Committee

PARTICIPANT CONSENT FORM

Title: "Delivering care when facing existential threats." Making sense of the end of GIDS.

Name of Researcher: Liam Pikett (he/him)

Please **initial** box

1. I confirm that I have read the information sheet dated 12 Jun 25 (version 1) for the above study and understand the purpose of the research and I have received a copy of the information sheet and informed consent form to keep. ☐
2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
3. I understand that my participation is voluntary and that I am free to withdraw from the research study up until 2 weeks after the interview (*see information sheet*) without my legal rights or medical care being affected. ☐
4. I understand that my personal information will be processed only for the purposes of research and that all material and personal information will be kept in accordance with General Data Protection Regulation (GDPR) and the Data Protection Act 2018. ☐
5. I understand that relevant anonymised data collected during the study may be looked at by individuals from the sponsor of the trial (University of Hertfordshire), regulatory authorities and transcription services where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data. ☐
6. I agree to be contacted again for future research studies. *(Optional)* ☐
7. I understand that the information I share, including anonymised direct quotes, may be included in any resulting report, publications and conference presentations, *(Optional)* ☐
8. I agree that the information collected about me can be used to support other research in the future, and may be shared anonymously with other researchers. *(Optional)* ☐
9. I would like to receive a summary of the research findings. *(Optional)* ☐
10. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix C: Participant Information Sheet

Date:

PARTICIPANT INFORMATION SHEET

Title: "Delivering care when facing existential threats." Making sense of the end of GIDS.

Name of Researcher: Liam Pikett (he/him)

Introduction

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand about the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link: https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs (after accessing this website, scroll down to Letter S where you will find the regulation)

What is the purpose of this study?

I am aware of many narratives being portrayed in personal and public ways from a very challenging time for staff who worked in this service. We want to consider potential emotional and ethical conflicts you faced during the review period and whilst facing uncertainty in service continuation and around your jobs.

Together we would explore your experiences through in-depth interviews, giving you space to reflect on your journey, where it left you and how it has shaped you.

Do I have to take part?

No. Participation is voluntary. If you decide to participate, after reading this information sheet, you must sign a consent form.

If you change your mind, you can withdraw up until two weeks after your interview is conducted, as from this point transcripts will be fully anonymised.

Are there any age or other restrictions that may prevent me from participating?

To participate you must be over 18 years old, have worked in the Gender Identity Service at the Tavistock and Portman NHS Trust between 2018 and 2024 and speak English fluently.

To get a mix of experiences from staff we may consider the following as additional inclusion criteria: job role, length of time in service, point of leaving the service.

How long will my part in the study take?

If you decide to participate in this study, you will be invited to attend an interview that lasts 1 to 2 hours. We will have time for breaks too, as needed.

What will happen to me if I take part?

If you decide to take part, you will complete a brief online Qualtrics questionnaire that takes around 2 minutes. We will then arrange a short introductory video call (around 15 minutes), where I can answer any questions you might have and discuss your eligibility.

Once this is confirmed, we can decide a date and time for the interview, which can last from 1 to 2 hours. I will be responsive to your needs. The interview will be online through video conferencing, at a mutually agreed time that works for you. There is the option to be compensated for your time via Love2Shop vouchers.

If you have any accessibility or communication needs, please let me know.

What are the possible disadvantages or risks of taking part?

Depending on your experiences working in GIDS, we could be talking about something that has been a positive and/or challenging experience for you. We can navigate this together and make a plan should you experience feelings of distress from recounting your experiences.

What are the possible benefits of taking part?

Unlike other studies, our outcome is only to explore your experiences and how you made sense of them, so it may be cathartic to have your voices heard and speak truth to your experience.

By joining the study, you will be contributing to the scientific evidence, and possibly help future clinicians and service providers when considering changes to policy and services in relation to minority groups.

How will my taking part in this study be kept confidential?

Everything you share will be kept anonymously and confidentially and only for research purposes. Data will be stored according to the Data Protection Act 2018. Interview audio and/or video recordings will be password protected and stored on the University of Hertfordshire OneDrive. Recordings will be destroyed after completion of my Viva exam. Transcripts will be generated from the recordings. They will not contain identifiable information. If a transcription service is used, they will not have access to any of your identifiable information and sign a confidentiality agreement.

A supervision group (comprised of two other researchers) will help me to look at the anonymised transcripts. This is to help me limit my bias when I am reading the transcripts.

