

“I Didn’t Want Him to Disappear” Parental Decision-Making on Access to Puberty Blockers for Trans Early Adolescents

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Abstract

Puberty can be a particularly challenging time for adolescents who are transgender. Access to puberty blocking medication, commonly called ‘puberty blockers’, is considered an integral component of gender affirmative healthcare. Existing literature provides little insight into how parents of trans children entering into early adolescence navigate decision-making related to puberty blockers. This unique research examines parental perspectives on medical decision-making from a cohort of families with trans children who socially transitioned pre-adolescence (average age 7), and who at time of parental interview were in or approaching, early adolescence (average age 11). Data were analysed through inductive reflexive thematic analysis. Parental reflections are presented within three main themes, concern for protection of adolescent mental health and well-being, parental perspectives on adolescent consent, and managing decision-making without certainty. These findings hold relevance for healthcare policy makers, for parents of trans children, and for healthcare, social services and other professionals supporting trans adolescents and their families.

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GNRH analogues, colloquially known as ‘puberty blockers’, are a core component of gender affirmative healthcare for trans adolescents (WPATH, 2020). Puberty blockers have been in use for delaying early (precocious) puberty in children since the 1960s, and have been used for delaying puberty in trans adolescents from the late 1980s (Cohen-Kettenis et al., 2011). Puberty blockers halt the progress of endogenous puberty, including pausing or delaying the changes associated with puberty such as the development of secondary sex characteristics (for example deepening of voice, breast growth), the development of fertility (maturation of gametes) and pubertal increases in bone density (Telfer et al., 2018). Puberty blockers have a temporary and reversible impact on pausing secondary sex characteristics, with the development of secondary sex characteristics recommencing once puberty blockers are discontinued (Hembree et al., 2017). Puberty blockers also have a temporary and reversible impact on fertility – when puberty blockers are discontinued, endogenous puberty recommences, including the maturation of gametes (Hembree et al., 2017).

Global and national healthcare guidelines from institutions such as WPATH (the World Professional Association for Transgender Health), the American Academy of Paediatrics, and national healthcare services in countries such as Australia and New Zealand have endorsed the use of puberty blockers as a vital component of healthcare for trans early adolescents (Murchison et al., 2016; Oliphant et al., 2018; Telfer et al., 2018; WPATH, 2020). The global Endocrine Society produced consensus based trans healthcare guidance in 2017, recommending puberty blockers for trans adolescents “at early puberty” (Hembree et al., 2017, p. 3880). Quantitative research highlights the important benefits of puberty blockers with evidence of them being protective for trans adolescent mental health (Achille et al., 2020; Miesen et al., 2020; Tordoff et al., 2022). At the same time, evidence has highlighted potential risks of puberty blockers, noting potential side-effects including ‘hot flushes’, particularly when used in adolescents who are in late puberty, and concerns relating to bone density, particularly when blockers are used without HRT for many years (Rew et al., 2021). Beyond these concerns, there is an overarching criticism of the quality of evidence underpinning the use of puberty blockers (Rew et al., 2021).

A 2021 UK National Health Service evidence review concluded that the evidence underpinning blocker usage was of “very low certainty” (National Institute for Health and Care Excellence - NICE, 2021, p. 21), though the assumptions and methodology behind that evidence review have been

strongly critiqued (Eckert, 2021). Debate and discussion on the use of puberty blockers has intensified in recent years, entwined with politicised attacks on trans healthcare more broadly (Abreu et al., 2021). Controversy about trans healthcare in the UK culminated in a December 2020 court judgement that in practice, following NHS England guidance, curtailed access to puberty blockers for trans early adolescents in England and Wales (Bell vs Tavistock, EWHC 3274, 2020). The case was later overturned on appeal, with significant criticism of the shortcomings in the original judgement (Bell vs Tavistock, EWCA Civ 1363, 2021). At present, puberty blockers remain a topic of public and media debate, in spite of strong statements released by medical professionals defending their use (AusPATH, 2021; WPATH, 2020).

Current literature contains diverse perspectives on trans adolescents' healthcare needs, including a range of stated reasons for prescribing puberty blockers to trans adolescents who want to access them (Rew et al., 2021). The Endocrine Society notes that for many trans adolescents "pubertal physical changes are unbearable", with puberty blockers leading to "a better psychological and physical outcome" (Hembree et al., 2017, p. 3880). Other sources emphasise puberty blockers offering time, whether that be time for adolescent decision making about HRT, time for clinician diagnosis, or time for parents to learn to understand and support their child (Brik et al., 2020). Dutch qualitative research undertaken with trans older adolescents (median age 17-years-old) emphasised the importance of puberty blockers in reducing suffering related to the development of secondary sex characteristics, in providing time for decision-making on gender affirming treatment, or as a first step towards gender affirming treatment (Vrouenraets et al., 2016, 2021).

