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Watchful Waiting Doesn't Mean No Puberty Blockers, and Moving Beyond Watchful Waiting

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In volume 19, number 2, of the *American Journal of Bioethics*, a peer commentary on Maura Priest's article "Transgender Children and the Right to Transition" (2019) by Michael Laidlaw, Michelle Cretella, and G. Kevin Donovan was published. The peer commentary argues against access to puberty blockers for trans youth. The authors claim that puberty blockers "would constitute an unmonitored, experimental intervention in children without sufficient evidence of efficacy or safety" and that the best approach to trans youth care is to wait until 16 years old before allowing any transition-related intervention. Their argument relies on a mischaracterization of the academic literature on the topic, as watchful waiting does not oppose puberty blockers and cannot be claimed to constitute the clear standard of care worldwide.

The authors substantiate their argument by citing an article by Annelou L. C. de Vries and Peggy T. Cohen-Kettenis on the watchful waiting approach. According to Laidlaw et al. (2019):

Watchful waiting with support for [gender dysphoric] children and adolescents is the current standard of care worldwide until the age of 16 years, not [gender-affirmative therapy] (de Vries and Cohen-Kettenis 2012). Children referred for psychological therapy or simple watchful waiting have been able to alleviate their [gender dysphoria] without the damaging health consequences of [gender-affirmative therapy]. These methods are the obvious and preferred therapy for [gender dysphoria], as they do the least harm with the most benefit for the greatest number.

The authors also speak of "the consequences of PBA/GAT," suggesting that puberty blockers are specific to the gender-affirmative approach and not a part of the watchful waiting approach.

It is false that the watchful waiting approach does not prescribe any transition-related intervention prior to 16 years old. On the contrary, the watchful waiting approach, also known as the Dutch approach, is known

for traditionally initiating puberty blockers beginning at 12 years old. In the cited paper, de Vries and Cohen-Kettenis (2012, 311) explain:

If the eligibility criteria are met, gonadotropin releasing hormone analogues (GnRHa) to suppress puberty are prescribed when the youth has reached Tanner stage 2–3 of puberty; this means that puberty has just begun. [...] Because the protocol for young adolescents had started in a period when there were no studies on the effects of puberty suppression, the age limit was set at 12 years because some cognitive and emotional maturation is desirable when starting these physical medical interventions. [...] It is, however, conceivable that when more information about the safety of early hormone treatment becomes available, the age limit may be further adjusted.

The main difference between the watchful waiting approach and the gender-affirmative approach is not whether they allow puberty blockers in tween years—both do—but rather their attitudes toward prepubertal social transition and the extent of assessment required to initiate puberty blockers. The watchful waiting approach is increasingly falling out of favor as evidence of the positive impact of allowing prepubertal social transitions accumulates (Durwood et al. 2017; Ehrensaft et al. 2018; Olson et al. 2016) and various ethical challenges are raised (Ashley 2018).

Treatment guidelines are increasingly coming out in favor of the gender-affirmative approach. The Australian and New Zealand Professional Association for Transgender Health (Telfer et al. 2018), the American Academy of Pediatrics (Rafferty 2018), the Pediatric Endocrine Society Special Interest Group on Transgender Health (Lopez et al. 2017), and the prestigious journal *The Lancet* have recently expressed their support for the gender-affirmative approach. Although the watchful waiting approach remains common in many countries, it cannot be accurately described as "the current standard

of care worldwide,” considering the growing acceptance of the gender-affirmative approach in the field.

The leading approach is the gender-affirmative model, not watchful waiting. Even if it were otherwise, Laidlaw, Cretella, and Donovan’s argument would fall flat since, contrary to what they claim, watchful waiting does allow youth to take puberty blockers when they begin to undergo puberty. ■

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