With your consent, some quotes from what you share with me will be used for dissemination on scientific journals and/or social media, but will remain anonymous so you will not be identifiable.

The only reason that might break confidentiality, is if you or someone near to you is at immediate risk. If that is the case, we will discuss what is the best way forward together.

Will the data be required for use in further studies?

All identifiable information will not be used for anything further and will be destroyed once I received my Doctorate degree. The anonymised transcripts might be used for future publications and projects.

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield, Hertfordshire
AL10 9AB

Researcher contact details:

Project Lead: Liam Pikett – l.pikett@herts.ac.uk

Supervised by:

Dr Rebecca Adlington – r.l.adlington@herts.ac.uk

Appendix D: Study advertisement poster



Appendix E: Ethical Approval Letter

To: Liam Pikett

Your application for ethics approval for the study listed below has been approved by the Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. **Please read this letter carefully.**

Study Title: "How do we care for people in the face of existential threat?" Making sense of experiences at the end of the first Gender Identity Development Service (GIDS)

Your UH protocol number is: **1215 2025 Oct HSET**
This reference must be quoted on all paperwork, including advertisements for participants.

If you wish to use the UH Ethics Committee logo disclaimer in your communications with participants, please find it in our UH Ethics Canvas site under 'Units - Application Forms': UH Ethics Approval - Ethics Forms.

This ethics approval expires on 31/05/2026

Amending your protocol

Individual protocols will normally be approved for the limited period of time noted above. Application for minor amendments (including time extensions) of a protocol, may be made for a maximum of 4 working weeks after the end date of that protocol.

It is expected that any amendments proposed via the online system will be minor. Should substantial modification be required, it would be necessary to make a fresh application for ethical approval.

Note that you must obtain approval from the relevant UH Ethics Committee with Delegated Authority **prior to implementing any changes**. Failure to do so constitutes a breach of ethics regulations (UPR RE01).

Adverse circumstances
Any adverse circumstances that may arise because of your study/activity must be reported to ethicsadmin@herts.ac.uk as soon as possible.

Permissions
Any necessary permissions for the use of premises/location and accessing participants for your study/activity must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Ethics Administration Team

ethicsadmin@herts.ac.uk

Appendix F: Debrief Sheet

Debrief Form

Thank you

Thank you so much for taking part in this study. Your contribution is deeply valued. By sharing your experiences, you are helping to build a better understanding of the challenges faced by clinicians and services working with gender diverse young people at a crucial time. This insight will support learning for future practice and service provision.

Your rights

As noted in the consent form, you remain free to withdraw your data from the study at any point **up until the analysis and write-up stage**. If you would like to do so, please contact me (details below).

Taking care after the interview

Sometimes, reflecting on your experiences can bring up unexpected feelings. If you notice any distress following this interview, please consider reaching out for support—whether to trusted friends, family members, colleagues, or a healthcare professional.

Sources of support

- **Your GP** – for ongoing support with your health and wellbeing.
- **NHS 111** – for urgent medical advice when it's not an emergency.
- **Samaritans** – 116 123 (free, available 24/7) or visit www.samaritans.org.

Researcher contact

If you have any questions about the study, or wish to withdraw your data, please contact:

Liam Pikett
University of Hertfordshire
l.pikett@herts.ac.uk

Appendix G: Excerpts from Reflexive Log

December 2024

People keep saying this project is controversial? To who exactly? That requires acceptance of a baseline I do not. This story doesn't make sense to me from the presented logic and evidence, I've seen advanced critique of the Cass review. What happened and why did it happen?

06.06.2025



08.02.2026

Thinking on language, again. Caution and safety, in the wrong mouth, is conversion practice.

That's the entry.