Where trans adolescents wish to access puberty blockers parental support is recognised as critical, both in health systems where parents play a key role in enabling or impeding trans adolescent access to healthcare (Riggs et al., 2020; Riggs & Bartholomaeus, 2018), and in circumstances where family rejection would leave trans adolescents at risk of poor mental health or homelessness (Ashley, 2019; Priest, 2019). Parents are known to face barriers to understanding their trans children, with a well-documented need for information, advice and support across different domains including social, legal and healthcare (Pullen Sansfaçon et al., 2015; Riggs, 2019; Riggs et al., 2020). Current literature on puberty blockers provides limited experience-based insights from trans adolescents or their families (Rew et al., 2021). Some literature has started to explore how parents of trans children navigate decision making, including examination of how parents approach and reflect upon decisions related to social transition (Horton, 2022a) or the role of parents in supporting trans adolescent access to healthcare (Riggs et al., 2020).

The Current Study

When trans early adolescents wish to access puberty blockers parental support is known to be important and at times pivotal to their access (Ashley, 2019; Riggs et al., 2020). However, no research to date has specifically examined how parents of trans early adolescents view, or make decisions related to puberty blockers, with this present study addressing an identified knowledge gap. Focusing on a sample of UK-based parents of trans children who socially transitioned in pre-adolescence, this study explored the following research questions:

1. What are parents' perceptions about puberty blockers?
2. How do they navigate decisions of providing parental consent?
3. How do parents weigh up and reflect upon the risks and benefits of puberty blockers for trans early adolescents?

Method

Study Participants

Thirty parents were interviewed from across England, Scotland and Wales. 100% of interviewees were cis, 90% were white, 93% were female and 23% were disabled. 70% were aged 40–50 years old, and 10% were immigrants to the UK. In terms of sexual orientation, the cohort was diverse: 60% of parental interviewees were heterosexual, 23% pansexual, 10% bisexual and 7% gay or lesbian. The parents interviewed shared experiences of 30 socially transitioned trans children including 15 girls, 12 boys and 3 non-binary children. These children socially transitioned at an average age of 7 years-old (range 3–10). At time of parental interview their children were an average of 11 years-old (range 6–16).

The dataset was analysed to extract information on current stage of puberty and access to puberty blockers. Analysis of interview data revealed that nine children in this cohort had recently started the early stages of puberty but were not yet on puberty blockers. Twelve children were approaching but not yet started in puberty. Seven adolescents in the cohort (aged 11–16) had been prescribed puberty blockers including five boys, one girl and one non-binary child, all of whom had started blockers at the age of 11 or 12 years old. One adolescent in the cohort, a 12-year-old boy, had started puberty and had not accessed, and had not wanted to access blockers, according to parental report.

Participant Recruitment

The inclusion criteria for parent interviewees were (i) being a parent or career of a socially transitioned trans child in the UK (ii) their child having socially

transitioned under the age of 11 (iii) their child currently being under age 16. To recruit participants, details about the study were shared on closed online spaces in six UK support groups for parents of trans children. None of these six support groups are actively trans-hostile, with group moderators ensuring the groups are a safe space away from transphobic discourse. Avoidance of advertisement on trans-hostile parenting sites was judged as unlikely to affect the sample, as trans-hostile parents would by definition not support a trans child's social transition under the age of 11, and therefore would not fall into the cohort prioritised in this research. Access to hard-to-reach parents and children, in families with significant concerns related to trust and confidentiality, was enabled by the author's positionality as a non-binary parent of a trans child, helping overcome trust related barriers to hearing from this cohort. The author is themselves a member of four of these closed online spaces, and posted there directly, with other parents sharing details on two other groups. Research participants received a project information sheet in advance, outlining the purpose of the research, their rights, and how their data would be used, with all participants signing a consent form. After interview each interviewee completed a demographic survey.

The research received ethical approval from the author's university. The research built in ethical best practices for trans-related research (Vincent, 2018). Participant anonymity was a high priority, given the vulnerable and small population that this research cohort is taken from. Joint with research participants it was agreed to avoid linking individual quotes to specific pseudonyms, as well as omitting child ages from specific parental quotes, thereby preventing patchwork identification. This particular cohort places a high level of importance on privacy and safety, and a strong duty of care was upheld to respecting interviewee preferences in how their data were shared.

Data Collection

Interviews were conducted remotely via Microsoft Teams during the period December 2020 to September 2021. Semi-structured interviews, covering broad topics including healthcare, education and families, lasted 1–3 hours (average 2 hours). Each parent was interviewed separately. This article considers a sub-set of the wider data corpus, focusing on portions of the interviews discussing puberty blockers, and specifically, portions of interviews discussing how parents navigate decision-making related to puberty blockers. The key questions pertaining to the current analysis are shown in Table 1. Interviews utilised broad open-ended questions, allowing interviewees to talk openly and at length around each topic. The semi-structured interviews were intended to be warm, safe, friendly and interested, listening supportively and encouraging each parent to share their individual

Table 1. Key Interview Questions.

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- Have puberty blockers been something you have needed to think about?
 - What do you see as the purpose of puberty blockers?
 - How have you navigated decision-making related to puberty blockers?
 - What do you see as the risks and benefits of puberty blockers?
 - What has been your experience of the consent aspect of puberty blockers?
 - How confident were you/would you be in giving parental consent for puberty blockers?
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perspective. Interviews were recorded and transcribed by the author. Transcripts were checked against the recording, with anonymised transcripts uploaded into NVivo.

