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Legacy of Money: A Qualitative Analysis of Attitudes Toward Treatment of Intersex Individuals

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Walden University
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Abstract

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M.Phil Psychology, Walden University, 2019

M.S. Psychology, Texas A&M University, 1980

B.S. Criminal Justice, Abilene Christian College, 1975

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

General Psychology – Research and Evaluation

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Abstract

No significant research exists that addresses mental health providers attitudes toward the treatment of intersex individuals. The purpose and primary goal of this qualitative study was to provide insight into mental health providers' attitudes toward and understanding of treatment of intersex individuals, including possible changes in attitudes over the past 25 years. Using the theoretical foundations of social constructivism and gender variant phenomenon, the guiding research questions sampled mental health providers' views of attitudinal shifts in treatment of the intersex population over 25 years, their changing views toward intersex over the course of their careers, and what mental disorders they believed to be prevalent among the intersex community. A questionnaire was used to collect data from 10 mental health providers who may or may not have worked with or previously known about intersex. Analysis involved coding themes and using NVivo12, a statistical software package, to discover common words reflecting the research questions. Understanding and trauma were the most prevalent themes that emerged for each of three research questions. Depression emerged as the most expected psychological disorder. While the available literature and an interpretive analysis of the results suggested both attitudes and treatment of intersex may have changed over time, the results also illuminated a glaring deficit in mental health providers' knowledge and understanding of intersex and suggested the need for a major modification in training programs to include specific training in treatment of intersex individuals. The results of this qualitative study will inform administrators and directors of psychology training programs' current and future curriculum decisions regarding treatment of the unique intersex population.

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Dedication

My deceased husband, Douglas, as well as my deceased son, Rocky, were driving forces in encouraging me and keeping me on track to continue my education and complete my degree. I would not have been able to continue without their support and encouragement. My friends Karen Brown and Ann Parkinson have also stood by my side with thoughts and suggestions to further help me to delve into other thoughts and ideas when working on this dissertation. They will always be in my prayers.

My spiritual guidance has come from my Lord Jesus Christ. He has helped to guide me in my vision to complete my education throughout my entire life.

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Lastly, I would like to thank my dear friend, Wayne Lashley, for his continued support during the many deaths in my family and my illnesses. He has been a stalwart friend, as well as an encourager to keep me on track. Thank you, dear friend.

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Chapter 1: Introduction to the Study

Introduction

The majority of individuals are born with a single set of genitalia that clearly defines them as belonging to either the male or female sex. One in 1,666 births result in children born with genitalia of both male and female sexes (Hofman, 2012). These children are referred to as *intersexed children.* The term intersexuality was originally formulated in a paper entitled *Intersexuality and the Endocrine Aspect of Sex* (Goldschmidt, 1917). It was not until the 1940s, however, that Cawadias suggested replacing the word *hermaphrodite* with intersex (Cawadias, 1943). Intersex is characterized by the atypical development of both primary and secondary sex characteristics. Some medical professionals also use the term "disorders of sex development" when referring to this condition (Donohoue, 2012, p. 1959; Morland, 2012, p. 20; Topp, 2012, p. 180). Among the most prevalent intersex conditions are androgen insensitivity syndrome (AIS) and partial androgen insensitivity syndrome (PAIS) (Mendoza & Motos, 2013). The prevalence of individuals with AIS and PAIS is between two and five per 100,000 people (Mendoza & Motos, 2013).

The presence of internal and/or external physical characteristics of both genitalia is the first indication of what Hofman (2012), Witchel (2018), and Al-Omar (2019) referred to as a disorder of sexual development. Hofman (2012) explained that there are many ways that one might consider a person either a male or female, such as an individual's attraction to certain types of toys, being attracted to the opposite sex, or having either 46XX (female) or 46XY (male) karyotype. In comparison, gender identity refers to the gender, male or female, with which an individual feels most comfortable and with which they are most emotionally compatible (Wisniewski, 2012). Importantly, gender identity also refers to how one perceives themself. In many cases of gender ambiguity, physicians have made arbitrary gender assignments and surgically altered an intersexed individual's genitals to conform to the surgeon's decisions (Milloy, 2014). However, according to Beh and Diamond (2015), individuals who later express feelings that the assigned gender does not match their internal sense of self can experience profound negative emotional consequences. Milloy (2014) asserted that medical professionals used negative language regarding not having the gender assignment surgery, which reflected the medical professions' lack of understanding of intersex.

According to Lenhart (2015), there is uncertainty for children who are born with an intersex condition. Furthermore, Lenhart (2015) stated that gender ambiguity often leads to poor medical treatment. One noted physician, Dr. Jorge Daaboul, speaking of the previous medical treatment of intersex children, admitted: "Many of my colleagues do not believe we have been deceptive [about the impact of early genital surgeries], and they would resent my saying we have been deceptive . . . But we have been deceptive." He later articulated: "I hope we can make amends to the [intersex] individuals we have harmed over the years, and I think our profession should do that in a formal way" (Daaboul, 2000).

To promote healthy development during all phases of the intersex individuals' life, Lenhart (2015) cited Rev. James Sullivan (1934-2012) who suggested that a team of individuals be formed, which should include an obstetrician, urologist, pediatric endocrinologist, psychiatrist/psychologist, and geneticist who would then assist, educate, and counsel the family prior to any surgery. Lenhart's (2015) writing reflects a definite paradigm shift in thinking among professionals. In the years between 1950 and 1970, medical professionals made their best guess and assigned a gender to the child born with ambiguous primary and secondary sexual characteristics. It was during this time that surgical solutions were strongly recommended (Human Rights Watch, 2017).

In a Human Rights Watch interview (2017), one 60-year-old intersex woman said that when she was 19 and attempting to understand what had been done to her, including a large scar on her abdomen, the child psychiatrist told her she did not need her medical records. When she finally obtained the records from the hospital, the doctor told her that when she was born, her parents did not really know if she was a boy or a girl. At that point, the doctor left the room. The woman said she left the doctor's office in a suicidal state.

Being lied to your entire life by authority figures, including parents and doctors, makes it difficult to understand who you truly are (Human Rights Watch, 2017). Major trust issues were prevalent because everyone she believed she should have been able to trust had lied to her (Human Rights Watch interview, 2017). One endocrinologist stated that many years ago, he believed he was doing the best for his patients. However, after listening to his patients, the endocrinologist's approach evolved. He gave the family time to explore the decision-making process since the surgery was not an emergency (Human Rights Watch interview, 2017).

Background

It is significant to note that many surgeons today do not see the need to perform surgery immediately after birth unless there is an actual physical emergency; simply being intersexed is not considered a medical emergency (Davis & Murphy, 2013).

Davidian (2011), and Davis and Murphy (2013), agreed that doctors should not construe intersex as an emergency when there is no medical problem, nor should they try to convince parents to allow their children to have genital reconstructive surgery at an early age. Grumbach, cited by Melmed (2017), stressed that there should not be gender identity decisions without including parents, patients, and counselors in the decision-making process. In response to infant gender assignment surgery, Lenhart quoted Rev. John Harvey, who stated, "There is no way one can morally justify such operations" (Lenhart, 2015, p. 57). Quinn et al. (2014) explained that many individuals reported negative healthcare experiences and included reports of negative interpersonal interactions. The intersex individuals felt that they were discriminated against by their healthcare providers. This perspective is in contrast to the earlier research of John Money (Goldie, 2014), who believed that nurture was more important than nature when it came to choosing a sex for a child and was an enthusiastic proponent of early gender assignment surgery.

Researchers have diverse opinions regarding genital surgery. According to Terry Goldie, author of the biography *The Man Who Invented Gender: Engaging the Ideas of John Money* (Goldie, 2014), Dr. John Money believed that without obviously male or female genitalia, a child could not function well socially. In contrast, Beh and Diamond (2015), Schönbucher et al. (2012), and Simonsen et al. (2015) are among those whose research participants consistently reported negative emotional consequences of genital reconstructive surgery. These academics and researchers found that gender often has negative connotations when an early gender assignment does not later match the intersex individual's gender identity or internal sense of self (Beh & Diamond, 2015). Lenhart

(2015) reported that individuals diagnosed with AIS are born with a female body lacking a uterus and with internal undeveloped testes. Unfortunately, this is not usually discovered until the individual fails to menstruate during puberty. Lenhart further stated that many intersex adults reported that they had intense problems, especially physically, because of having had genital surgery as a child. Nelson (2016) discussed the case of Alex Jinkinson, who identified as a male in childhood. Jinkinson reported that his childhood memories were ones of bullying and depression (Nelson, 2016). Even Dr. Money's supposed success story, David Reimer, committed suicide after suffering most of his life from depression because he had been raised as a girl as the result of a botched circumcision, which destroyed his penis (Goldie, 2014).

Despite numerous examples of negative consequences (Chase, 1998; Domurat Dreger, 1998, 1999; Fausto-Sterling,1993; Kessler, 1998), some medical personnel found patients reported more life satisfaction with early genital reconstructive surgery (Dr. C. Reynolds, personal communication, March 24, 2014). Many pediatric urologists and other medical professionals performed genital reconstructive surgery on intersex individuals for whom the genders assigned were later considered appropriate by the intersexed individual (Dr. J. C. Jones, personal communication, January 12, 2016). These medical professionals made the argument that emotional scarring would be worse without the early assignment surgeries (Neilson, 2018 as cited in Delisle, 2018; Dr. C. Reynolds, personal communication, March 24, 2014; Zucker, 2002).