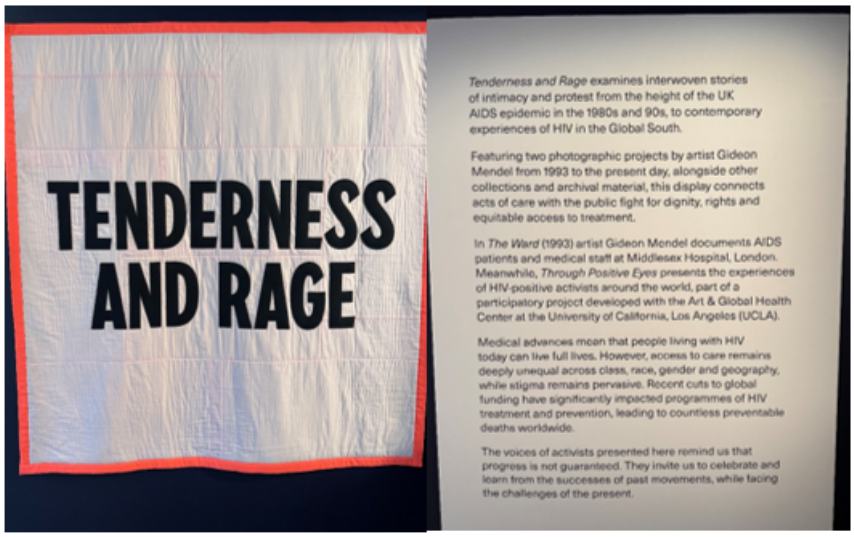
29.03.2026

So much internal resistance to put myself into the work and sit in the stories. How much reflexivity do I need to do? I wonder what I'm resisting or avoiding.

18/06/2026

One of my final meetings with my supervisor ahead of submitting the thesis and I'm in the Wellcome Collection. I walk up the spiral staircase and comments I wrote about living in the shadow of the aids crisis and section 28, thinking of all the lives and culture lost, and this is the exhibition between the ground floor and the library. I don't have time to look other than at this entrance. Same as it ever was, but also, validating. "The voices of activists ... remind us that progress is not guaranteed. They invite us to celebrate and learn..".

Who tells your story? Who writes the history books? Who are the real victors and villains, of the world as we have been fed it.



24/06/2026

As I check and appraise my final write up, edit, the radio plays a clip from the BBC archive, where the capture different moments in time. They are introducing the idea of men using a bag, there is an insinuation it is effeminate, and in their feedback, there is learnt distain for femininity, and who presents it and its purpose. It is light hearted in tone, but the phantasm of gender is omnipresent. The clip is from the early 90s and the host comments how its acceptable for men to carry them now. Flippant but privileged.

Appendix H: Topic Guide

"Thank you so much for agreeing to take part in this interview. I really appreciate the time and thought you are giving to this—it matters a great deal to hear directly from people who have lived and worked through these experiences.

As you know from the consent form, I'll be recording our conversation so that I don't miss anything. The recording will only be used for research purposes, and your words will be anonymised—nothing that could identify you will appear in the final thesis or any publications. What you share here is confidential, with the exception that if you were to tell me something that suggests you or someone else is at risk of harm, I would have to act on that.

I also want to acknowledge that talking about your time at GIDS may bring up strong or mixed feelings. If at any point you'd like to pause, take a break, or move the conversation in another direction, please just let me know. You are in control of how much or how little you share.

There are no right or wrong answers here. I'm not looking for particular kinds of responses—I just want to understand your experiences, in your own words, and to hear your story of working at GIDS.."

