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Stigma in Medical Settings As Reported Retrospectively by Women With Congenital Adrenal Hyperplasia (CAH) for Their Childhood and Adolescence

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Abstract

Objectives To perform a qualitative study of stigma experienced in medical settings by children and adolescents with congenital genital ambiguity (CGA). **Methods** 62 women with classical congenital adrenal hyperplasia (CAH) of variable severity took part in a qualitative retrospective interview that focused on the impact of CAH and its medical treatment, with an emphasis on childhood and adolescence. Categorization of stigmatization was based on deductive content analysis of the interview transcripts. **Results** Many women recalled experiencing the genital examinations in childhood and adolescence as adverse, stigmatizing events, leading to avoidance reactions and self-perception as abnormal, particularly when the examinations included groups of trainees. Some women also experienced as adverse the nonverbal and verbal reactions of individual physicians who were unfamiliar with CGA. **Conclusions** Genital examinations constitute salient events for children and adolescents with CGA. They are easily experienced as strongly stigmatizing, especially when combined with teaching.

Key words: adolescent; ambiguous genitalia; child; congenital adrenal hyperplasia; disorders of sex development; stigma.

Introduction

Sex is a fundamental binary category of all mammalian species, including humans, because functional differences between the two sexes are essential for mammalian reproduction. This fact presumably is the cause underlying the large role that binary gender categorization has in the organization of traditional human societies. Congenital genital ambiguity (CGA) literally places a newborn “between the sexes” (Latin: “inter sexes”); such CGA is currently subsumed under the more broadly defined term, “disorder of sex development” (DSD; Hughes et al., 2006). The condition

confronts parents and physicians with the challenge of how to fit the child into the binary societal structure: i.e., what gender to assign, and if, when, and how to surgically align the genital appearance with the assigned gender. In addition, some syndromes with CGA constitute a medical emergency requiring hormone treatment and/or surgery for survival.

Most parents try to protect the child with CGA from exposure of the genitals to peers and others outside the family, and many make the condition a family secret and want to keep the information even from the child when old enough to understand such

information. Yet, the routine physical examinations of the children and adolescents with CGA place considerably more emphasis on genital development than examinations of individuals without CGA. This is particularly so in syndromes like congenital adrenal hyperplasia (CAH) in girls, in which genital examinations serve as an important tool in monitoring the effectiveness of daily glucocorticoid treatment in suppressing the endogenous androgen excess.

The medical focus on the genitals is further enhanced by the fact that CGA conditions are rare. Genital examinations of children and adolescents with CGA are, therefore, more likely to be used as training occasions for medical students, residents, and other physicians interested in that experience than those of other children. Illustrative case reports of adverse emotional reactions of children and adolescents with CGA to genital examinations have led to the critique of this practice as “nosocomial abuse” (Money & Lamacz, 1987) and recommendations to develop alternative methods of training (Meyer-Bahlburg, 2008).

Adverse emotional reactions of children and adolescents with CGA are best conceptualized in the broader context of social stigma defined as “undesired differentness” (Goffman, 1963, pp. 3–4). Clinicians who specialize in working with this population are aware that intersex-related stigma experienced and/or anticipated in a variety of social situations is of concern to many individuals with CGA and may be a factor contributing to the documented increase in psychiatric problems and especially suicidality (Schützmann, Brinkmann, Schacht, & Richter-Appelt, 2009). Such stigma is one major reason among several for the use of early “corrective genital surgery” to bring the genital appearance in line with the assigned gender (Meyer-Bahlburg, 2002). However, this type of surgery presents many technical challenges and may put later sexual functioning at risk. Critics of genital surgery performed for social considerations rather than strictly medical indications belittle such surgery as merely “cosmetic” and point to the lack of systematic evidence regarding CGA-related stigma (Lindemann, Feder, & Dreger, 2010). Indeed, clinical assessments of individuals with CGA by mental-health service providers focus predominantly on gender, sexuality, and psychiatric function (Asciutto, Haddad, Green, & Sandberg, 2011). In the literature, CGA-related stigma as experienced by such individuals has been documented mostly by way of brief case notes (Preves, 2003; Karkazis, 2008) and a few detailed testimonials and case reports (Davis, 2015; Dreger, 1999; Money, 1991; Money & Lamacz, 1987). In recent years, several studies have been conducted on the psychological effects of having a child with CGA on the parents (Duguid et al., 2007; Pasterski, Mastroyannopoulou, Wright, Zucker, & Hughes, 2014; Wolfe-Christensen et al., 2012), and one study devised questionnaire scales for parental reports of stigma associated with their children’s CGA (Rolston, Gardner, Vilain, &

Sandberg, 2015). Yet, except for one study of a clinical sample using simple stigma ratings (Frisén et al., 2009), no systematic studies of CGA-specific stigma have been performed directly on individuals with CGA, and no CGA-stigma assessment instrument has been developed that could be used for routine clinical assessment or for research.