Research Design

Data were analysed through inductive reflexive thematic analysis (Braun & Clarke, 2006) to understand parental perspectives on puberty blockers, with data-driven development of codes and themes. The research was informed by critical realist epistemology, with an experiential orientation to data and predominantly semantic coding. This approach centres parents' own accounts of perspectives on puberty blockers, in keeping with the study's research questions. In reflexive thematic analysis researcher knowledge and positionality is valued as a resource to enrich analysis, prioritising "reflexive and thoughtful engagement with the data" (Braun & Clarke, 2019, p. 594). A key principle was to reflect parental accounts "as faithfully as possible", while prioritising data that most meaningfully answer the study's research question and "acknowledging and embracing the reflexive influence of my interpretations as the researcher" (Byrne, 2021, p. 4). To ensure quality, the study was designed to meet a 20 point checklist for quality reflexive thematic analysis (Braun & Clarke, 2021).

The research is underpinned by a trans-emancipatory and social justice approach, building on wider work on emancipatory research (Noel, 2016). Here a trans-emancipatory approach is one that recognises and takes account of the role of cisnormativity in upholding structural injustice (Wesp et al., 2019). Cisnormativity is the assumption that everyone is cis (i.e. not trans) or should be (Keo-Meier & Ehrensaft, 2018). The research recognises the negative impacts of cisnormativity on trans children in research as in society (Ansara & Hegarty, 2012). The research maintains an ethical commitment to trans-emancipatory research, recognising that gender diversity is neither pathological nor problematic, acknowledging that trans lives are equal to cis lives, and being attentive to cisnormativity within and across the research.

Herein the word “trans” is used to include those who are binary-oriented as well as non-binary (Vincent, 2020). The term “socially-transitioned” is used to indicate that a trans child is socially accepted and respected in their gender, commonly accompanied by a change in pronoun (Ehrensaft, 2020). This article uses the word “children” when referring to groups that may contain both children and adolescents, and utilises the term “adolescent” when referencing a specific child who has started puberty, even if puberty has been blocked through puberty blocking medication. The article also distinguishes between “endogenous puberty”, which is puberty driven by the sex hormone produced in an adolescent’s body, a puberty that can be traumatic for many trans adolescents; and “exogenous puberty”, which is a puberty driven by externally administered sex hormones, or Hormone Replacement Therapy (HRT) (Chung et al., 2020).

Data Analysis

The analysis comprised re-reading each transcript to become familiar with the data followed by the generation of initial codes, coding diversely without pre-conceived coding categories. The initial codes were then reviewed to identify broader themes, with all extracts for each theme collated and re-read. The initial themes were reviewed, and themes and sub-themes revised to ensure they were internally coherent, consistent, distinctive, and accurately captured the dataset. Each sub-theme was analysed, interpreted with reference to existing literature, and illustrated with indicative quotations from a range of interviewees. Efforts were made to include multiple quotations, with this decision informed by the underpinning emancipatory theoretical perspective. A number of interviewees expressed a hope that their voices would be shared directly, noting a lack of voice of parents of socially transitioned trans children in the literature or wider discourse, and emphasising the privacy and safety concerns that limit their ability to safely share their experiences in other fora. The analysis accompanying the quotations is recognised as the author’s interpretation, acknowledging the role of any researcher in actively interpreting data (Braun & Clarke, 2006).

The research’s underpinning commitment to a trans-emancipatory and social justice informed approach was applied in reviewing the presentation of the findings for cisnormative bias or transphobic language. This led to one intervention in the presentation of interview data, making a decision to remove an adjective (male) in two quotations, replacing it with a more nuanced word (testosterone-driven or testosterone-affected) that I interpreted as conveying the same meaning in the given context. This intervention was applied to avoid perpetuation of cisnormative language in research, recognising that such language can reinforce and even legitimise transphobic attitudes and assumptions. Within a social justice and trans emancipatory approach, I upheld a

commitment to presenting transphobic language only when explicitly justified, and avoiding trans-oppressive language when it is not explicitly justified. I judged the two parents to be using simplified language, without intending delegitimization, to discuss their children's bodies. I am aware that many trans people would not use language in the same way as these cis parents, and could find such phrasing inappropriate and harmful. I prioritised a duty of care to trans communities in modelling trans-positive language in research that is likely to be read by cis parents of trans children. I upheld a duty of care to trans readers, in avoiding transphobic language in research articles unless explicitly justified to convey meaning or intent. Moreover, I upheld a duty of care to the trans children referenced in those two quotes, ensuring misgendering language about their body is not attached to their story in a published research article.

Findings

Three main themes are presented (1) protecting mental health and well-being, (2) parental perspectives on consent, and (3) decision-making without certainty. Each major theme is divided into two or three sub-themes, each illustrated with parental quotations.

Protecting Mental Health and Well-Being

Interviewees reflected on the purpose of puberty blockers, with all parents mentioning that the immediate aim of blockers was to avoid development of secondary sex characteristics. However, the purposes parents spoke most about were the indirect impacts of puberty blockers. Two prominent indirect aims comprise the two sub-themes presented here: (1) protection of short and long-term mental health, and (2) enabling adolescent well-being and quality of life. For the purposes of this analysis a distinction is drawn between mental health, here focusing on clinically diagnosable levels of mental distress including depression, self-harm or suicidal ideation; and well-being or quality of life which herein considers whether a child is happy, whether they are able to partake in social activities, whether they attend school, whether they can join in sports, whether they are able to enjoy their adolescence. The two sub-themes are recognised as overlapping and interlinked.