****

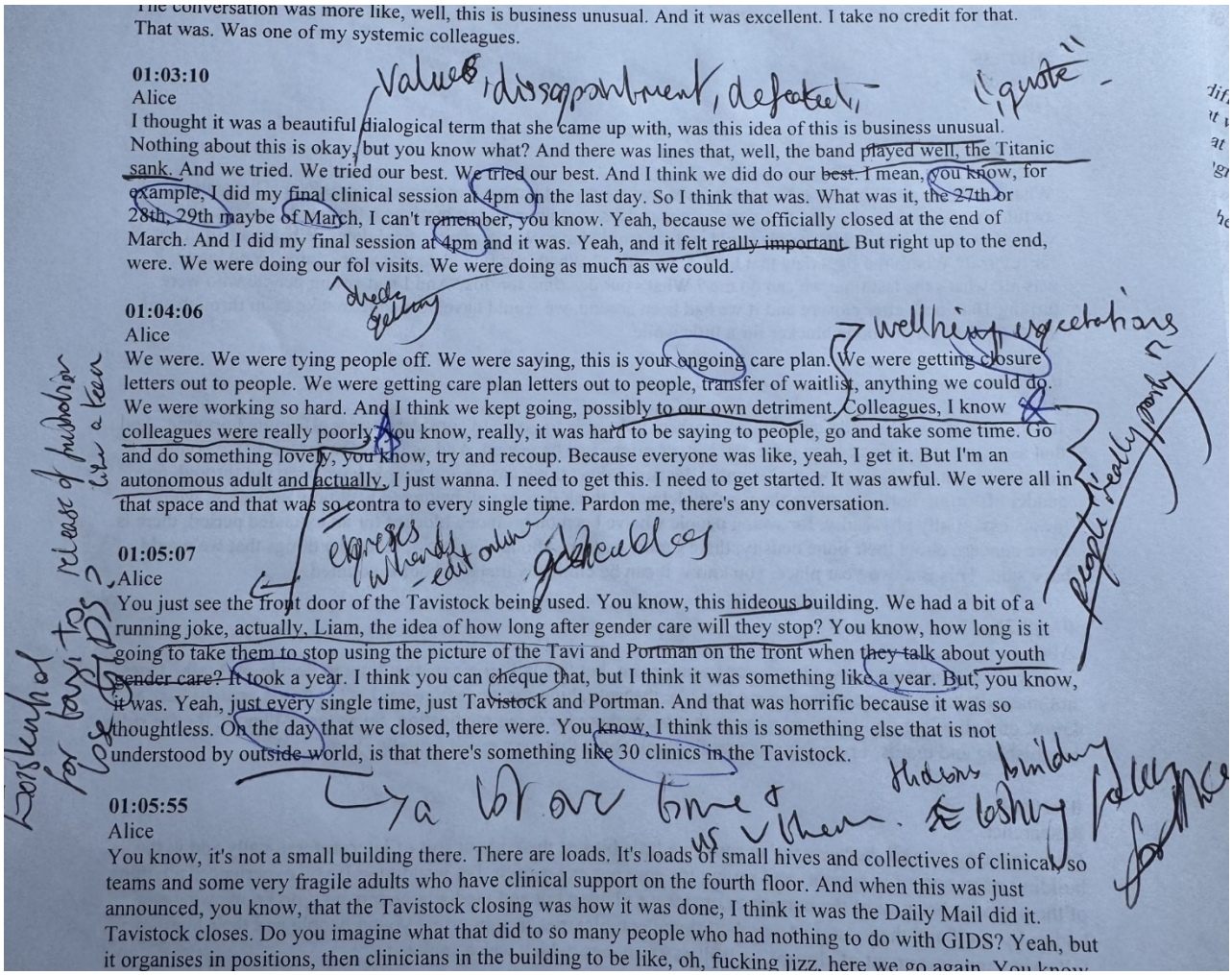
1. **Tell me a little about your role and journey at GIDS:**
    a. When did you start working there? / How long did you work there?
    b. And what led you to join the team?
    c. Tell me about your role and duties?
    d. And did expectation and reality align in what the service was?
    e. Which site did you work at?
    f. What led you to apply for a job working at GIDS?

2. **Tell me what it meant for you to work at the only NHS service of its kind. What did that feel like?**
    a. Can you tell me about a moment (or moments) that has shaped your approach to working with YP with gender dysphoria?
    b. Were there moments where you felt proud, or conflicted, about carrying that responsibility?

3. **How have your views on gender and identity evolved over the time you've been working in this field?**
    a. How so?
    b. What do you connect that too?
    c. Has your journey around the end of GIDS and leaving, impacted your views or ways of working? How?
4. Lots of existential questions, external realities forcing short answers

5. **Can you recall how you and your colleagues responded, both through the CASS review process, and upon hearing the news the service would close?**
    a. Where were you when you heard?
    b. How do you think this experience influenced the view of yourself, your identity, or your journey?
    c. How do you feel that your values or beliefs were influenced by what happened?
    d. How has this experience influenced your perception of healthcare providers or systems more generally?
    e. What was the feeling following the announcement?
    f. How did you navigate this?
    g. Were there moments when you felt you had to act against what you believed was right (or couldn't act as you wanted to)?
    h. Did this affect your sense of trust in the organisation, colleagues, or yourself?

Appendix I: Data analysis extract Phase 1



The conversation was more like, well, this is business unusual. And it was excellent. I take no credit for that. That was. Was one of my systemic colleagues.

01:03:10
Alice
I thought it was a beautiful dialogical term that she came up with, was this idea of this is business unusual. Nothing about this is okay, but you know what? And there was lines that, well, the band played well, the Titanic sank. And we tried. We tried our best. We tried our best. And I think we did do our best. I mean, you know, for example, I did my final clinical session at 4pm on the last day. So I think that was. What was it, the 27th or 28th, 29th maybe of March, I can't remember, you know. Yeah, because we officially closed at the end of March. And I did my final session at 4pm and it was. Yeah, and it felt really important. But right up to the end, were. We were doing our fol visits. We were doing as much as we could.