Problem Statement

In reviewing articles from multiple academic databases, there appears to have been little research to date that has discussed the attitudinal changes toward intersex individuals and types of treatment from a mental health professional's perspective. The early lack of understanding of intersex by physicians, psychologists, and other health care professionals contributed to negative attitudes toward intersex individuals, resulting in arbitrary decisions regarding surgery and, eventually, negative social and emotional outcomes for many of the intersex individuals. The limited number of research studies left a significant gap in the literature, which was addressed by this qualitative study.

Nature of the Study

The methodology for my study was qualitative. Participants for the qualitative study were mental health care professionals who may or may not have interacted with intersex individuals. The research consisted of sampling mental health care providers' attitudes toward the treatment of intersex individuals including how their attitudes might have changed over the past 25 years.

Research Questions

The guiding qualitative questions were:

RQ1. As time changes, so do attitudes. How do mental health providers view attitudinal shifts in working with the intersex population?

RQ2. In the psychological literature, new and innovative methods and theories continue to be created. How do mental health providers view changes in theory over the course of their work?

RQ3. As new editions of the DSM have emerged with time, clusters of symptoms are recognized as psychological disorders that were not considered so in the past. How do mental health providers view these changes when working with the Intersex community?

Research Objectives

The objective of the study was to determine how mental health care professionals viewed intersex individuals at present, what their attitudes toward intersex may had been in the past, and how their attitudes toward treatment of intersex individuals vs non-intersex individuals had changed over the course of their career. A second objective was to determine if mental health care professionals believed there was an increase in the prevalence of psychological disorders in intersex individuals. The overall objective was to determine if trends existed that suggested a change in mental health providers' attitudes toward the treatment of intersex over the past 25 years.

Purpose of the Study

The purpose of the study was to conduct a qualitative investigation to determine how mental health care professionals viewed intersex individuals. It was also to determine those same professionals' past attitudes toward intersex, and whether their treatment of intersex versus non-intersex individuals had changed over the course of their career. Using a narrative approach allowed me to review mental health care professionals' attitudes toward intersex individuals over the past 25 years and provide insight into the lived experiences of treatment providers.

Conceptual Framework

The theoretical framework for this study was social constructivism. This theory (Galbin, 2014) explains that much of human life exists as it does because of influences of social and interpersonal experiences. According to the theory of social constructivism, mental health care professionals who have worked with or who have known of intersex individuals may have some previous bias toward those individuals.

Operational Definitions

Androgen Insensitivity Syndrome (AIS): AIS is an inherited genetic condition (except in rare cases) whereby the bodies' cells are unable to respond to androgen (male hormones; ISNA, 2014).

Partial Androgen Insensitivity Syndrome (PAIS): PAIS typically results in ambiguous genitalia. The clitoris is large, or the penis is small. Generally, individuals diagnosed with PAIS have been subjected to corrective surgery during infancy (ISNA, 2014).

Assumptions

An assumption inherent in this study was that the mental health care professionals would answer the questions in an honest and candid manner. A second assumption was that the inclusion criteria of the sample participants were appropriate, and that the participants were all members of the mental health professions who may or may not have had experience with intersex individuals. The last assumption was that the mental health care professionals participating in my research had a sincere interest in promoting understanding of intersex and did not have hidden motives.

Limitations

Limitations of the study were unknown factors or conditions that existed where the mental health care professionals worked that would bias some of their responses. A second limitation was that there may not be enough willing participants to draw significant conclusions for my study. Saturation of the data must be achieved, or the study would not yield meaningful results.

Scope and Delimitations

The composition of the target group included mental health care professionals of different ethnicities, ages, genders (as determined by the individual), and socioeconomic levels. Participants in the proposed research were limited to mental health care professionals who may or may not have had experience with intersex individuals. Participants were selected based on the individuals' willingness to participate in the study. All mental health care professionals in the targeted areas were contacted by email explaining the research project in an attempt to recruit them, and all participants were over the age of 18.

Significance of the Study

The results of my qualitative study determined the nature of perceived attitudinal impact on treatment of intersex. Results revealed some differences in mental health care professionals' manner of treating intersex individuals versus non-intersex individuals over the past 25 years. It is expected that the results will inform mental health care professionals' current and future decisions regarding the types of treatment being considered for intersex individuals. The results of this qualitative study may also encourage the addition of intersex information to the curriculum of psychology training programs.

Summary

Because of the limited research focusing on mental health care professionals' attitudinal changes in the treatment of intersex individuals and their treatment of intersex individuals versus non-intersex individuals, there was a gap in the literature. Several studies had reported negative effects regarding an intersex person's attitudes toward health care professionals. However, no study to date had addressed the attitudinal changes of mental health care professionals toward treatment of intersex that may have occurred over the past 25 years. The focus of my qualitative research was to determine the changes in attitudes, if any, of mental health care professionals in their treatment of intersex individuals.

Chapter 2 will include an in-depth literature review that addresses how mental health care professionals had not been surveyed regarding their views on the treatment of intersex, and how attitudinal changes had not been documented over the past 25 years. Chapter 3 will describe the methodology that was used to conduct this qualitative study. Chapter 4 contains the descriptive analysis and findings of the study. Chapter 5 will describe the analysis of the qualitative questions and report the results that were obtained. Chapter 5 will also include implications for further research and social change.

Chapter 2: Literature Review

Introduction

Much of the research involving intersex individuals has focused on reports of diminished sexuality experienced by intersex individuals who have undergone reconstructive surgery as children (Guterman, 2012). Many research participants have attributed their feelings of diminished sexuality to the lack of information given them about their intersex condition and the reconstructive surgery (Jordan, 2016). However, there has been no substantive research conducted regarding the attitudes of mental health providers toward the types of treatment available for intersex individuals. There has also been no research addressing any possible differences between the types of mental health treatment offered to intersex versus non-intersex individuals. My qualitative investigation examined both attitudes of mental health providers toward intersex individuals and the mental health providers' treatment of those individuals. The primary goal of this study was to provide insight into, and an interpretive analysis of, the attitudes toward the different types of treatment offered by mental health providers and the types of treatment that may differ between intersex and non-intersex individuals. Nomenclature for the unique intersex condition varies. Donohoue (2012), Morland (2012), and Topp (2012) use the term *disorders of sex development*. However, this study used the term *intersex*.

Chapter 2 includes the literature research strategy, the conceptual framework, and the theoretical foundation I used for this study. I have provided a comprehensive review of the available literature and a summary of current intersex literature as it relates to intersex individuals and their treatment by mental health providers. Many different sources were used to find relevant research involving individuals with an intersex condition and mental health providers. I used different databases from EBSCO Research such as Dissertation & Theses at Walden University, ERIC – Educational Resource Information Center, LexisNexis Academic, LGBT Life with Full Text, MEDLINE with Full Text, Open Book Publishers, PsycARTICLES, PsycINFO, SAGE Journal (formerly SAGE Premier), SocINDEX with Full Text, and Thoreau Multi-Database. I also searched Google and Google Scholar. I read many books that dealt with the topic of intersex. These included the following: *The Boundaries of Her Body: The Troubling History of Women's Rights in America*; *Fixing Sex: Intersex, Medical Authority, and Lived Experience*; *As Nature Made Him: The Boy Who Was Raised as a Girl*; and *Lessons from the Intersexed*.

The key word search began with the main themes of my study: *intersex*, *emotional well-being*, and *intersex surgery*. Other key words were used including *intersexuality*, *gender*, *gender identity* and *hermaphroditism*, *disorder of sex development*, *transgender*, *LGBTI*, *constructivism*, and *gender variant phenomenon*. There were also searches regarding mental health providers and their attitudes toward working with intersex individuals. These searches included terminology such as *attitudes*, *health care*, *attitudinal changes*, *mental health*, and *intersex*.

A number of the searches were combined to fully saturate the literature review. Some of the combined key words were *intersex* and *gender variant phenomenon*, which displayed few results. Another combination was *intersex surgery* and *emotion*. This brought even fewer results. *Disorder of sex development* and *transgender* brought a minimal number of results, as did *mental health providers* and *intersex therapy*. It was more productive to find results by using only one search criteria, which was *intersex*.

Theoretical Foundation

My study used a combination of social constructivism and gender variant phenomenon. The two theories combined to offer an exploratory microscope into the attitudes of mental health providers as they treated intersex individuals. In addition, gender variant phenomenon suggests how being intersex affects the development of psychological disorders in intersex individuals. The theories that I used are discussed in further detail below.

Social Constructivism Theory

When performing a Google Search, one clear definition of social constructivism that mirrors my study is the following: "Social constructivism maintains that human development is socially situated and knowledge is constructed through interaction with others. It is a sociological theory of knowledge that applies the general philosophical constructivism into the social" (Malley, 2016, p.1). McLeod (2014) and Cheu-Jey (2012) both explained that a constructivist viewpoint may have multiple realities. This theory is relevant to mental health providers who interact not only with their patients, but also with their peers. Cheu-Jey used the following as an example of an ontological viewpoint.