Our team is currently planning the development of a questionnaire for the assessment of CGA-specific stigma in older children and adolescents with such conditions and their related coping mechanisms. As part of the formative phase, we are conducting qualitative studies of CGA-related stigma in the most prevalent CGA syndrome, classical CAH due to 21-hydroxylase deficiency (New, Lekarev, Mancenido, Parsa, & Yuen, 2014). Chromosomally female (46,XX) individuals with this genetic syndrome are born with CGA due to excess prenatal production of adrenal androgens that affect the sexual differentiation of the reproductive tract and thereby induce variable degrees of genital masculinization (i.e., labial fusion/formation of a scrotum, clitoral enlargement/formation of a penis, fusion of urethra and vagina). Masculinization of gendered behavior including sexual orientation and other psychological sequelae such as gender dysphoria have also been shown (Meyer-Bahlburg, 2014). Given the sensitive nature of CGA-related stigmatization, we did not want to begin this work with interviewing children and adolescents, but instead used retrospective interviews with adult women with CAH that covered their development from early childhood through young adulthood. In this work, we follow the application of the stigma concept to patients with diverse chronic diseases by Earnshaw, Quinn, Kalichman, and Park (2013) and distinguish three types: experienced stigma, i.e., actually being exposed to stigma enacted by others; anticipated stigma, i.e., expecting exposure to stigma to occur in specific situations, which is commonly associated with attempts to avoid it; and internalized stigma or self-stigma, i.e., seeing oneself as abnormal or denigrating oneself. The current report concerns stigma experiences in medical settings. Separate reports on CGA-related stigma in the general social environment such as the family and the peer-group and in girls’ and women’s sexual lives are in preparation. The specific purpose of the present report is threefold: (1) to document the existence of CGA-related stigma (Goffman’s “undesired differentness”) as experienced by children and adolescents in medical settings, (2) to highlight plausibly contributing factors and contexts, and (3) to make examples of stigma experiences readily available for use in the training of professional staff that care for such youths, because in our experience with clinical training, the presentation of narratives of actual experiences as provided by patients is much more powerful than rating categories or scale scores.

Subsequently, this qualitative material will also be used in guiding the formulation of items for the systematic assessment of CGA-related stigma and its context by self-report.

Methods

Participants

The participants of the current study represent a convenience sample recruited through two subspecialty clinics in the northeastern United States, whose patients are distributed widely across the United States; the sample includes a total of 62 women with classical CAH, 41 of these with the more severe, salt-wasting (SW) variant of the disease and 21 with the less severe, simple-virilizing (SV) variant, all varying in age from 18 to 51 years. Most had undergone genital surgery, many more than one. Of the total, 84% were white, 10% Hispanic, and 6% African-American. The current study is part of a comprehensive project on the long-term outcome of 46,XX patients with classical or nonclassical CAH due to 21-hydroxylase deficiency (Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). The respective institutional review boards approved all project procedures, and all participants provided written informed consent.

Procedure

All women took part in an 8-10-hr comprehensive protocol including various questionnaires and interviews assessing the long-term outcome with CAH. It ended with an open-ended, nonblindly administered interview; its topical guide focused on the impact of CAH and its treatment with hormones and genital surgery on diverse aspects of women's psychosocial development. The guide was derived from the lead author's clinical experience with patients with CGA in general and CAH in particular. It was designed to elicit accounts of the women's experiences of the diverse aspects of the CAH condition and its treatment with hormones and surgery at different ages from childhood through adulthood and in diverse social environments. The questions were open-ended and did not explicitly focus on "stigma" or "differentness," but were worded so that reports of stigma-related experiences and feelings were facilitated. For instance: "In our experiences, many children and teenagers with a medical condition harbor secret questions, expectations, hopes, fears and worries, and other thoughts about their medical condition and what it means for their future lives, that they sometimes do not even dare to share with anyone. When you think back to childhood, what secret hopes and worries did you have?" Probes focused on body image, gender role, dating/courtship, steady relationships, various aspects of sexuality including sexual functioning, and

parenthood. Several probes concerned the influence of genital examinations on sex play of childhood, masturbation, and becoming sexually active later. Most interviews were conducted by one of two women with MA or PhD degrees in clinical psychology who were specifically trained for this project, a few by a male (H.M-B.) because of scheduling problems. The interviews varied in length from 0.5 to 1.5 hr. A transcription company certified in medical research confidentiality transcribed the audiotapes of the interviews.