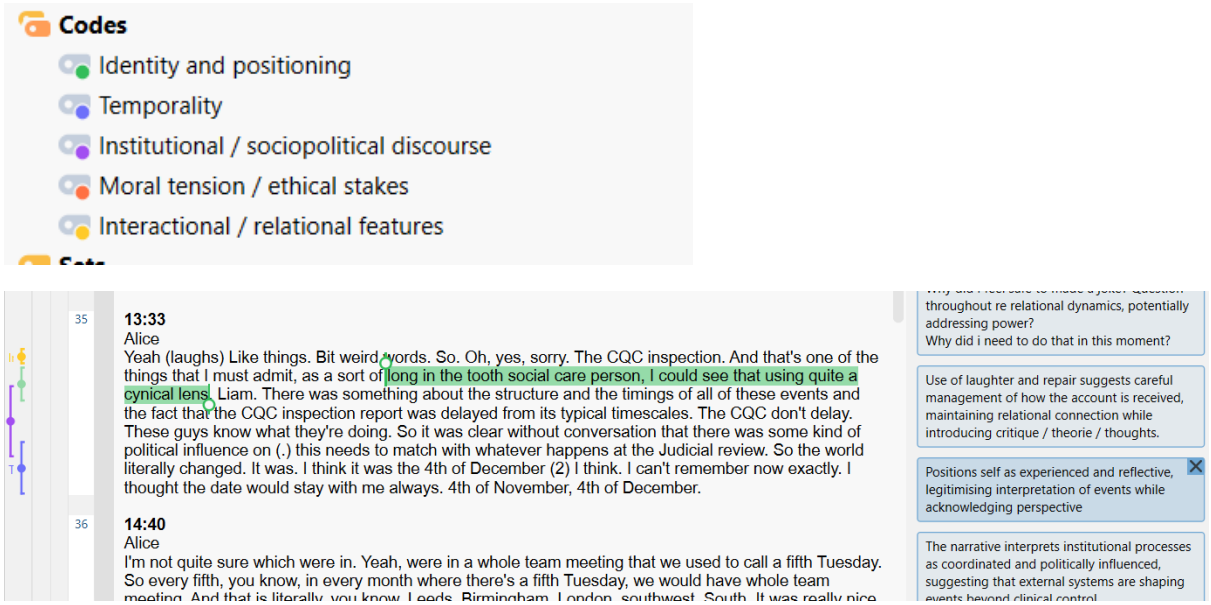
01:04:06
Alice
We were. We were tying people off. We were saying, this is your ongoing care plan. We were getting closure letters out to people. We were getting care plan letters out to people, transfer of waitlist, anything we could do. We were working so hard. And I think we kept going, possibly to our own detriment. Colleagues, I know colleagues were really poorly. You know, really, it was hard to be saying to people, go and take some time. Go and do something lovely, you know, try and recoup. Because everyone was like, yeah, I get it. But I'm an autonomous adult and actually, I just wanna. I need to get this. I need to get started. It was awful. We were all in that space and that was so contra to every single time. Pardon me, there's any conversation.

01:05:07
Alice
You just see the front door of the Tavistock being used. You know, this hideous building. We had a bit of a running joke, actually, Liam, the idea of how long after gender care will they stop? You know, how long is it going to take them to stop using the picture of the Tavi and Portman on the front when they talk about youth gender care? It took a year. I think you can cheque that, but I think it was something like a year. But, you know, it was. Yeah, just every single time, just Tavistock and Portman. And that was horrific because it was so thoughtless. On the day that we closed, there were. You know, I think this is something else that is not understood by outside world, is that there's something like 30 clinics in the Tavistock.