> Suppose that you and I were in line for doughnuts. There was one person before you, and I was waiting after you. Usually, there is a long line, but this time there were only three of us. Though I didn't know you, I smiled at you and said, 'We are lucky. There is only one man before us'. (Suppose also that the person before us was at a distance and could not hear whatever we discussed.) Looking a bit confused, you replied, 'I think it is a woman'. Here is a scenario where there was a person before us whose gender we had different opinions about. The person

> before us had long hair and wore earnings which probably made you categorize the person as a woman. Yet the person also looked stout and had overalls on, the characteristics I associated with a man. Due to different aspects of the person we focused on, you and I came up with different interpretations of the person's gender. Yet the same person (one reality) was still referenced regardless of our disagreement on the person's gender. We were not talking about two different person's realities. (p. 408)

Gender labeling, according to Copeland et al. (2012), commences when a child comes out of the womb. If the child has a penis, it is a boy. If the child has a vagina, it is a girl. Lenhart (2015) explained that biological gender is not simply a matter of being male or female in the initial stages of childhood. Gender is a social construct, reflecting what society dictates, according to Copeland et al., (2012). Galbin (2014) explained that much of human life exists based on influences from social and interpersonal experiences. A statement by Fausto-Sterling (2015, p. 3) explained that "There is no either/or. Rather, there are shades of difference. …Labeling someone a man or a woman is a social decision." Mental health providers may not be aware of their own attitudes toward intersex individuals when they first start to interact with them. Intersex individuals often are alone in the challenges they face living with their assigned gender because of being different from their peers. Working toward being *normal*, yet not knowing how to do it, is an ordeal they face daily. Believing that human development is based on the intersex individual's communication with others, the intersex individual only knows that they often feels different from how they believe others feel and how they understand a particular situation, as in Cheu-Jey's (2012) example. According to Cheu-Jey, social constructivism explains how the influence of individuals who are not intersexed enables intersex individuals to come to accept their assigned gender more fully.

The social constructivism perspective is also used to emphasize the importance of culture and a theoretical framework to fully grasp the importance of beliefs and knowledge construction in understanding a society and then building an individual's knowledge of society based on this understanding (Jha & Devi, 2014; Kalpana, 2014).

Gender Variant Phenomenon

Another theory that applied to my study is the gender variant phenomenon (Vitale, 2003). This theory explains that gender identity disorder is characterized during the developmental stages of a child's life by gender dysphoria (Vitale, 2003). If the disorder is not identified and treated, the developmental stages of an individual's life could be fraught with confusion, disappointment, and secrecy (Vitale, 2003). The confusion adds to their shame, and in some instances, it actually causes them shame. Individuals with an intersex condition and especially those who have had gender reassignment surgery are often confused by what has happened to them. This is especially true when parents and medical professionals have not given them all the facts of their intersex condition or of the surgery (Carpenter, 2016). Collier et al. (2013) found that intersex children are often not accepted by their peers because of the way intersex individuals experience gender.

If a mental health provider holds a bias or negative attitude toward intersex, it is unlikely that the provider will understand the deep-rooted issues associated with this type of gender identity disorder, and the prognosis for a positive therapeutic outcome will be dim (Rose, 2017). Therefore, it is especially important for mental health providers to fully understand how intersex individuals view themselves. In order to provide effective treatment, the mental health provider must not only understand how and why the individuals may have negative feelings about themselves but must also understand their own implicit bias toward an intersex individual’s sexual orientation. Because the gender variant phenomenon is not always identified in an individual’s developmental stage, the mental health provider must be aware of this phenomenon to not allow it to affect the provider-patient relationship (Nota et al, 2019).

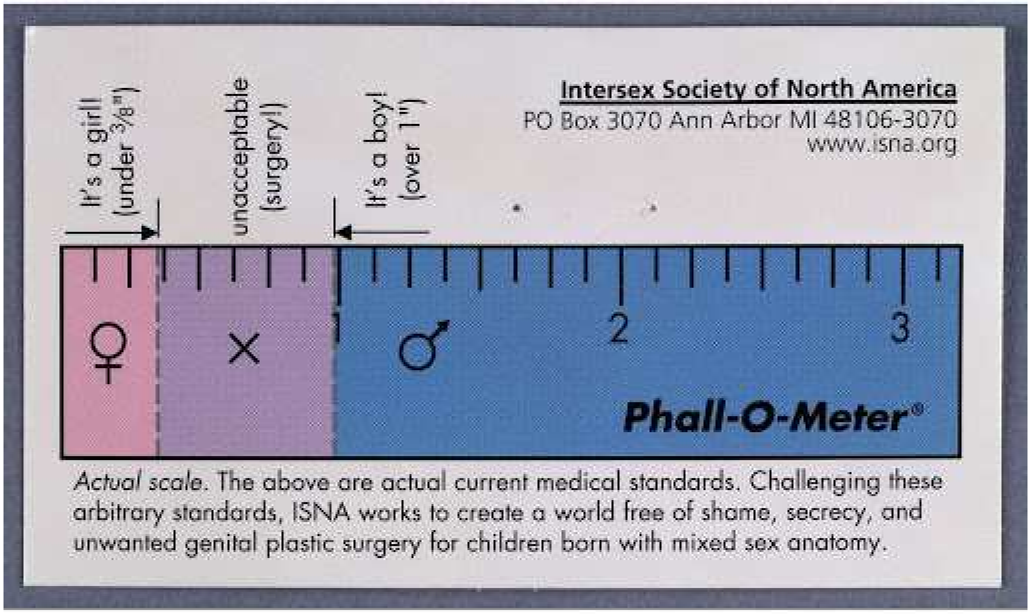
Literature Review Related to Key Concept

Research to date has not addressed the attitudes of mental health providers toward intersex individuals or their attitudes toward treatment of intersex individuals. Nor has the research addressed the question of a possible increase in psychological disorders among intersex individuals over the past 25 years. Therefore, research relating to the decision-making processes of mental health providers in recommending genital reconstructive surgery and the reported consequences of such decisions were used in identifying mental health providers’ attitudes toward intersex individuals and their treatment.

According to Hofman (2012), one in 1,666 births result in a child with genitalia of both genders. Beh and Diamond (2015) discussed the idea that one’s sex refers to biological characteristics, and gender refers to a social or psychological presentation. Creighton et al. (2014), reported that, until recently, the decision to perform genital reconstructive surgery was often made for a child born with atypical genitalia based on the size of the phallus (See Figure 1).

Figure 1

Checking for Size of Penis With the Phall-O-Meter



Intersex Society of North America
PO Box 3070 Ann Arbor MI 48106-3070
www.isna.org

Actual scale. The above are actual current medical standards. Challenging these arbitrary standards, ISNA works to create a world free of shame, secrecy, and unwanted genital plastic surgery for children born with mixed sex anatomy.

Note: Retrieved June 8, 2021 from

https://commons.wikimedia.org/w/index.php?title=File:Phall-O-meter%27,_Intersex_Society_of_North_Wellcome_L0031936.jpg&oldid=481363955

According to Creighton et al. (2014), the assignment of females versus males was approximately 9:1. Addressing this skewed ratio, one doctor, Dr. John Gearhart, stated, “it is easier to make a hole than a pole” (Holmes, 2008, p. 148). See Figure 2.

Figure 2

Dr. Gearhart's Statement on Intersex Surgery

Note: Retrieved April 9, 2017 from
http://www.lyn.lowenstein.eu/projects/freaks/p_freaks.htm (Lowenstein, 2007)

There are numerous pertinent articles relating to the criteria used by professionals and parents in making the decision to surgically alter the genitalia of intersexed individuals; however, no research directly addressing mental health providers' understanding of or attitudes toward treatment options was found. Dr. Gerhart's callus comment, although not labeled as such, is a clear indicator of the lack of thought historically applied to gender assignment and strongly suggests a bias against intersex individuals. Indeed, the lack of mention of provider views and opinions in the research might glaringly reflect a very real and pervasive, if unconscious, bias toward intersex individuals on the part of providers.

According to Rose (2017), one of the problems discovered by research into healthcare is that of bias. Rose stated that either implicit or explicit bias can contribute to disparities in healthcare when the provider has interactions with patients with a different sexual orientation from that of the provider. Migeon et al. (2002) provided research on the medical, surgical, and psychosexual outcome of persons who had genital reconstructive surgery as children and who were not able to provide input into the decision. A document called *ALGBTIC Competencies for Counseling LGBQQIA Individuals* was prepared by a taskforce for the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling in 2012 (Harper et. al., 2012). One of the comments regarding competencies for working with intersex individuals was that the LGBTQIQA communities did not include the needs or concerns of the Intersex community. Migeon et al. documented long-term life satisfaction of 39 individuals who had gender assignment surgery chosen by parents and physicians. Migeon et al. obtained participants from former patients at the Johns Hopkins Pediatric Endocrine Clinic in Baltimore, MD. The 39 individuals were all over age 21. To evaluate the participants' long-term medical and surgical outcome, Migeon used both a written questionnaire and a physical examination. To determine participants' long-term psychosexual development, Migeon used both a written questionnaire and a semi structured interview. Migeon et al. reported mixed results, explaining that the results indicated more rather than less satisfaction with physical and sexual appearance on the part of the participants. A national study by Rosenwohl-Mack et al. (2020) revealed a high prevalence of self-reported anxiety disorders and depressive disorders. Suicide attempts, according to the study, were 31.8% of their analytical sample of 198 intersex individuals. In an article by

Dastagir (2020), the CDC indicated that the number of suicide deaths in the general population was 14.2 deaths per 100,000 individuals. The high percentage of suicide deaths in the Rosenwohl-Mack et al. study, along with the prevalence of mental health disorders, suggests severe negative self-concept among intersex individuals in the study. The researchers also noted that approximately one third of the participants had reported that they had previously attempted suicide. Extrapolating on the work of Rose and the statistics provided by Rosenwohl-Mack et al., one can draw some tentative conclusions. If bias, either implicit or explicit, can contribute to disparities in health care, one can speculate that disparities in health care based on provider bias could contribute to negative self-concept and development of psychological disorders in intersex individuals.