Protection of Short and Long-Term Mental Health. One parent placed emphasis on an assumption that prevention of unwanted secondary sex characteristics would be important in safeguarding her daughter's mental health in the short and long term.

To prevent, basically, to prevent irreversible changes from happening, that she's been asking for them not to happen for many years. So, it's to prevent the changes she really doesn't want to happen. And therefore, you know, ultimately protect her mental health, isn't it? And her future life? Because being trans isn't easy. I think it probably is easier, if you don't have (Testosterone-driven) secondary sex characteristics. You know, that's, that's what she doesn't want anyway. She doesn't want to be a woman with a (Testosterone-affected) body.

Another parent highlighted the massive emotional toll secondary sex characteristics would take on her daughter.

The benefit is to [Child's] mental health, to give her that, that ease that she's not going, you know, once puberty blockers are working, you know, her voice won't break, she won't develop an Adam's apple, she won't get facial hair. You know, she's told me, she's been watching videos on YouTube of - she's been doing vocal exercises, she's so paranoid about her voice.... the benefits outweigh any risks.

Other parents were aware of their child reacting with dread to any suggestion of incongruent secondary sex characteristics, and feared how their child's mental health would cope with endogenous puberty.

That actually mentally mental health wise, I dread to think what would have happened with [Child], if he was already pushing down his boobs from a young age so they're not going to grow? What the hell is he going to do, if he knows they're going to grow? You know, there is all that - the self-harm.

It would be depression and self-harm. For him, obviously. I would worry that he would just not be able to cope anymore.

The risk of acute mental health distress was a key risk factor for many interviewed parents.

We did a for and against, if we don't take puberty blockers, what will that mean for our child? Well, it will mean they have to go through the wrong puberty, it will mean they have to suffer the consequences of a body that doesn't match who they are. And what does that mean? Well, that means they're at higher risk of self-harm, they're at high risk of suicide, they're at higher risk of social anxiety and mental health issues.

Enabling Adolescent Well-Being and Quality of Life. Beyond the avoidance of severe mental health consequences, parents also spoke about the impact of blockers in protecting their child's happiness and self-esteem.

This medication means that [Child] will be more happy and confident in their presentation.

Many parents described access to puberty blockers as important for enabling their child to succeed at school and allowing them to enjoy their adolescence.

Over the next 5, 6, and 7 years, I want him to think about his schoolwork. And I want him to think about his friendship groups, and I want him to think about what he enjoys doing. One of the things he loves doing, he does [sport]. I want him to engage with that and love doing his [sport]. I want him to just enjoy being a teenager, which is hard enough for any teenager ... I just want him to enjoy his life. Without blockers, a lot of that gets wiped away. Because, he will pass less and less as male, as his body changes. And that would have a major psychological impact on him. So, yeah, I want him to just get on with his life.

Several parents had noticed the impacts of early puberty on their child's confidence, and felt denial of blockers would have a substantial negative impact.

As [Child] got older and then puberty did kick in, the showers weren't happening, the almost withdrawing into himself, walking around like this (bent over) to try and hide things. ...To have delayed it would have been cruel, in my mind, it would have been cruel... I thought if he starts his period, I'm not quite sure how he's going to manage that. It's almost then, having to be forced to tell everybody...he wouldn't have been able to continue his school, because how can you have been, from, you know, year seven, in secondary, up until he's now gone into year 10, a boy, to everybody, and then all of a sudden, because of no fault of your own, you've got boobs. He would not have gone to school. I can tell you that now.

A large number of parents in the sample felt their child would have refused to attend school if forced through incongruent puberty, with a large number of parents having seen this scenario in other families with trans adolescents.

I know of children, where they're not accessing school...they now don't want to go to school, because, their body, you know, doesn't equate to what they, what they feel their gender is.

Some parents had seen the impacts of puberty on other trans adolescents' self-esteem.

I've met so many trans teenagers now who, you know, they bind, but because of the amount of chest tissue they have, they're hunched over and they're - it's like

they're trying to disappear. And I didn't want that for my child. I looked at my child who was just confident, and swinging off trees and at home with their body. I didn't want him to disappear. And that was what I knew was potentially in our future, if we didn't get him blockers.

Other parents were concerned about how adolescents could manage schoolwork whilst going through incongruent puberty.

(If they didn't have access to blockers) there's just - they won't be able to do their work. It's like, secondary school, it is actually important. They're gonna spend all their time being really, really miserable about all the changes that are in their body. It's not like I haven't said to them, are you sure it wouldn't be okay to just go through your puberty, and they just looked me and they were like "Yes. But that's not my gender."

The findings across this theme draw attention to parental perspectives on blockers as preventative and protective, safeguarding mental health, self-confidence and adolescent quality of life. The parents in this sample felt puberty blockers were critical for providing trans youth with a good quality of life, emphasising the importance of bodily autonomy, of trans youth feeling they have control over their lives and bodies, of trans youth feeling understood, affirmed and supported. Parents interviewed within this research wanted to protect trans children from the high levels of mental health distress commonly found in trans youth, but also outlined a higher ambition, for their children to have a happy, secure, fulfilled adolescence.