Data Analytic Approach

On the basis of the conceptualization of stigma in the context of chronic diseases by Earnshaw et al. (2013), we performed a deductive content analysis (Patton, 2014, pp. 541–552) of the de-identified transcripts. Women's descriptions of experiences and feelings that expressed CAH-related adverse "differentness" were excerpted as "vignettes" by two of the authors (J.K. and H. M.-B.). These vignettes were independently categorized by at least two of the authors (J.K., J.R.-P., and H. M.-B.) in regard to three categories of social context (social environment in general, e.g., family, peers; romantic/erotic situations; and medical settings) and the three stigma types (experienced or enacted stigma; anticipated stigma including various forms of avoidance; internalized or self-stigma). Initial disagreements occurred mostly due to the fact that many vignettes represented more than one type of stigma and some also more than one context; they were resolved by permitting multiple codes of stigma type and context for a given vignette, and otherwise by clarifying the operationalization of categories. The current paper provides the findings on stigma in medical settings, illustrated with examples that highlight specific contexts and factors contributing to stigma, along with emotional reactions and coping responses.

Results

Stigma experiences were common and provided by nearly two-thirds of the participating women with classical CAH. Accounts pertaining specifically to medical settings were provided by 17 women (27%), about equally distributed across the two CAH variants (SV 24%, SW 29%). Several women provided multiple examples.

Each illustrative vignette below is identified by the respective woman's first name (assigned as research code, not her real name), followed by her age at evaluation, her CAH variant (SV or SW), and the vignette code (V#). Where necessary for facilitating the understanding, the [bracketed] interview context or the question posed by the interviewer (Int) precedes a woman's statement.

The genital medical exams, which are quite regularly performed in girls with CAH because of their responsiveness to androgens, may be experienced as unpleasant and intrusive, and, thereby, become salient aversive events.

Grace (37 years, SW, V4): [In regard to sexuality in adolescence:] “I guess I always associated it with pain. Genital things. I mean, I was having the ‘female exam’ long before the rest of the world. And I didn’t like it then, and I still don’t like it. . . You know, it’s the ultimate intrusion when you’re very young and you don’t understand it.”

Anne (43 years, SW, V10): “Half my life I’ve been probed and plucked and cut and twisted, and how can that not have an impact on me?”

The very fact that the genital examinations of girls with a CGA condition go beyond the check-ups of other girls conveys a message that there is “something wrong with me,” leading to an internalization of the notion of being abnormal or a “freak” (see also Grace’s V4 above and Laura’s V18 below).

Sophie (25 years, SW, V14): [Impact of genital exams:] “I think it made me aware that I was different there [referring to the genitals], because why else would they want to examine me? And my mom was always very frank. . . [saying] ‘Yes, you had surgery, yes, you’re different.’ She would answer questions if I asked them. She wouldn’t bring them up, I would guess. So it made me aware I was different, I would say is the impact it had.”

Linda (36 years, SV, V108): [Int: Impact of genital exams on sexuality later:] “You mean maybe it made me more aware of something being wrong? Of course, I cannot imagine my two little girls—now this is speaking as a mother of two little girls—I cannot imagine those two little girls having to go through—every six months—a whole bunch of people peeking down below on them, . . . and them not thinking anything’s wrong with them [Int: It made you focus more on. . .] Yes, of course, it made you know there was something wrong.”

Some physicians who are not familiar with the condition may express surprise in their verbal remarks or facial features while performing the examination, which are experienced as denigrating by the patients.

Alice (23 years, SW, V54): “The only time when I was in middle school, we had, you know, to try out for sports, like they give physicals at school. The doctor at school, he wouldn’t pass me. He’s like, ‘Wow, what weird condition you have!’”