Migeon et al. (2002) are only a few of many researchers to conduct research into the outcome of arbitrary gender assignment via genital reconstruction surgery. Schönbucher et al. (2012) performed a literature review of databases covering 1966-2008 to provide an updated review of intersex persons and their sexual quality of life. They found different results than Migeon et al.. The sample sizes included in the Schönbucher et al. research ranged from 3-72 individuals between the ages of 14 and 70. In 21 studies of individuals with the 46,XY intersex condition who had had genital reconstructive surgery, most reported less physical satisfaction with their sexual functioning. There was no specific number or percentage noted by Schönbucher et al. However, the results speak to the bias inherent in arbitrarily assigning gender and surgery without the consent of the intersex individual.

Diproperzio (2014) stated there should be a team of professionals to help parents make decisions about the sex of their child; these professionals include a pediatric endocrinologist, a urologist, and a psychiatrist. However, Diproperzio also believed doctors and parents should determine the assigned gender for a child, with the outcome in all probability to be what a child is more likely to feel growing up. Diproperzio (2014) also reported that Dr. Devore, a clinical psychologist whose specialty is sex therapy, believed that you should not force a child into an identity that might not be a good fit later in their life. Diproperzio's research is indicative of a shift in attitudes toward intersex. The focus on how the child's assigned gender fits with the adult's perceived gender identity later in life is indicative of a shift from biased attitudes toward better understanding of intersex on the part of the providers.

Christmas (2013) proposed that many intersexed individuals hesitated or refused to be involved in research studies because of their previous negative physical and emotional experiences with doctors and hospitals. Christmas interviewed five individuals, whom she recruited by different methods. She met with gay, lesbian, bisexual, transgender, intersex, and queer/questioning (GLBTIQ) organizations and gave presentations regarding her research to conferences and meetings organized by different organizations. The ages of the participants were not identified other than as young adults. One parent of an intersex child that Christmas (2013, p. 145) interviewed gave the following comment: "As a child you're wearing a girl's school uniform or a boy's school uniform... you have to be one or the other. Every single child in New Zealand – and when they are growing up alongside other little children, every child knows that everybody's either a boy or a girl. Children are black and white. Adults can be grey as much as they want to, but children are not."

In her book, *Bodies in Doubt: An American History of Intersex*, Reis (2009), detailed the experience of some intersex individuals and their suffering as a result of genital reconstructive surgery. According to Reis (2009, p. 153), she reviewed “hundreds of cases” of hermaphrodite and intersex individuals in both medical and popular literature. She explained how definitions and understanding of intersex have changed over the years, and how these shifting definitions have caused tensions regarding what was considered normal and natural. Although the intent was to illuminate the mistake of performing arbitrary gender assignment through involuntary surgeries, the author’s use of language is significant. By emphasizing *shifting definitions* of what is considered *normal* and *natural*, she draws attention to the existence of a widespread professional bias toward intersex as abnormal and unnatural.

Despite numerous examples of negative consequences, some researchers found higher life satisfaction following genital reconstructive surgery (Dr. C. Reynolds, personal communication, March 24, 2014). Pediatric urologists and other medical professionals perform genital reconstructive surgery and work with successful intersex transformations for whom the gender assignments were considered appropriate by the intersex individual (Dr. J. Jones, personal communication, January 12, 2016). Based on professional experience, Dr. C. Reynolds made the argument that emotional scarring would be worse without the early assignment surgeries (Dr. C. Reynolds, personal communication, March 24, 2014). Zucker (2002) came to the same conclusion after reviewing related cases he had previously completed. There was no mention of any mental health issues with these individuals.

The research conducted by Zhu et al. (2012) does not appear to support the experience reported by Reynolds and the work of Zucker (2002). Zhu et al. (2012) evaluated the quality of life with the intersex condition, using 84 participants between the ages of 6 to 17 who met the criteria for a disorder of sexual development. Fifty had complete follow-up data and were included in the study. Most of the participants (42/50) were assigned the female gender. One half of the participants assigned the male gender in the study (8) displayed social limitations and had poor inter-social communication with family or other children. In addition, they had academic difficulty in school. Twelve of the 42 participants assigned the female gender also displayed social limitations and had poor academic performance. Zhu et al. (2012) reported the participants displayed psychological problems such as depression and somatic complaints. In addition, they exhibited behavior problems, often displaying violent behavior. The results of the study by Zhu et al. denoted the complexities that an individual faces when dealing with intersex conditions. I was unable to find an exact number of actual surgeries performed in the United States each year; however, as of September 2017, there were currently approximately 222 studies regarding intersex or disorders of sexual development (National Institute of Health, 2017). These trials are occurring in various hospitals throughout the United States.

Recent research suggests that provider attitudes toward intersex and treatment of intersex individuals may have changed over the last 25 years. There appears to be a growing disparity in thinking by doctors and parents regarding how to handle intersex uncertainties, which may contribute to emotional complications and difficulties with social experiences for those with an intersex condition. Even surgeons’ opinions are divided; some believe immediate reconstructive surgery is the way to handle intersex conditions while other surgeons believe that it is better to wait until the child is older (Davis & Murphy, 2013). It is significant to note that many surgeons do not see the need to perform surgery immediately after birth unless there is an actual physical emergency (Davis & Murphy). Davis and Murphy carried out 65 interviews with medical professionals, parents of intersex children, and intersex individuals themselves, which lasted between 45 minutes and three hours each. The purpose was to address why unnecessary intersex surgery was continuing and how it was being justified. There were four institutions from which the participants were recruited: Intersex Society of North America (ISNA), Accord Alliance, The Androgen Insensitivity Syndrome Support Group-USA (AISSG-USA), and Organisation Intersex International (OII) (p. 136). The participants were chosen from these organizations because the organizations themselves appeared to be involved in intersex advocacy in various ways (Davis & Murphy). ISNA and OII were activist organizations, AISSG-USA was a support group, and Accord Alliance was an organization seeking to distribute educational resources to medical professionals (p. 136). Davis and Murphy discovered several reasons why intersex surgery was still occurring even after the 2006 consensus statement that surgical intervention should be avoided unless it promotes a “functional outcome rather than a strictly cosmetic appearance” (Lee et al., 2006, p. 491). Justification included the opinion of medical professionals who stated that society still thinks in black and white, male and female; parents usually want gender ambiguity resolved quickly. In addition, the medical professionals also cited cosmetic reasons. The conclusion of the study was that unnecessary surgery will continue to occur until society disentangles sex from gender, understands that gender is fluid, and no longer sees intersex bodies as either deviant or abnormal (Davis & Murphy). It did not appear that mental health providers were included in any of the studies that viewed the intersex individual as requiring any special help for their depression or other emotional difficulties.

Although Davidian (2011, p. 9) did not do his own research but rather conducted an extensive literature review, his findings agreed with Davis and Murphy (2013, p. 148) that doctors should not construe intersex as an emergency when there is no medical problem, nor should they try to convince parents to allow their children to have genital reconstructive surgery at an early age.

According to Lee et al. (2006, p. 491), the medical community's consensus statement that surgical intervention should not be performed unless it will promote a functional outcome rather than only cosmetic is not always followed. In reviewing literature, Lee et al. (2006, p. 491) concluded that surgical professionals frame their surgery as emergencies in order to justify the genital reassignment.

Boyle et al. (2005) advocated the necessity of waiting to impose genital reconstructive surgery for adult intersexed individuals. Their goal in performing the study was threefold: the decision-making process for surgery, the surgical experience itself, and the perceived outcome of the surgery. Six participants were obtained from a women's support group and asked to participate in a semi-structured interview. The women were given a choice between being interviewed in their homes or in a hospital setting. Four accepted the interview in their homes and two were interviewed in a hospital psychology department. The interviews were recorded and lasted between one and a half and two hours. The participants ranged in age from 27 to 52, and their age at surgery was between

19 and 43. There were three types of surgical interventions noted: clitoridectomy (1), vaginoplasty (4), and dilators only (1). Three of the participants had one surgery, and two participants had two surgeries. One of the participants was divorced, two were with a male partner, including the divorced individual, and four were not in a relationship. The clinical implications of the research by Boyle et al. (2005) were that medical professionals need to reconsider what information to give to the individuals considering surgery, to encourage earlier and more in-depth reasoning to see that surgery is not the inevitable and only solution, and to give medical professionals more of a vocabulary to discuss intersex and surgical solutions with their patients. The Intersex Society of America (ISNA) has been vocal against performing surgery on children until the child can have input into the surgical process; however, the ISNA has not addressed surgery pertaining to adults (ISNA, 2014). The fact that the ISNA is strongly against surgeries without input on the part of the intersex individual is a clear indicator of a shift in attitudes toward intersex.

Literature Review Related to Research Design

My study used a qualitative approach. Sauro (2015) explained the intersex condition is not well enough defined to lend itself explicitly to quantitative research. Mental health providers have not been studied regarding their ideas regarding intersex, and this is a problematic issue. Further, the complexity of the subject matter goes beyond numbers. Understanding the context of an intersex individual, as well as their environment, is extremely important; quantitative research would not be able to cover this type of information. One also needs to explain the thinking of the individuals behind the responses. Taking into consideration the complexity of the factors just listed and the depth to which they must be explored, qualitative measures fit the intersex problem well. Therefore, qualitative methods were better suited to establish a testable hypothesis. Husserl (2011) believed that intuition and logical thinking were the principal methods in fully understanding a phenomenon. For the purposes of my study, I reviewed whether the attitudes toward types of treatment of intersex individuals had changed over the past 25 years, the difference in treatment between intersex and non-intersex individuals, and the question of a possible increase in psychological disorders among intersex individuals.