Parental Perspectives on Consent

The second major theme examined parental perspectives on their child consenting to taking puberty blockers. These interviews were all conducted in the period after the original December 2020 *Bell vs Tavistock* court judgement and before that court judgement was overturned on appeal in September 2021. All interviewed parents within the sample were aware of that judgement and its emphasis on consent, and reflected upon aspects of child consent in their interviews. This theme is divided into three sub-themes on (1) Inappropriate consent (2) Appropriate consent and (3) Consideration of fertility.

Inappropriate Consent. Parents talked about aspects of the current consent process that they felt were inappropriate, in particular a focus on genital surgery. Parents were frustrated that children who were consenting for puberty blockers were asked to discuss and consent to things unrelated to puberty blockers, like the potential impacts of future HRT or genital surgery. A parent who had experience of attending a pre-surgical consultation with a trans adult,

felt it was entirely inappropriate to cover any such topics with trans early adolescents who were just deciding on accessing puberty blockers.

I've sat in on these like preassessment meetings with a surgeon and a trans friend of mine, and they cover all that kind of stuff, complications in surgery, loss of function. And they share lots of statistics on it. And, you know, those are adult conversations, and they should be, I don't really see why you would tell a nine-year-old that they might have an impact on their sex life, if they go for surgery (as an adult).

Other parents shared similar thoughts on the inappropriateness of asking pre-teens to discuss surgery that would not occur until adulthood, if at all.

I think these decisions about surgery are huge. Absolutely huge. And I don't think that really has any bearing on my 11 year-old's life right now. It doesn't feel appropriate for her to think about that. Obviously, she might think about it by herself.

Others pointed out that children being expected to provide consent for other interventions gave an unhelpful message that blockers were a direct path to HRT and surgeries, when parents felt it was important for their child to know each intervention is separate.

It's like, almost as if they think it's an inevitability that a child will go on to blockers, then they'll go into sex hormones, and then of course they'll have surgery. So, they need to understand all that. But it's like, you can go onto blockers and hormones, and still not have surgery. That's a possibility, too. You know, that's an individual choice. It's not a pre-determined pathway. I don't get it.

One parent found the seriousness and weight placed on the decision to take reversible puberty blockers, gave an unhelpful impression that it was a uniquely huge decision to take. A parent found it unhelpful to expect a child to express certainty about their future needs, with the parent instead wanting their child to have space to find what they need gradually, taking each step at a time, without pressure or commitment to a pre-defined final destination.

For me, it's like trying on clothes, you try them on, does it look good? You can't tell when it's on the hanger. You have to try it on. And go, yeah, this feels good... So, I feel it's really important that she is allowed to take one step at a time. Without this kind of, you have to buy the whole package, like you're in or you're out, you know, you're trans full surgery, or you're not trans. I don't want her to feel like that.

Appropriate Consent. Parents talked about the approach to consent they would like for their child, wanting the consent process to focus specifically on the impacts, risks and benefits of puberty blocking medication. One parent felt it was important to simplify decision-making about blockers, not to over-complicate it.

She needs to understand that taking this medication will stop her body from producing hormones. She can learn the word Testosterone, she already heard this word. She can know exactly what Testosterone does, it will do this, this, this. Puberty blockers are going to stop all that. That's it. That's all you need to know. And she should also know that if she changes her mind, she can stop taking them, and her body will continue doing what it was always going to do. I mean, what more do they need to know?

Parents described high expectations of child consent within NHS gender services (Tavistock), with it treated as a test of a child's knowledge of a wide range of associated issues.

What they do, why she would need them, and what they were going to stop that she didn't want, and any possible side effects. I think Tavistock do go through that very thoroughly. You know, they kind of almost test her really. Those meetings we had last year, that she would be tested on, you know, what vitamins you should be taking, and bone density and all that. I think she had a good understanding of all that.

For another parent, the key aim of a consent process should be for their child to have his questions answered, and to make clear what a child's options are.

I think that he should just have his questions answered. Whatever information he's seeking, he should be given, in the most factual, well-informed way possible. I just want him to know what his options are.

Several parents described a decision to take puberty blockers as being a potentially less significant decision than for a trans child to decide to go through endogenous puberty, and wanted the consent process to acknowledge that.

There's no such thing as doing nothing. If you don't give a child puberty-blockers there is a consequence - it's not that nothing happens. There's a massive consequence... If they don't have the capacity to decide that they shouldn't go through (endogenous) puberty, how do they have the capacity to decide that they should go through (endogenous) puberty? That doesn't make sense. Either they have the capacity to have an opinion about that, or they don't.

Unanimously, interviewed parents recognised the importance of being guided by their child's needs and wishes, regardless of their level of ability to formally consent.

It was his choice. As much as you can allow a 10-year-old to choose this sort of decision. We never said that you need to have blockers, we asked him. We even talked about the downsides with him.

Consideration of Fertility. A number of parents expressed concerns on how fertility discussions were brought into the process of consenting for puberty blockers. One parent describing finding it hard to have conversations on fertility with a young adolescent.

We said you deciding to have blockers now might mean you can't carry a child. Now, if you ask him right now, there's no way he wants to carry a child, because (he thinks) that's what women do. And he's not a woman. But he's 11. I didn't want children at 11 necessarily.