Kate (38 years, SW, V25a): “I mean, if you’re with some gynecologist that hasn’t had experience with CAH, I mean, it’s a bad scene. . . I think just watching doctors’ faces. I mean when you see them look between your legs, you know, I picked up on a lot of stuff when I was a kid. . .”

Other physicians convey to their patients with a rare medical condition such as CAH that they are an object of medical curiosity.

Stacey (25 years, SW, V60): [In regard to “group” medical exams] “I was the new thing on the block. . . They [medical residents] had to check it out. . . Some people were going to take advantage of that and try to see the difference, I guess, in the genitals. . . The guy here [medical resident] kind of blew it out of the water pretty bad. Because after that, I’ve been totally turned off to exams and everything.”

Eve (38 years, SV, V24): [Impact of genital exams in the hospital:] “You know, because we were seen as a medical curiosity as opposed to. . . caring about how you actually felt about what they were doing to you.”

In this context, a poor outcome of genital surgery adds to the self-perception of being abnormal.

Susan (51 years, SW, V29): [In regard to clitoral-surgical outcome:] “I mean, not even knowing what it was supposed to look like, I could see that there was sort of ragged, jagged surfaces. And it just looked as though somebody. . . well it had been through a meat grinder, to me. It was not nicely smooth the way the rest of my body was. There was still that sense that I had had surgery because there was something wrong with me to start with, and this was the best they could do about it.”

Stacey, 38 years, SW, V25b): “I guess I knew I was different. I knew I was missing stuff. I knew it was totally like artificial, like kind of like plastic surgery down there. . . The thing I had wasn’t looking like a woman, so they made it like a surgical woman that was very, you know, artificial.”

When physicians explicitly refer to possible future CGA-related problems for the patient but noticeably evade providing details, patients may experience this withholding of information as aversive, presumably because it implies a prognosis of future differentness.

Amy (21 years, SW, V44): “I was told [by her physician], ‘Oh, yeah, you might have some problem with sex, but don’t worry about it now, because you’re only in high school,’ which I don’t think was very helpful. . . It’s like leaving me with half the story.”

Physical exams that are combined with teaching students and/or residents are experienced as particularly aversive.

Karen (32 years, SW, V34): “It was never a pleasant memory of going to the doctor’s in terms of where I went at [hospital name], and being surrounded by seven to ten people looking at my genitals was not a pleasant experience.”

Some girls experienced these teaching situations as aversive group shows.

Stacey (38 years, SW, V25c): [In regard to medical group exams] “I mean, they were like, full out. I mean, they were big-time displays. They were like, not

[just] one or two doctors in the room. . . [As a result] I guess I don't like my legs being opened up. . ."

Eve (38 years, SV, V41): "We went to a teaching hospital. . . There was this doctor, and then he would have all of his residents come in the room, and there you would be. . . and he's like, 'Okay, let's do the show now. . .' I mean, he didn't say that, but that's the feeling that you get. . . Once I hit high school, I hated to go to the doctor, because the last thing you want to do, when you're a fifteen year old girl, is lay down on an exam table and have eight or nine other guys come in the room and stare at your genitals."

Such teaching experiences contribute to the internalization of being a freak.

Laura (35 years, SW, V18): "I remember medical students always telling me, and they're standing around the table and staring and pulling down my pants and staring at me. That I remember. And hated that. I hated that. I always felt like I was on display. I thought I was a freak. I've always been studied."

Early adolescence with its focus on pubertal development is likely a particularly sensitive period for such exposure.

Veronica (32 years, SV, V20): [In regard to genital surgery] "I would have much preferred if I had the surgery done when I was a baby. . . The experience of being in the hospital when I was twelve was horrible. I think back [to it] as like the worst part of my life. It was awful. . . It was so awful." [Later statements clarify this was in part because she could not tell anyone the real reason—clitoral reduction surgery—why she was in the hospital for three weeks.]

Some girls may develop intense avoidance reactions to such group examinations.

Dianne (33 years, SV, V3): [In regard to medical exams] "Towards the end, before they finished. . . before they quit doing physical exams, the last two years, I would say, from like ten to twelve years old, Mom would find me hiding and crying because I didn't want to go to my doctor's appointment. And she would ask why. . . and I would tell her that it was because I didn't like. . . they would troop in there with six, seven people, and you would be laying there, and you're six. . . five, six years old. . . and they're poking around at you down there."