By using a questionnaire that had been specifically geared toward mental health providers, the responses to this research instrument fit well into my qualitative study. When completed, the questionnaire provided information regarding how the providers currently conceptualize and evaluate the intersex individuals whom they see.

Summary

The research reviewed in Chapter 2 revealed that there has been no designated study among mental health providers regarding their views and opinions of intersex. The existing research suggests widespread and long-standing professional bias against intersex individuals. Current research also suggests there is a growing verbalized consensus regarding how to handle intersex conditions in a way that will minimize psychological damage to the individual. However, no specific study has been forthcoming regarding attitudes of mental health providers toward intersex and the treatment of intersex.

Chapter 3 explains the research design and how the data collection was conducted. It further discusses the population and how the participants were obtained. The data analysis is also explained.

Chapter 3: Methodology

Introduction

Chapter 3 presents a description of the research design, the participants, the research instruments used, the data collection procedure, and the statistical treatments used to determine whether the attitudes of mental health providers toward the types of treatment offered to intersex individuals have changed over the last 25 years and how those changes have impacted their practice. The methodology will also examine the degree to which changes in treatment between intersex versus non-intersex individuals have occurred over the past 25 years. The last area to be determined is the lived experience of mental health providers and their belief in the possible increase in psychological disorders of intersex individuals over the last 25 years. The use of structured questions in the questionnaire is well suited to the purpose of this qualitative study.

Research Design and Framework

When using the qualitative approach, there are five primary research designs that can be used: phenomenology, ethnography, grounded theory, case study, or a narrative research study (Lewis, 2015; Merriam & Tisdell, 2015). According to Butina (2015), the narrative approach involves inquiry directed at narratives of human experience or inquiry that produces data in narrative form. One of the methods of the narrative approach includes collecting data from individuals or small groups (Butina, 2015). This study used a questionnaire to collect data. While the concept of intersex life can be perceived as a phenomenon, it was the narrative of the providers that I was interested in collecting.

In using the narrative inquiry approach, data were classified according to its significance for each mental health provider. Providers were divided into four age ranges: 20-30; 31-40; 41-50; 51+. These groups were then examined for trends. However, there were not an equal number of participants in each group and an insufficient number of participants in each group to explore potential trends between groups.

The questionnaire that was used allowed the participants the opportunity to express their beliefs and attitudes toward all types of mental health treatment for intersex individuals. Employing the narrative inquiry framework enabled me to analyze and explore the mental health providers' beliefs regarding the question of an increase in psychological disorders among intersex individuals.

The theoretical framework for this study was a qualitative research model (Creswell, 1998, 2009, 2013, 2015). To fully comprehend the mental health providers' attitudes toward different types of treatment for intersex versus non-intersex individuals, and potential attitudinal changes toward intersex individuals over the past 25 years, qualitative methods were used in the study. The qualitative methodological approach was chosen as it can fully explore 25 years of mental health involvement with intersex individuals. Qualitative methods also allowed me to identify how the interactions between mental health providers and intersex patients may have changed over the same 25-year period. To employ qualitative methodology effectively for my study, a questionnaire was used. Results were determined by statistical analysis of the mental health providers' questionnaire data (Nastasi, 2005; Polkinghorne, 2005).

The qualitative research design was also chosen because it is grounded in the social constructivism viewpoint, which emphasizes the importance of culture and context in perceiving what happens in society, and then builds knowledge based on this understanding (Bhandari, 2020; Creswell & Creswell, 2017). Especially important in choosing a qualitative methodology was the fact that sample sizes can be either small or large and the overall goal of the study can still be achieved (Jha & Devi, 2014). While a quantitative approach was originally viewed as a possible choice for this study, Table 1 reflects the justification for my choice of a qualitative research design.

Table 1

Key Features of Qualitative and Quantitative Research Strategies

Qualitative	Quantitative
Seeks to explore, explain, and understand phenomena – What? Why?	Seeks to confirm a hypothesis about a phenomenon – How many?
Data provided as a narrative, pictures, or objects	Data is in the form of numbers and statistical results
Methods less structured – Data gathered through interviews, observations, content analysis, etc.	Highly structured methods – Data gathered through the use of tools, equipment, questionnaires, etc.
Asks open-ended questions in an effort to explore	Asks closed-ended questions that give quantifiable answers
Research design has flexibility – can emerge and evolve as study develops	Research design is highly structured and laid out in advance of the study
Results may be presented subjectively – may reveal biases, values or experiences that impact how the results are interpreted	Results are documented using objective language

Note: Center for Innovation in Research and Teaching (Grand Canyon University, Arizona, n.d.).

Research Questions

The limited scope of this qualitative study focused on questions that helped me better understand the lived experiences of treatment providers for the intersex population. This study focused on the following:

RQ1. As time changes, so do attitudes. How do mental health providers view attitudinal shifts in working with the intersex population?

RQ2. In the psychological literature, new and innovative methods and theories continue to be created. How do mental health providers view changes in theory over the course of their work?

RQ3. As new editions of the DSM have emerged with time, so have psychological disorders. How do mental health providers view these changes when working with the Intersex community?

I ascertained the data with the following questions:

IQ1. Based on your lived experience as a treatment provider, how do you believe attitudes have changed over the past 25 years with regard to working with the intersex population?

IQ2. As a mental health provider who has participated in a variety of empirically validated treatment modalities, how has the treatment of those who are in the intersex community changed over the course of your professional practice?

IQ3. As a mental health provider, what beliefs do you have about the prevalence of certain psychological disorders found within the intersex community? Do you see any trends? If so, what are they?

Setting

Data collection occurred via email to mental health providers. I have completed the National Institute of Health Office of Extramural Research web-based training course “Protecting Human Research Participants” (see Appendix A). This course was designed to prepare investigators who are involved in conducting research that involves human subjects and to help them fully understand the obligations they have to protect the rights and welfare of subjects in their research.

The time required to complete the questionnaire was approximately 30 minutes to 1 hour. Since most of the questions were open-ended, time may have varied. There were no special resources required to complete the questionnaire.

Participants

Participants for the qualitative methods study were mental health providers who may or may not have interacted with intersex individuals. Participants were chosen by contacting mental health providers in many small towns and cities including the following: Bangor, ME; Orlando, FL; Albany, NY; Mobile, AL; Caspar, WY; Wooster, OH; Houston, TX; Lancaster, OH; Columbia, MD; Washington, DC; Philadelphia, PA; Santa Barbara, CA; and Tucson, AZ. The sample size for my phenomenological study was 10 participants as this is an adequate number to answer the research questions. Creswell (1998) suggested that five to 25 is an appropriate number of participants, while Morse (1994) recommended at least six persons when participating in a qualitative study. The number of participants is based on a determination of when data saturation occurs (Fusch & Ness, 2015), and when there is enough information to replicate the study (O’Reilly & Parker, 2012).

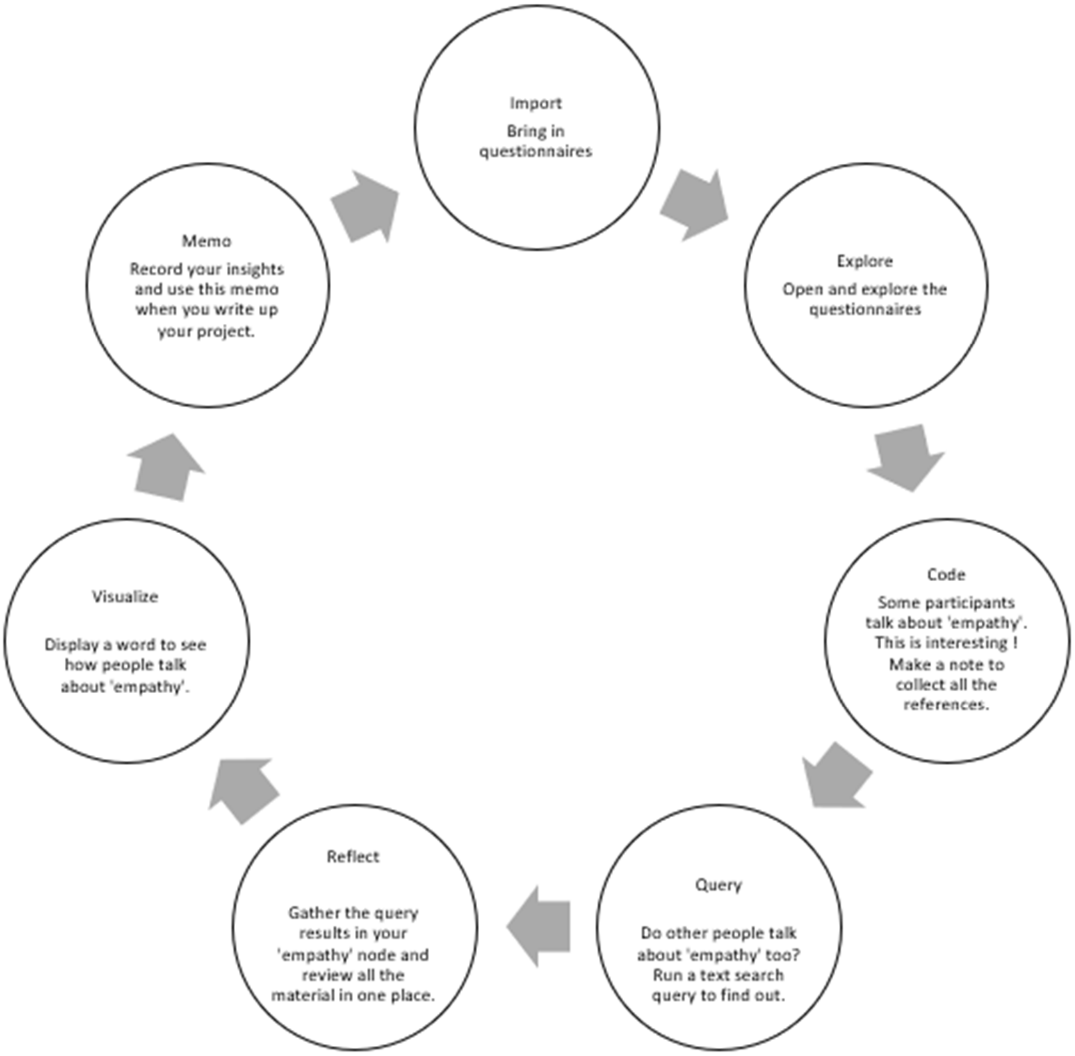
In a qualitative study, the decision regarding the number of participants becomes a reflection the study's purpose. Ten to 12 participants may prove sufficient in qualitative inquiries involving the understanding of experiences and perceptions of participants (Wu et al., 2015). A successful purposeful sample in a qualitative study could range from 1 to 40. Larger sample sizes have the obvious advantage of providing more data with which to work (Zamboni, 2018), and qualitative design would be better served by the larger sample size.