Some parents felt gender service clinicians holding a dual role of gate-keeper, taking the decision to refer an adolescent for puberty blockers, and fertility counsellor, was problematic.

They expected to have a conversation around fertility. When I was like, at the end of the day, he's just gonna say whatever it is, that makes you shut up, so that he can get the blocker... [Child] is emotionally intelligent enough, and articulate enough, to be able to see ... I think in his head, he was like, I'm gonna say this, this and this, because that's what they want to hear.

It's like, how do I think you want me to answer this? How do I think I should answer this, to get the outcome that I want? And that is not any kind of, you know, therapeutic exploration ... it's nonsensical to consider that's actually going to produce or inform someone's choice, when actually there's such a power dynamic at play really, particularly in a child.

An overarching question raised by parents in this sample, was whether trans adolescents need to discuss fertility at the point of starting puberty blockers, given puberty blockers themselves do not impact on fertility.

Decision-Making Without Certainty

A third major theme relates to decision-making without certainty, with two sub-themes on (1) Quality of evidence and (2) Parental confidence in decision-making.

Quality of Evidence. The interviews took place at a time of scrutiny on the evidence base underpinning use of puberty blockers for trans early adolescents. In particular, parents were aware of an NHS NICE study that critiqued the evidence base underpinning blockers (National Institute for Health and Care Excellence - NICE, 2021). Many parents shared their thoughts on the evidence underpinning blockers, including evidence of decades of use by cis children, finding this evidence reassuring.

I know the research into blockers, and how many years they've been used for precocious puberty. The safety of them in that field was reassuring.

Parents felt there was clear evidence of the negative implications of denying blockers, weighing that significantly in their decisions.

The evidence is that if you don't have them, it's very clear that it creates huge, huge problems for kids. That's my main evidence, you know, is the absence of them, is deeply damaging.

A number of parents raised their frustrations in people who are not trans, and not trying to make effective healthcare decisions for trans children, asking for evidence like Randomised Control Trials (RCT). Where interviewees brought up the topic of RCTs they were prompted to consider "would you like your child to participate in a RCT?" All interviewees who shared thoughts on this topic raised serious concerns about the ethics of RCTs for puberty blockers, with several parents making it clear they would never give consent for their child to be part of such an RCT.

I can understand the thought behind it, but not a chance in hell would I put my child up to that...With blockers, if you have a bunch of 12 or 13-year-olds, let's say, one in the hormone blocker group, one in the psychotherapy group. The ones that are in the psychotherapy group, well by the time you've done the trial, if the psychotherapy hasn't worked, then you now have a child who is 14, 15. And puberty's hit, it's happened...You know, how do you correct the damage of a (Testosterone-driven) puberty on a trans girl? That's my first problem with it. My second problem with it is, if we're talking about either hormone blockers, or therapy, psychotherapy. That suddenly starts to feel very much like conversion therapy.

Another parent articulated their ethical concerns with applying RCTs to this cohort.

I'm just really struggling with the medical ethics of this, because you can't. I mean, that's just some very difficult, dark, territory there. You can't really do

that. Can you? There has to be a neutral setting – That is not neutral - the default control group has to be neutral.

Other parents were forthright in their view on the inappropriateness of suggesting RCTs on trans adolescents that included denial of puberty blockers:

(That's) conversion therapy. No thanks. I mean, I just think that is ethically completely flawed. No. Not in a million years.

I'm sorry, that is eugenics level

Parental Confidence. Parents varied in how confident they felt about giving parental consent for their child to access blockers. Several parents described feeling well informed and confident that it was right for their child:

We felt quite well informed about the process. The negative aspects were sort of negligible, in comparison to the positive aspects of being on blockers, to help affirm her identity, but to also stop her body changing in ways that she just didn't recognise, or accept, or understand.

100% confidence. Yeah, no doubt in my mind.

Several parents felt that there wasn't a choice, that puberty blockers were the only viable option for their child.

I think blockers are crucial

There didn't seem to be any option really, if he was going to be happy.

One parent spoke about how her views on risk had evolved over time.

If I'd been making that decision when I was reading desistance studies, I'd have been quite anti them. But as we've moved along as a family and taking a holistic view, yes, there are risks. But for me, the benefits outweigh the risks. And most of the risks can be mitigated with vitamin supplements, healthy diet, you know. There are things that you can do. So, parental consent was very easy. Because this is about, again, a fixed point in time saying, what is it that we need, right here and right now...Because I want my kid to be happy and healthy. It's about weighing up the risks and benefits and being informed.

Some parents found the process of having to make decisions about puberty and puberty blockers isolating and stressful, though those parents also emphasised understanding the importance of access to puberty blockers for their child's well-being:

The idea of puberty and of hormone blockers makes me feel overwhelmed, at times, like completely overwhelmed, and really, really worried and stressed and alone and isolated... (Blockers) prevent irreversible changes from happening, that she's been asking for them not to happen for many years. So, it's to prevent the changes she really doesn't want happening... I feel like I just have to do what is right for my child. Which is to find a way for her to have hormone blockers.