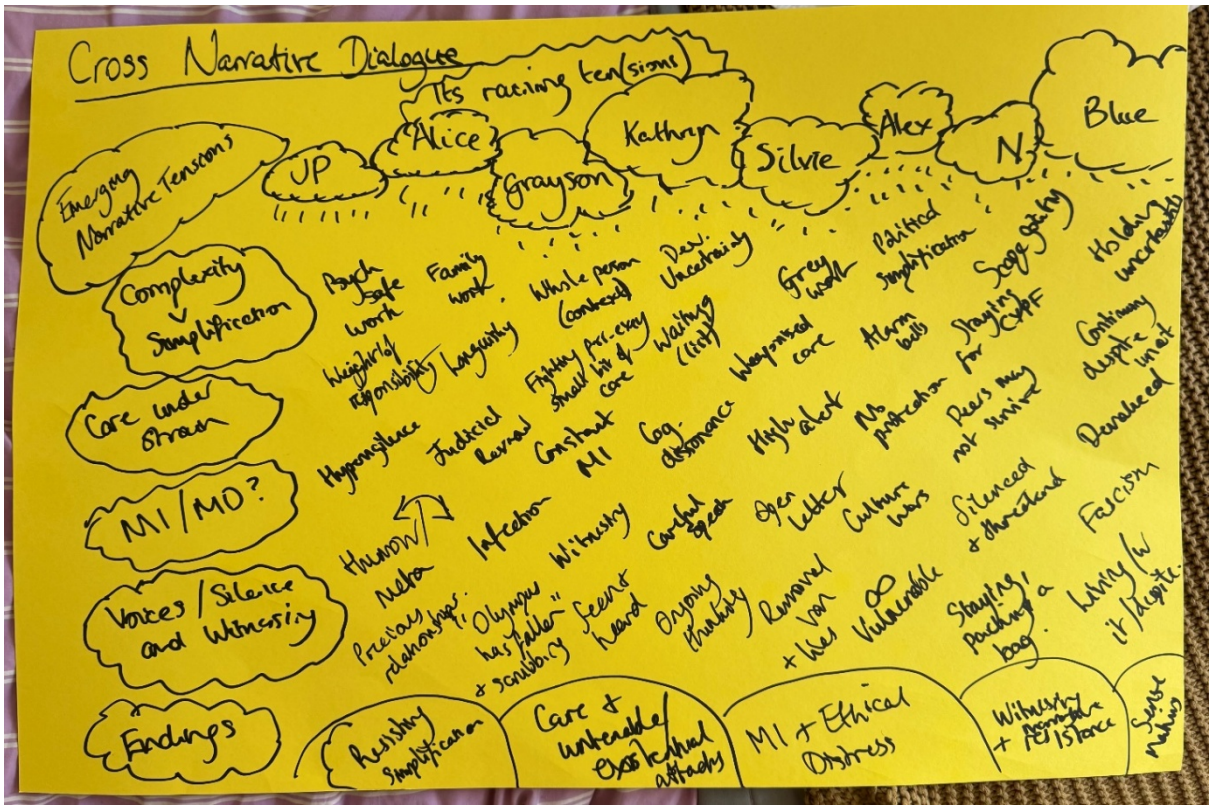
01:05:55
Alice
You know, it's not a small building there. There are loads. It's loads of small hives and collectives of clinical, so teams and some very fragile adults who have clinical support on the fourth floor. And when this was just announced, you know, that the Tavistock closing was how it was done, I think it was the Daily Mail did it. Tavistock closes. Do you imagine what that did to so many people who had nothing to do with GIDS? Yeah, but it organises in positions, then clinicians in the building to be like, oh, fucking jizz, here we go again. You know

Appendix J: Example of MAXQDA Phase 2

Interview transcripts were organised, coded, and managed using MAXQDA Analytics Pro (Version 26) to support systematic data management and retrieval throughout the analysis (VERBI Software, 2026).



Appendix K: Cross Narrative Dialogue Matrix



Appendix L: Qualtrics (Online Survey) Questionnaire

Qualtrics questions:

Job role and banding at GIDS?

Years working with GIDS (e.g. 2018-2020)

Did you receive redundancy?

If you take part in the study, what pseudonym would you like to use throughout your involvement?

Demographic information:

Age, Gender, Class, Sexuality, Ethnicity

https://herts.eu.qualtrics.com/jfe/form/SV_cHhpAaoKvYjRn1A

Appendix M: Research Aim and Guiding Research Questions

Research Aim

To explore the lived experiences of clinicians delivering care during the decommissioning and closure of the Gender Identity Development Service (GIDS), with particular attention to how they understood, negotiated, and made sense of providing care within a rapidly changing organisational, political, and sociocultural context.

Guiding Research Questions

This narrative inquiry was guided by the following questions:

1. How did clinicians experience delivering care during the decommissioning and closure of GIDS?
2. How did clinicians understand and negotiate the organisational, political, and ethical challenges that arose whilst continuing to care for young people and their families?
3. How did participants describe the impact of these experiences on their professional identities, wellbeing, and sense of ethical responsibility?
4. How were experiences of moral distress, moral injury, and related moral tensions narrated and understood within the broader context of care?
5. What broader narratives about healthcare, institutions, and care emerged across participants' accounts, and what might these illuminate about working within services experiencing profound organisational and sociopolitical change?