Data Collection

The instrument used to collect data was a questionnaire. The questionnaire was emailed to mental health providers who had agreed to participate in the study. The questionnaire was prepared based on the research questions. As this study sought to provide an in-depth look into the history and thinking of those mental health providers who work with the Intersex population, there was the general hope of completing a thematic comparative analysis. All data were collected and coded, and then entered into NVivo12, a qualitative software package. Figure 3 is an example of how the interface between the input of the coded data and the writing in the final project.

Figure 3

Example Using NVivo12 for Qualitative Research



Note. Adapted from www.qsrinternational.com

No face-to-face participation was conducted during this process. As mentioned earlier, this study also included a detailed analysis of the attitudinal shifts and theoretical adaptations that may contribute to how mental health work with this population is ever expanding.

Participant Selection

Participants were initially contacted by email to determine their interest in the study and to explain the study itself. The email included my name, address, telephone number, and email address (Appendix A). In addition, a Consent Form was included for them to sign agreeing to participate in the study (Appendix B).

Data Analysis

A coding protocol was used to gather data from the questionnaires. Data collected on this protocol form were then imported into NVivo12, which I used as the key instrument for data encoding. The NVivo12 software was identified by the literature as a standard instrument for qualitative data coding, which allowed further analysis (Siccama & Penna, 2008) and permitted me to prepare bubble clouds. The software application allowed me the ability to collect and analyze/organize unstructured and/or semi-structured coded data. The software is sectioned off into the following features: Analyze cases, which provides initial comparative analysis; Sets of data, which organizes and groups all similar data; Attributes and classifications, which outline those factors that are distinctly different from other concepts; Nodes, which are codes to signify themes and subthemes; Queries; which allow researchers to ask meaningful questions of the data collected; and Matrices, which help the researcher to cross-tabulate related information.

I obtained, organized, and coded all factors gathered to study the chosen mental health providers. The plan for coding included reading through the questionnaires repeatedly and coding them throughout the analysis. I further scrutinized each concept that described an attitude or idea and began to code several anticipated themes and emergent themes that appeared often in the literature related to attitudes from health care professionals. The first order coding separated the common attitudinal ideas and the second order coding allowed me the opportunity to discern how the themes were reliable with this particular group of mental health service providers either working with or understanding of intersex individuals. I used constant comparison in the analysis to ensure that the thematic analysis represented all perspectives. By using the rich data of experience, and evidence gathered from the participants, the features of the NVivo12 software was employed (See example of flowchart using NVivo12 in Appendix B). Thus far it has been found that every attitude tends to motivate behavior and potentially a treatment approach. The goal of including attitudinal data was to provide a more detailed analysis that may lead us to better understand factors associated with the mental health providers' treatment tendencies. Each provider chosen for this study provided a unique look into the mind of a Scientist/Practitioner working with Intersex populations. Every piece of data included and analyzed played a vital role in the development of this study. Once the data was processed through NVivo12, I proceeded to cluster the data into categories of attitudes, feelings, and commonly used words to describe competence, beliefs, and attitudes. After using a coding chart I created, I began to chart the concepts through the interpretation stage. This process helped me fully understand the research questions. (See example coding chart in Appendix C.)

Summary

Chapter three included a discussion of my research, which utilized a qualitative narrative approach using both social constructivism theory and gender variant phenomenon. My role as the researcher was that of collecting the data from the questionnaire, determining themes, and inputting the data into NVivo12, the software package for coding, analysis, and interpretation.

Chapter 4: Results

Introduction

The purpose of this qualitative research was to better understand mental health professionals and their attitudes toward working with intersex individuals. I engineered three questions to understand the mental health professionals' attitudes and perspectives regarding their beliefs about intersex individuals. Walden University IRB granted research approval in March 2021 to conduct this qualitative study to research mental health care providers' attitudes toward treatment of intersex individuals and how their attitudes might have changed over the past 25 years (Approval number 03-24-21-0039650). For my qualitative study, I sought to determine whether bias was inherent in the way in which the providers worked with intersex individuals. I asked three specific questions: How do mental health providers view attitudinal shifts in working with the intersex population? How do mental health providers view changes in theory over the course of their careers? How do mental health providers view the changes when working with the intersex community? The purpose of Chapter 4 is to document and report the findings of this study using data collected from participants recruited from Bucks County in Pennsylvania and Tucson, Arizona. To determine answers to the research questions, a survey was used with the following questions:

IQ1. Based on your lived experience as a treatment provider, how do you believe attitudes have changed over the past 25 years with regard to working with the intersex population?

IQ2. As a mental health provider who has participated in a variety of empirically validated treatment modalities, how has the treatment of those who are in the intersex community changed over the course of your professional practice?

IQ3. As a mental health provider, what beliefs do you have about the prevalence of certain psychological disorders found within the Intersex community? Do you see any trends? If so, what are they?

Chapter 4 contains both a description of the setting of the study and the demographics of the participants. Chapter 4 also includes a description of the data collection and analysis as well as the results. The study consisted of 10 mental health professionals who worked with or knew about intersex individuals. The data collection method using a prepared questionnaire and the evidence of trustworthiness are summarized in this chapter. The results are presented in the form of themes from data analysis using NVivo12 software. The themes are analyzed for relationships to formulate the theory for this qualitative study. The chapter is concluded with a summary.

Research Setting

The setting for my study was in Bucks County, Pennsylvania and Tucson, Arizona where the participants live and work. My focus was on mental health providers who either treated clients who were intersex or may have had knowledge of intersex individuals. I reached out to different practitioners in several states including Georgia, Arizona, Pennsylvania, and California. The respondents came from Pennsylvania and Arizona, with no responses from either Georgia or California.

Demographics

My study consisted of 10 mental health professionals who may have worked with intersex individuals; however, it was not necessary that they had done so. Of those who participated in the study, seven (70%) were women and three (30%) were men. Three (30%) of the participants had a Ph.D., one had a bachelor's degree (10%), one had a PsyD (10%), and five had a master's degree (50%). The participants ages were mixed: one individual was between 20 and 30; two were between 31 and 40; two were from 41 to 50; and five were 51+ (See Table 2). Convenience sampling was used in this study as it was uncomplicated, efficient, and inexpensive. This ensured that the study would be completed in a timely manner.

Table 2

Participant Demographics

Participant	Sex	Age range	Degree
P1	F	51+	Ph.D.
P2	M	51+	Ph.D.
P3	F	31-40	Ph.D.
P4	F	20-30	Bachelor
P5	F	41-50	Psy.D.
P6	M	51+	Masters
P7	F	51+	Masters
P8	F	31-40	Masters
P9	F	51+	Masters
P10	M	41-50	Masters

Data Collection

Data for this narrative study were collected using a questionnaire that would answer the research questions. Participants were selected using a convenience sampling technique, for which I used mental health providers who expressed an interest in my topic.

A letter was emailed to the potential participants explaining the study. A Consent Form and the questionnaire was also sent to the 10 participants. The Consent Form was used to protect the participants' rights and also to explain the limits of participation and the scope of the study. The participants were asked to return the signed Consent Form and the questionnaire via email. All but one emailed the documents. One individual asked to mail it via USPS instead and was given my address. There were no participants who chose to withdraw from the study after agreeing to participate.

Data Analysis

I asked 10 individuals to fill out questionnaires to determine the answers to three questions. The first question requested their response to attitudinal changes in working with the intersex population. After receiving the questionnaires, I entered their answers into a spreadsheet to better identify and understand the themes. There were three major themes that emerged from the first question (see Figure 4). These themes were acceptance, attitudes, and understanding. Although there were several subthemes, I chose to use only the major themes to better clarify the analysis.