One parent emphasised that they would much rather their child did not need to take puberty blockers, but emphasised that blockers would be an important safety net if their child was distressed at the idea of incongruent pubertal changes:

I don't think we'd want to access blockers unless we felt there was a need to. And that would be if, if there's a need to - you know if there was distress and that was - it's really our last option. It is the safety net. So, we would get that from wherever we'd need to.

Another parent emphasised their own emotions about puberty blockers, seeing them as important for their child's well-being and dysphoria, whilst also expressing concern about the amount of time their child might be on blockers (in an NHS system that does not allow HRT until age 16).

You know, if it's up to me, and if I'm thinking of my happiness, then he wouldn't have any medical intervention whatsoever. But this isn't about my happiness, this is about his happiness. So, I certainly would give consent, if that's what will make him happy, not just - not just happy, though, like actively non-dysphoric. My fear is if he has an early puberty - How long does he spend on blockers? Like, if he starts puberty at 10? Is he on blockers for 4 years? Six? An awfully long time.

Some parents wanted greater certainty, but after careful consideration of available options judged puberty blockers the best option for their child.

When it comes to blockers... you are gambling on the blockers and any consequences of the blockers being better, being preferential, to the damage and impact of puberty on your child. That's what you're counting on. And it is a gamble and it's not perfect, but it's the only option available. So yeah, I'm, I'm hedging my bets. And I'm making an informed judgement. That is the least damaging course of action for my child.

Discussion

This study explored parental views on puberty blockers, aiming to understand how supportive parents of socially transitioned trans children view puberty

blockers, how they consider risks and benefits, and how they approach decision making. Three key themes were presented, relating to the purpose of puberty blockers, parental perspectives on consent, and parental approaches to decision making without certainty.

When discussing the purpose of blockers, parents mentioned the importance of avoiding incongruous secondary sex characteristics, but also emphasised that avoiding unwanted puberty was vital for trans children to have the opportunity to enjoy their adolescence, focusing on protection of mental health, quality of life, and well-being. These findings reinforce existing quantitative research on the mental health benefits of access to affirmative healthcare (Achille et al., 2020; Miesen et al., 2020; Tordoff et al., 2022). It is noteworthy that for the parents in this sample, whose children had socially transitioned at an average of 7 years old, time to think about identity was not raised as a significant purpose of blockers, despite this being a common narrative in clinician accounts (Brik et al., 2020). Some parents did see puberty blockers as providing time to reflect upon their options for medical intervention, in particular, how and when, to proceed through endogenous or exogenous puberty. Parents in this sample made a distinction between time to explore identity, and time to explore options for medical transition, seeing the latter as much more significant. This mirrors the findings of one of the only qualitative studies to engage with trans adolescent perspectives on puberty blockers, which found that “most adolescents did not use puberty suppression for further exploration of their gender identity” (Vrouenraets et al., 2021, p. 8). Similarly, trans adolescents interviewed by Riggs et al. (2020) emphasised that blockers were not critical to affirming their identity, but rather were important in preventing incongruent puberty. These parental and adolescent views on the purpose of puberty blockers stand in contrast to the identity-centred rationale for blockers commonly seen in clinician accounts, media discourse or legal proceedings. Indeed the 2020 *Bell vs Tavistock* court case described puberty blockers as “treatment that goes to the heart of an individual’s identity, and is thus, quite possibly, unique as a medical treatment” (2020, para. 134). These findings highlight the importance of any discussion, court case or policy review incorporating an accurate experience-informed perspective on the purpose of puberty blockers. These findings also hold relevance for healthcare research, demonstrating the importance of centring quality of life outcomes in any evaluation of blocker effectiveness.

A second key finding relates to parental views on consent for puberty blockers, highlighting parental concerns about the appropriateness of current approaches to consent. Parents perceived a divergence between what they considered medically necessary aspects of consent, and current clinical practice. Parents in this sample considered a decision for a trans child to proceed through endogenous puberty to be no less significant a decision, than a decision to proceed through exogenous puberty. Several parents raised

concern about the politicisation of trans adolescent healthcare, feeling the consent process was shaped by factors other than adolescent need, a finding that aligns with recent literature from other countries critiquing the politicisation of trans adolescent healthcare (Abreu et al., 2021). These parental concerns on consent also align with some published perspectives from healthcare professionals. Research by Vrouenraets et al. (2015) included a perspective from a paediatrician who questioned why consent for puberty blockers is deemed as unique and controversial, when more complex paediatric interventions are frequently prescribed with simpler and more streamlined approaches to either parental or child consent. The one study to focus on trans adolescent ability to consent demonstrated that the vast majority of trans adolescents are able to consent to puberty blockers (Vrouenraets et al., 2021). These findings reinforce a recent editorial on Child and Adolescent Health by the Lancet journal that critiqued politicised discourse on children's consent for puberty blockers, concluding that "disproportionate emphasis is given to young people's inability to provide medical consent" (The Lancet Child & Adolescent Health, 2021).