For some older girls, group teaching may lead to avoidance of specific doctors and, as also seen in Stacey's V60 above, may constitute an emotional barrier to seeking appropriate medical care.

Judy (29 years, SW, V32): [The doctor] "was always examining me down there, because of that implant thing. And he had some interns he wanted to show and brought them in. . . I was sixteen by then. I was more self-conscious than when I was a kid. So I stopped going to him, because I just felt self-conscious."

The aversive reaction to medical examination may generalize to other situations involving undressing in the presence of others or even romantic/erotic situations with a sexual partner.

Amy (21 years, SW, V39): [Int: Feelings about genital exams?] "A little bit embarrassed, but it was only once I started getting older. . . about 10 or 11. . . For a long time, I really hated locker rooms. I never wanted to get undressed in a locker room, even an all-women's locker room, obviously. [Int: What's the association?] I don't know exactly. . . [laughs]. . . but something about baring it all to the doctor and then there's these people around, just wanting to. . . [look]. [Int: Who?] My mother. . . I just don't like getting undressed, I don't like getting undressed for the doctor, either."

Dorothy (37 years, V92): [Int: Influence of genital exams on becoming sexually active:] "... I had very strong feelings about those exams. . . I dated this woman, this one time, . . . and we were getting intimate, and she wanted to look. She was fine with it. . . , and, in fact, it was great sex. But she wanted to look, and it made me hugely uncomfortable. And I told her it was ok. I mean, I could have said no. But I didn't realize how uncomfortable it was going to make me until we were actually doing it."

Table I summarizes the categorization of the vignettes according to the stigma concepts of Earnshaw et al. (2013). Experienced stigma has been further subcategorized according to four specific subcontexts: "Physical exam" (without a specified teaching purpose), "Doctor's reactions" (both verbal and nonverbal), "Teaching exam" (with groups of trainees present), and "Surgery" (i.e., the experience of the surgery process as well as its cosmetic outcome). Teaching exams stand out as the most frequently reported category of experience of stigma as adverse "differentness" in the medical context. None of the women made an explicit statement regarding anticipation of stigma. However, the two reports of avoidance (Dianne's attempt to hide from exams during childhood and Judy's cessation of medical appointments during adolescence) imply anticipation. A woman's conclusion that there is something wrong with her, that she is different, or a freak, was categorized as internalized stigma.

Discussion

About a quarter of the participating women with CAH reported experiencing the genital examinations in childhood and adolescence as adverse events that contributed to their sense of having an "undesired differentness" (Goffman, 1963). Thus, CGA-related stigma can be experienced even in medical settings at least by a sizable minority of girls and women with

Table I. Classification of Type of Stigma (As Adverse “Differentness”)

Vignette	Experienced				Anticipated	Internalized
	Physical exam	Doctor reactions	Teaching exam	Surgery		
Grace V4	(X) ^a					
Anne V10	(X) ^a					
Sophie V14	X	(X) ^b				X
Linda V108			X			X
Alice V54		X				
Kate V25a		X				
Stacey V60			X			
Eve V24		X				
Susan V29					X	X
Stacey V25b					X	X
Amy V44		X				
Karen V34			X			
Stacey V25c			X			
Eve V41			X			
Laura V18			X			X
Veronica V20				X		
Dianne V3			X		(X) ^c	
Judy V32			X		(X) ^c	
Amy V39			X			
Dorothy V92	X					

^aAdverse experience without expressed “differentness.”

^bMother’s comments on medical exams.

^cImplied by avoidance.

CAH; it is not an unusual, rare occurrence. If our exit interview had focused more specifically and with more detailed probes on the women’s recall of stigma experiences in medical settings, we would have probably obtained even higher rates of such reports. Based on our clinical experience, we would expect to obtain similar findings from adults with CGA syndromes other than CAH.

Experiences of directly enacted stigma by medical staff’s pejorative CGA-related remarks were not reported. The closest were verbal or nonverbal expressions of surprise by physicians apparently inexperienced with CGA. Such events were not confined to clinic and private-practice settings, but also occurred elsewhere, for instance in routine physicals required for sports participation.