Figure 4

NVivo12 Results for Question 1

Themes from Question 1

Theme 1. Acceptance

Participant 1 (P1) believed that people were more accepting of intersex and were letting their children choose when or if they should have surgery. Another participant (P2) had not heard of intersex 25 years ago and had only heard about hermaphrodites as a medical term. P3 believed that although there has been a huge growth in the acceptance of transgender individuals, not as much knowledge is available about intersex individuals. P6 believed that as more information has emerged, there is a greater focus on acceptance.

Theme 2. Attitudes

P4 believed that attitudes toward intersex individuals had changed dramatically in the last 25 years. P7 also believed that attitudes had changed over the past 25 years.

Theme 3. Understanding

Participant 10 (P10) believed that the LGBTQ populations have become more visible and further believed that as intersex continues to be more visible, there will be more understanding of this population also.

The second question asked the participants how the treatment of those who are in the intersex community may have changed over the course of their professional practice. There were three major themes that emerged from this question (see Figure 4). The themes were understanding, trauma, and treatment.

Figure 5

NVivo12 Results for Question 2

Themes from Question 2

Theme 1. Understanding

P1 explained that the issues surrounding sexuality specifically and non-binary in particular has opened up discussions regarding choice for an individual.

Theme 2. Trauma

P2 considered that when an intersex individual had surgery to change from a sex that later turned out to be other than what the individual believed themselves to be, it could cause significant emotional trauma.

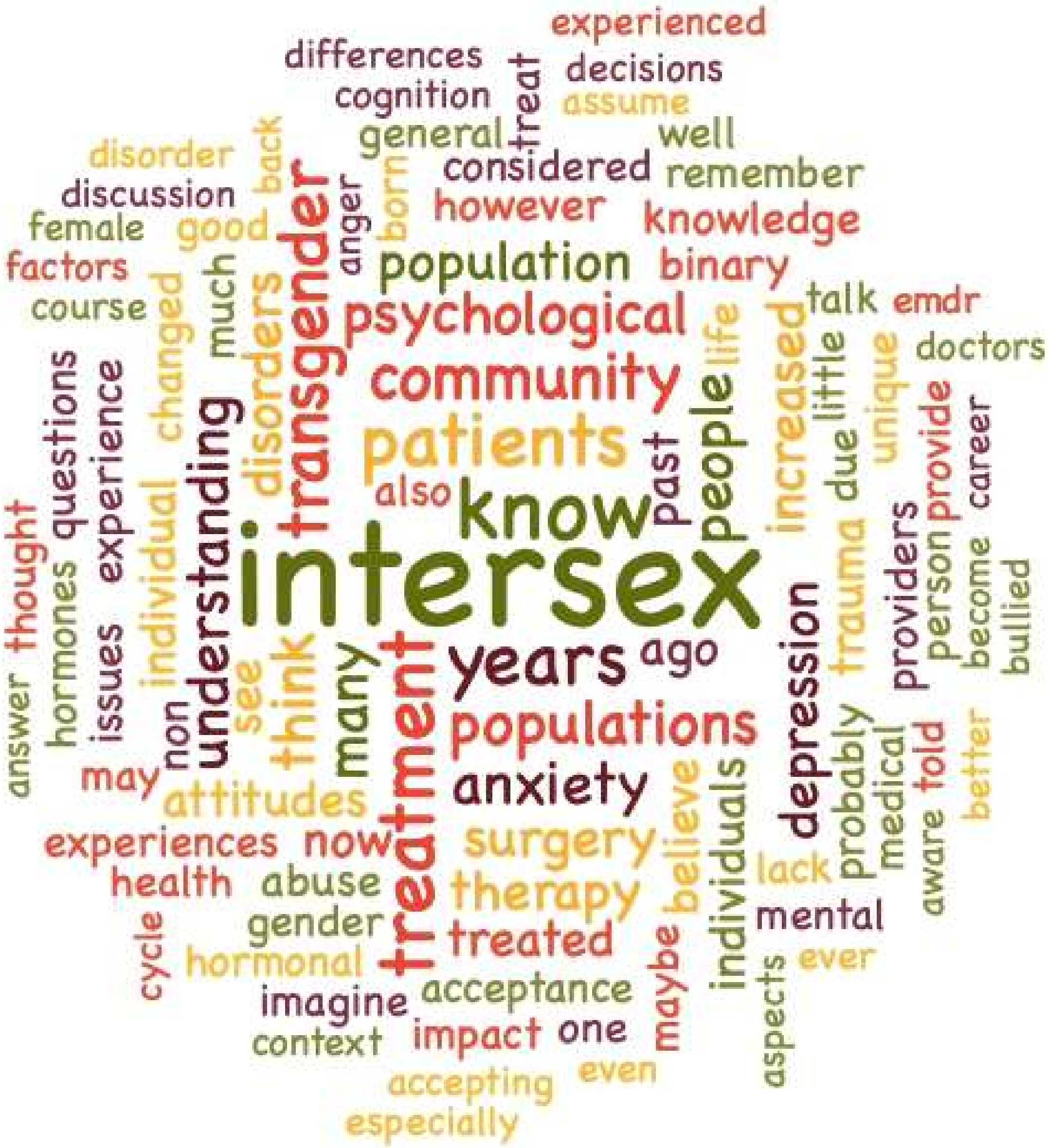
Theme 3. Treatment

P4 suggested that treatment of the intersex community is improving, and that intersex patients are able to seek treatment without fear of cruelty.

The third question asked the participants what beliefs they have about the prevalence of certain psychological disorders found within the intersex community. The question further asked for their perception of any trends. There were three major themes that emerged from this question (see Figure 6). These themes were depression, anxiety, and trauma.

Figure 6

NVivo12 Results for Question 3



Themes from Question 3

Theme 1. Depression

P2 noted a plethora of depression and anxiety in transgender patients and believed the same would be true of intersex individuals. P10 believed the intersex population would have an increased chance of suffering from depression.

Theme 2. Anxiety

P2 expressed a belief that anxiety and a suicidal nature could be seen if the individual were misunderstood, made fun of, or bullied. P4 also believed that intersex individuals had a higher risk for generalized anxiety disorder. P10 believed that there would also be an increased chance of anxiety in this group.

Theme 3. Trauma

P8 explained that although they have not worked with any intersex individual of whom they are aware, trauma could be more prevalent in this group.

None of the research participants had knowledge of the term intersex. Only one participant mentioned the term hermaphrodite, and this participant did not mention knowing the term hermaphrodite had changed to intersex in the 1940s. Two participants equated treatment of intersex with LGBTQ and/or transgender individuals. However, no participant reported knowledge or understanding of the unique characteristics or specific treatment of intersex.

Evidence of Trustworthiness

I ensured that my research met the four tenets of trustworthiness proposed by Lincoln and Guba (1985). Those principles were credibility, transferability, dependability and confirmability.

Credibility

According to Lincoln and Guba (1985), credibility is the confidence that can be placed in the truth of the findings. This establishes whether the findings represent plausible information from the source data. In my study, credibility was established. I have confidence of the truth of the findings; the data has been correctly interpreted and the findings accurately represent plausible information from the source data.

Transferability

Transferability explains that the methods and findings from my study can be used in other environments as well. In order to ensure my study has transferability, I have explained in a step-by-step manner the methods used, and the setting of my methods chapter.

Dependability

As my methods chapter was written in explicit detail, someone else can follow the same decision-making process that was used in my study and subsequently understand the choices that were made. Another way to ensure dependability would have been to ask another researcher to assist with data analysis.

Confirmability

With the first three principles of Lincoln's and Guba's (1985) guidance established, confirmability has been established. To enhance my confirmability, I maintained a reflexive journal of my ideas, individuals to whom I emailed my study, and the time it took to start and end the study.

Summary

Chapter 4 provides methodical parameters describing the process of data collection and how the data was analyzed. Both Braun and Clarke (2006) and King (2004) contended that thematic analysis is a useful method to examine the perspectives of different research participants, therefore highlighting similarities and differences and allowing unanticipated insights to be generated. I presented the themes for each of the answers to my initial questions. I then explained the data analysis and the use of the NVivo12 qualitative analysis component. The results of my research revealed unexpected results.

Chapter 5 will provide an in-depth summary of my research analysis as well as a review of the purpose and nature of the research. Chapter 5 will include a discussion of the study's relevance as it relates to the literature review as well as the lack of literature, knowledge, and training of intersex as it pertains to mental health providers. I also included a discussion regarding the study's limitations, recommendations for future research studies, and the anticipated implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

My qualitative study was designed to explore the attitudes of mental health providers toward intersex individuals. Specifically, the qualitative questions are as follows: RQ1: As time changes, so do attitudes. How do mental health providers view attitudinal shifts in working with the intersex population? RQ2: In the psychological literature, new and innovative methods and theories continue to be created. How do mental health providers view changes in theory over the course of their work? RQ3: As new editions of the DSM have emerged with time, so have psychological disorders. How do mental health providers view these changes when working with the intersex community?

I received the mental health providers' responses to my questionnaires in a timely manner and analyzed them. After identifying several themes from the results, I used the NVivo12 software program to find more themes than the ones I originally identified. Using NVivo12, I prepared a word cloud diagram for each of the three questions on the questionnaire.