This study also explored parental perspectives on the current evidence base for puberty blockers. For a large majority of parental interviewees, the risks of trans children being denied access to blockers outweighed any known risks of blockers, and in the absence of certainty informed a decision to support blockers. Parents evaluating evidence on puberty blocker effectiveness are informed by the histories and perspectives of trans adults who did not access puberty blockers, incorporating into any assessment consideration of the costs of not providing puberty blockers. This approach aligns with global healthcare bodies including the Endocrine Society and WPATH, who in response to the initial Bell vs Tavistock court case, released statements and submitted evidence to the appeal arguing the original verdict had "overlooked the harms of not providing puberty blockers", emphasising that restrictions on access to blockers "will have a significantly adverse impact upon gender diverse youth" (WPATH, 2020, pp. 1–2). Parents also refer to the multi-decade evidence base of safely providing blockers for precocious puberty, not seeing compelling evidence to exclude this evidence base. Finally, parents raised significant concerns at the suggestion of Randomised Control Trials for puberty blockers where a control arm would progress through incongruent puberty. A number of interviewees felt a randomised trial in which some trans adolescents would be offered psychological therapy with an incongruent puberty instead of affirmative healthcare, was an approach that would amount to "conversion therapy". This view aligns with a 2020 UN report on conversion therapy that named "preventing trans young people from transition" as part of conversion practices (UN Human Rights Council, 2020, p. 11). Existing literature has described such puberty blocker RCTs for trans adolescents as infeasible,

noting trans adolescents distressed about puberty would not be willing to take part in a study where the control arm would progress through incongruent puberty (Brik et al., 2020; de Vries et al., 2011; Giordano & Holm, 2020). Existing literature has also described RCTs where the control arm unwillingly progresses through incongruent puberty as unethical (Giordano, 2008; Giordano & Holm, 2020). As Brik et al. (2020, p. 6) notes “many would consider a trial where the control group is withheld treatment unethical, as the treatment has been used since the nineties and outcome studies, although limited, have been positive”. This current study reinforces the practical concerns already documented in the literature, highlighting significant levels of parental unwillingness to participate in such a trial.

Finally, this study explored parental confidence and parental approaches to decision making without certainty. A majority of parents described a careful process of weighing up the potential pros and cons of supporting access to puberty blockers. Given current evidence, parents in this sample were unanimous that having access to puberty blockers was the best option for their child after considering all known risks, including what they saw as the significant risk of a trans child being forced through an incongruent puberty. Whilst some parents agreed with the NICE review on the desirability of better evidence, parents highlighted concerns on how the limitations of the current evidence base were being used to deny healthcare. Indeed, many parents in this sample felt very strongly that given existing knowledge, denial of access to blockers required greater justification and burden of proof than supporting access to blockers, a finding that adds to the literature. For clinical policy to hold stakeholder confidence, policy makers need to engage with experience-informed perspectives such as those outlined here.

Several parents noted how their own views on risks and benefits had evolved over time, and especially how their perception of the risks of not supporting access to puberty blockers evolved as they grew in knowledge of, and connection to trans communities. It is speculated that the level of support for puberty blockers found here is related to the length of time parents in this sample have had to understand their child’s identity and build knowledge of trans communities, with interviews conducted an average of 4 years since their child’s social transition. Existing literature has highlighted the support that parents require to understand and advocate for their trans children (Pullen Sansfaçon et al., 2015; Riggs, 2019; Riggs et al., 2020). The findings presented here call attention to the support parents may need in navigating decisions related to puberty blockers, especially where parents do not benefit from connection to trans communities, or where parents have had less time to understand their child’s identity pre-adolescence. This aligns with recommendations from Ashley (2019) who calls for support and education for parents to help them understand and support their children through trans

adolescent healthcare decisions. Further research can expand understanding of how parental views towards trans healthcare evolve, including effective ways of building parental confidence in decision making without certainty.

Limitations

The parental views herein come from a cohort of parents who have become relatively trans-positive, and who have supported their trans children to socially transition under the age of 11. Parental perspectives presented here represent this sample, and cannot be assumed to relate to other cohorts. In particular, parents who are unsupportive of their trans child may be assumed to hold different views and different approaches to decision-making. This sample does not include child perspectives, and can only provide insight on parental perspectives and parental approaches to decision making. Further research can valuably focus on how trans early adolescents make decisions about puberty and puberty blockers, including further work by this author (Horton, 2022b). It is also important to highlight issues that are not reviewed herein, but are also critical considerations related to access to puberty blockers. This article does not explore the ethics of child-led medical autonomy, or legal and practical aspects of child consent and assent, nor does it explore the consequences where parents act to impede or deny their child's access to puberty blockers. Additional consideration of these issues can and should be made from a trans equity, adolescent rights, bioethics, and healthcare justice perspective.

Conclusion

This research provides a unique parental perspective on puberty blockers, with insights into parental decision-making from parents of socially transitioned trans children who are in, or approaching adolescence. Parents viewed puberty blockers as critical to protection of their children's mental health and quality of life. Parents raised concerns relating to how adolescent consent is taken for puberty blockers, questioning whether the consent process was tailored towards individual needs. Parents also spoke about decision-making without certainty, and the lengths parents had gone to understand and weigh up the evidence base. Despite some uncertainty, all parents who participated in this study considered puberty blockers an important option for trans adolescents. Parents expressed frustration on limitations in the evidence base being used to advocate for withdrawal of essential healthcare, with several parents challenging the ethics of RCTs for puberty blockers. These findings hold relevance for healthcare professionals working with trans children and their families, for those designing future longitudinal research studies, for healthcare policy-makers, for families with trans children, and for those advocating for adolescents' right to healthcare.

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