More commonly, “differentness” appears to have been conveyed by the frequency and unpleasantness of genital examinations that girls with CAH were exposed to in comparison with their non-CGA peers. This is likely enhanced by the modesty training common in U.S. child rearing, which aims at inhibiting the exposure of the child’s genital area and underwear to the eyes of others (Rosenfeld et al., 1984). It is no surprise then that the repetitive medical examinations of the genitals contribute to an internalized stigma of being somehow abnormal. Feelings of being degraded to a study object or target of a freak show were particularly elicited when the examinations involved groups of medical students and residents in addition to the treating physician. Such group exams are likely to be

even more experienced as a violation of one’s internalized modesty rules. Also the fact that most of the medical-settings-related vignettes provided by the participants referred to experiences during adolescence may plausibly reflect a combination of the age-typical increased sensitivity to aspects of one’s body image and growing awareness of romantic/erotic issues, but needs corroboration by systematic research.

The fact that none of the women explicitly referred to stigma anticipation is probably a consequence of the retrospective character of the exit interview and the lack of any specific probes for anticipation. However, stigma anticipation is implied in the avoidance of specific doctors or of adverse exams altogether, as described in some vignettes, which then may constitute a risk factor for future poor health care. Such reports related more to adolescence, presumably because children are usually signed up for medical monitoring by their parents and do not have the liberty to refuse.

Several other vignettes appear to represent examples of the generalization of an aversive emotional response to the genital examination from the medical setting to other social situations such as changing clothes in sports-related locker rooms or exposing one’s nude body to a sex partner.

As we know from our own institutions as well as from reports by our patients and our medical colleagues about situations elsewhere, tertiary-care institutions in the United States and Western Europe have much reduced the live demonstrations of genital

examinations on youths with CGA for teaching purposes, but they still occur in other medical settings in the United States and in resource-poor countries. In addition, for those who have experienced this type of stigmatization, the aversive memory stays with them for many years, if not forever, as exemplified by the vehemence, and sometimes tears, with which our participants reported such situations from their past. It may well continue to make them sensitive and vulnerable to CGA-related stigma in other situations.

Even this explorative qualitative study leads to the conclusion that it is important to make physicians and especially medical trainees aware of the stigma implications of CGA-related genital examinations. The frequency of examinations should be kept to the necessary minimum and the specific procedures explained to the patient in a manner appropriate to her cognitive level. Particularly contra-indicated are medical examinations involving groups of trainees. They should be replaced by videos of examinations, obtained with appropriate consent and done in a manner that prevents the patient's identification, and by the use of well-constructed medical models for examination exercises. The vignettes provided here may constitute useful material for the sensitivity training of clinical staff, as we have already learned from clinicians' feedback after presentations to medical audiences.

Limitations

Given the logistic problems of conducting studies on individuals with rare medical conditions, the qualitative interviews at the end of the overall protocol cast a wide net of topics of relevance to living as a female with the CAH condition. Thus, it is likely that our findings underestimate the frequency of CGA-related stigma experiences in medical settings. Moreover, we relied on recall of events that occurred years to decades earlier. A multi-informant study involving families shortly before and after medical exams of children with and adolescents with CGA would provide more detailed information. In addition, there may be cohort effects, given that the medical approach to CGA and the societal response to sex and gender atypicalities have changed; thus, studies of structural stigma of medical school and societal policies need to complement individual-level surveys.

A more narrowly focused study with a standardized procedure for the systematic assessment of GCA-related stigma is needed to answer questions regarding the frequency of such stigma experiences and their subtypes at different stages of development, in individuals with different syndromes and with different degrees of severity of CGA, and the relationship and interactions of stigma experiences in medical settings with those in other spheres of life. To devise a sensitive

screening tool for children and adolescents with CGA that can facilitate such research and is also useful for identifying those needing help in coping with CGA-related stigma is the first step in that direction. Until we have findings from systematic studies using such tools, the reduction of CGA-related stigma in medical settings and the respective training of clinical staff for such as well as instructions for parents about how to help their children to cope with these experiences need to borrow from findings in other areas of stigma management.

Conclusions

We conclude that in the lives of children and adolescents with CGA, the frequent physical and genital examinations by the family physician or in subspecialty clinics constitute salient events that may easily be experienced as strongly stigmatizing, especially when combined with teaching, and worst if the teaching involves groups of trainees. Given the salience of these experiences and the potential implications for both self-esteem in general and the reluctance to seek appropriate medical care later, tools for the systematic assessment of CGA stigma need to include the domain of medical settings. Moreover, it remains important to raise and maintain among physicians, medical students, and staff, the sensitivity to the CGA-specific stigma risk of such patients in general and in medical settings in particular.

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