In Depth Data Analysis

After reviewing the diagrams and the respondents' comments to the survey questions, I observed that 100% of the respondents believed they had had no experience with intersex individuals. Further, they were all unfamiliar with the term. Although one respondent was familiar with the term hermaphrodite, no respondents indicated any knowledge or understanding of the unique intersex population. Most of the research participants stated they did not believe they had ever treated an intersex individual. Those who had treated LGBTQ individuals believed the psychological disorders prevalent in the LGBTQ population would be similar to those of intersex individuals.

Relevance of the Results to the Literature Review

There is a significant lack of previous research studies on the topic of intersex as it pertains to mental health providers. There are many articles regarding the medical profession's views on intersex and genital assignment surgery as the commonly accepted approach to treatment. However, there was and still remains controversy regarding how to actually treat a child medically and psychologically who is born with an intersex condition.

Limitations of the Study

The major limitation to the study is the sample size of 10 participants. Although more than 50 potential participants were invited to participate, only 10 responded. However, it is significant and cannot be ignored that 100% of the respondents who responded had no knowledge of intersex.

Implications for Social Change

Although the data did not produce the expected results regarding attitudinal changes over the past 25 years, the results were significant. The significance lies in the illumination of a glaring void in training programs for psychologists. Although the term *intersex* has been in use since 1917 (Goldschmidt, 1917) and specifically used to describe individuals possessing complete or partial reproductive organs of both males and females since 1940 (Cawadias, 1943), the unique intersex population does not appear to be considered or addressed in psychology training programs. Further, there was no awareness among the research population of mental health workers that intersex is a condition unique unto itself, and it is a disservice to equate intersex with the LGBTQ and transgender populations. Further, we cannot arbitrarily assume intersex individuals to develop the same psychological disorders that might be prevalent among the LGBTQ population.

Recommendations for Future Research

There are several recommendations for future research as it pertains to mental health providers' understanding of intersex and possible ways to better serve the intersex population. Replication of this study with a larger and more diverse research population is needed. Should such research produce similar results, a review of the curriculum in training programs for psychologists would be indicated. A survey of directors of university training programs may reveal the apparent lack of attention to intersex as a distinct and unique population and may potentially lead to changes in the curriculum to include specific training regarding intersex as separate from LGBTQ and transgender.

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Appendix A: Letter to Potential Participants

March 10, 2021

Good morning,

My name is Jane Johnson. I am a student at Walden University where I am currently engaged in recruiting a minimum of 20 mental health providers to participate in my research, which is in partial fulfillment of requirements for a PhD in Psychology. I am working under the supervision of my doctoral committee, Dr. Barbara Backlund and Dr. Christopher Bass.

I am sending this email to request your participation in completing a brief survey regarding mental health providers attitudes toward treatment of intersex individuals. I believe mental health providers have been under-studied in regard to their opinions and ideas concerning the intersex population. The survey should take no more than 15-30 minutes to complete. The survey is completely confidential. To protect the privacy of your responses, no participant names will be used in the dissertation or for any other purpose, and all raw data will be maintained in a locked file cabinet in my home office. Participation is strictly voluntary. You may choose to stop at any point in the questionnaire. There is no penalty for stopping or for non-participation.

Although there are no foreseeable physical or emotional risks to participating in the study, there may be a small risk of fatigue or of becoming upset by one of the three main questions on the survey. For example, one of the questions is as follows.

Based on your lived experience as a treatment provider, how do you believe attitudes have changed with regard to working with the intersex population?

There may be an unforeseen risk of losing internet connectivity during the survey. However, there is no greater risk than that which occurs in normal daily life.

There is no compensation for completing the survey. However, there are many possible benefits. With the paucity of research investigating the intersex community, this population is often overlooked. This study will add to the body of literature that promotes diversity in the field with the intersex population. Mental health providers who work with this population will benefit from a deeper understanding of the attitudes and clinical practices related to diagnosis and treatment from practicing clinicians. In addition, information gleaned from this study may inform parents', physicians', and mental health providers' decisions regarding gender assignment surgeries.

A Consent Form is attached. Information on the form should answer all questions you might have regarding the nature of the study. Should you agree to participate, please sign and return the Consent Form to me using the contact information below. Your name and email address at the bottom of the form will confirm your agreement to participate and your understanding that this is a voluntary survey.

Thank you for your consideration. If you need further information regarding the study or have further questions, my contact number is [redacted], or you may email me at [redacted]. My mailing address is [redacted]

The following is the contact information for my committee members.

Dr. Barbara Backlund - [redacted]

Dr. Christopher Bass – [redacted]

Appendix B: Mental Health Provider Questionnaire

Circle your choice.

1. Age range: 20-30; 31-40; 41-50; 51+
2. Gender? Male, Female, Intersex, Other
3. Educational background? Bachelor; Master; Ph.D.
4. Currently work with intersex individuals. Yes – No
5. Ever worked with intersex individuals? Yes – No

1. Based on your lived experience as a treatment provider, to what degree do you believe attitudes have changed over the past 25 years with regard to working with the intersex population?

____

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2. As a scientist/practitioner who has participated in a variety of empirically validated treatment modalities, how has the treatment of those who are in the intersex community changed over the course of your professional practice?

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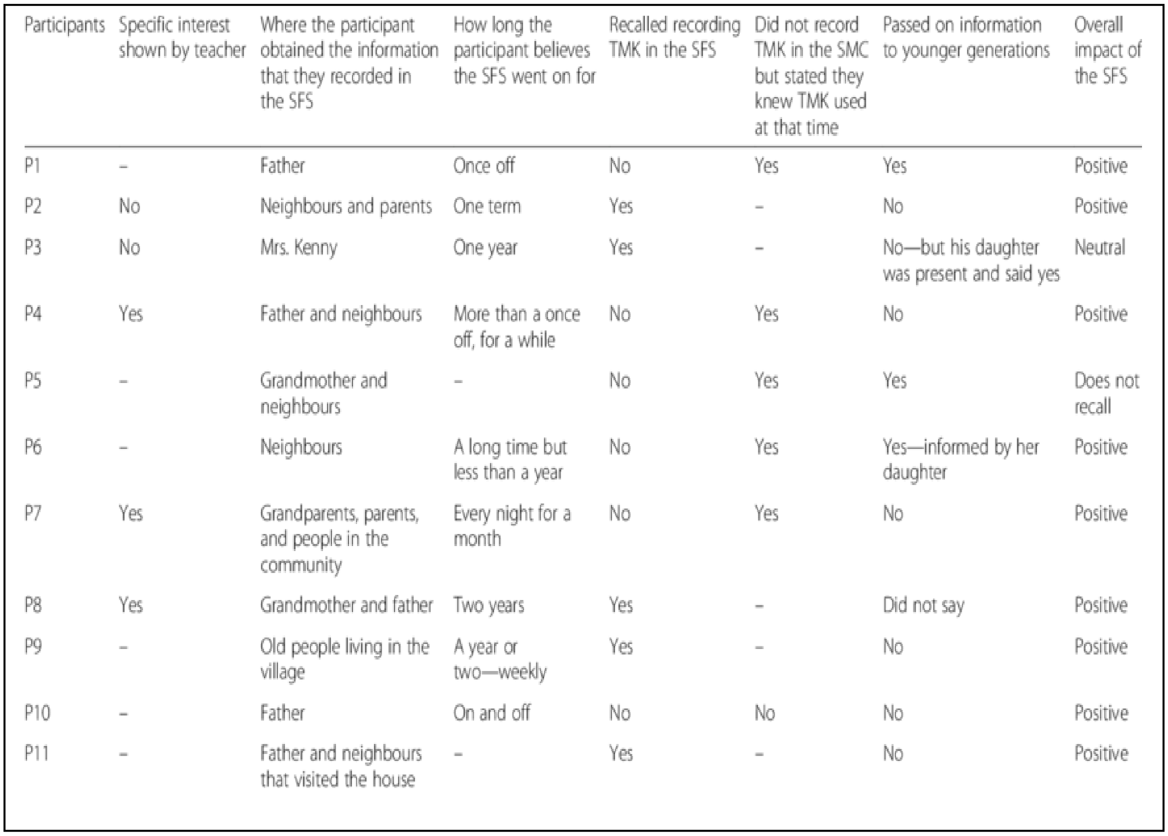
3. As a clinician, what beliefs do you have about the prevalence of psychological disorders found within the Intersex community? Do you see any trends? If so, what are they?

Appendix C: Coding Chart Example



Participants	Specific interest shown by teacher	Where the participant obtained the information that they recorded in the SFS	How long the participant believes the SFS went on for	Recalled recording TMK in the SFS	Did not record TMK in the SMC but stated they knew TMK used at that time	Passed on information to younger generations	Overall impact of the SFS
P1	–	Father	Once off	No	Yes	Yes	Positive
P2	No	Neighbours and parents	One term	Yes	–	No	Positive
P3	No	Mrs. Kenny	One year	Yes	–	No—but his daughter was present and said yes	Neutral
P4	Yes	Father and neighbours	More than a once off, for a while	No	Yes	No	Positive
P5	–	Grandmother and neighbours	–	No	Yes	Yes	Does not recall
P6	–	Neighbours	A long time but less than a year	No	Yes	Yes—informed by her daughter	Positive
P7	Yes	Grandparents, parents, and people in the community	Every night for a month	No	Yes	No	Positive
P8	Yes	Grandmother and father	Two years	Yes	–	Did not say	Positive
P9	–	Old people living in the village	A year or two—weekly	Yes	–	No	Positive
P10	–	Father	On and off	No	No	No	Positive
P11	–	Father and neighbours that visited the house	–	Yes	–	No	Positive