Cultural Influences in Research and Therapeutic Practice: A Counselling Psychology Perspective

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A Portfolio Submitted for the Award of Doctorate in Counselling Psychology (DPsych)

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September 2015

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Acknowledgements

Firstly, I would like to express my heartfelt thanks to all those men who came forward to take part in this research project. Their willingness to talk about their experiences has been invaluable.

I am very grateful to my research supervisor, Dr Deborah Rafalin, who has supported me throughout and for her patience in helping me to keep going and to develop my thinking along the way.

I would also like to thank my wife, Caroline, for her unstinting love and support throughout the process, with all its twists and turns. My children, Tom, Henry, Jack, Lily and George have all helped in their own individual ways, but especially through grounding me in what is truly important.

Lastly, I would like to thank Dimitra Lorentzatou, Rosemary Rizq and all my friends who have been there when the going got tough.

Declaration of Power of Discretion

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Part A: Preface to the Portfolio

The central linking theme between the parts of this DPsych portfolio is the consideration of cultural differences and their impact on research findings and therapeutic practice. I consider culture in its wide sense as 'The ideas, customs, and social behaviour of a particular people or society' (Culture [Def. 1], n.d.). I make no prescription as to the size of a particular group that may be considered as having a culture, and prefer to think of a multiplicity of cultures and sub-cultures some overlapping and others not. As Eliot (2010) has pointed out, from one point of view religion may be considered as part of culture but culture and religion may also be viewed as incarnations of each other. For the purposes of this portfolio, I generally refer to culture in the sense that it is also inclusive of religion, although sometimes I refer to religion by itself for the purpose of clarity.

I have been fascinated with exploring cultural backgrounds from my late teens onwards, whether living with tribes in Amazonia, Buddhist monks in Northern India or considering London's cultural diversity at home. My travels have particularly brought me face to face with the difficulties faced by marginalised cultures and their struggles against dominant ones. Cultural diversity has been one hallmark of the clients I have seen throughout my training. This has particularly been a feature of working on placement in a large male remand prison in London for the last three years. Many of the men I see have often lived in two or more different countries. They come from a multitude of cultural backgrounds with many having experienced sectarian or religious violence and civil war. I present a client study of one such man in Part C of this portfolio.

In one of my first placements, for a national mental health charity, I worked with a male client who experienced traumatic memories of being circumcised when he was about seven years old. He struggled with psychosexual issues and related these issues directly to the trauma he felt had been inflicted upon him as a child by the circumcision. Having myself been circumcised at a

similar age I was struck by the differences and similarities in our experiences. When trying to find research literature about male circumcision (MC) that might have helped my understanding of this client, it was clear that there was a paucity of research available. This acted as an initial source of my interest and a spur to carrying out research into this topic. In Part B, I present my research into 'Men's experiences of being circumcised men'. MC is well-known for its cultural origins. Perhaps less well-known is the variety of ways in which this ancient practice persists. Certainly, the voices of circumcised men themselves have been almost completely absent in psychological research even though The World Health Organization (2008) estimates that 660 million men alive today have been circumcised.

Part D is a literature review of cultural differences in Social Anxiety Disorder. This review was largely written at the end of my first year of training as my interest in cultural differences and their impact on mental disorder was growing. I have updated this review in the light of my current thinking, discussing how and why I have done this.

I hope that the reader may find this focus on cultural differences to be particularly relevant as Counselling Psychology continues to develop in the transformational era of the 'global village' (Wang & Heppner, 2015, p. 5).

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Part B: Research

Men's Experiences of Being Circumcised Men

Abstract

This empirical study explores 'Men's experiences of being circumcised men' using the methodological approach of Interpretative Phenomenological Analysis (IPA). Semi-structured interviews were undertaken with eight adult participants. The interview data was analysed using the IPA protocol (Smith, Flowers, & Larkin, 2009). From this analysis, three main themes emerged: The first is 'Who am I? – Circumcision and my Self' in which the participants' experiences of male group belonging, feeling different from other men, and their perception of others are explored. The second main theme is 'The physical experience – Circumcision and my body' exploring how the men talk about circumcision affecting their bodies, in the way it looks, feels and in terms of how they talk about health and the impact of the procedure itself. The final theme that emerges is 'Reflecting on the decision' in which the men's experiences of the choice that was made and their sense of whether it was 'right' are presented. The three main themes are discussed in relation to broad theories of body image, theories of identity and theories of male hegemony, drawing tentative links between these. Throughout the research process the impact of culture and context acts as a background that informs the study. The findings have implications for Counselling Psychologists who work with men who enter therapy and for whom such issues may remain unexplored. The research informs the male circumcision debate and offers a way of understanding opposing viewpoints. The quality, transferability and limitations of the study are considered together with a discussion of the findings in the light of theory and research. Areas for future research are suggested.

1 Men's Experiences of Being Circumcised Men

'There is nothing either good or bad, but thinking makes it so.'

(Shakespeare, 1603/1992, 2.1.266-267)

1.1 A Description of Male Circumcision

Male circumcision (MC) is a very common surgical procedure; Hammond (1999) estimates that 13 million circumcisions are performed annually. MC entails the partial or complete removal of the foreskin (prepuce) of the penis. The foreskin is the fold of skin at the end of the penis which consists of an outer part and an inner, sensitive, mucous layer (Cold & Taylor, 1999). Enough is removed to ensure that the glans is permanently exposed (Grossman & Posner, 1981). MC is practised worldwide for religious or cultural reasons, particularly amongst Muslims and Jews. In countries where it is carried out for non-religious reasons, as in the USA, the perceived health benefits of the procedure are often used to promote it as a medical practice. More recently, in Africa, MC has been promoted as a tool to help prevent the transmission of the Human Immunodeficiency Virus (HIV) (Weiss, Dickson, Agot, & Hankins, 2010). However, controversy and disagreement surrounds MC (Gollaher, 2000). Despite the fact that MC is generally accepted as being a low risk procedure, some research has questioned its need (British Medical Association, 2006). Furthermore, MC has been called the 'hidden trauma' by Goldman (1997, p. 2), who points to the possibility of psychological harm. MC is often reported as being a significant feature of male identity, through surgical alteration of the appearance of the penis and through what it symbolises (Zoske, 1998).

1.2 Prevalence

The World Health Organization (WHO, 2008b) estimates that 660 million men over the age of 15 have been circumcised, of whom 65% are Muslim. Almost 95% of Muslims are circumcised by adulthood, at an average age of six (Sahin, Beyazova, & Aktürk, 2003) while the WHO (2008b) estimates that close to 100% of Jewish males are circumcised. Worldwide rates of MC vary by country: South

Korea 95% (Pang & Kim, 2002), Philippines and Angola 90% (WHO, 2008b), USA 57% (Hill, 2007), Indonesia 25% (WHO, 2008b), UK 16% (Dave et al., 2003), Finland 1%, (Denniston, 1996).

1.3 Early Recorded History

Boon (1994) has written that 'Foreskins are facts; cultural facts' (p. 554). The practice of MC amongst different cultures and religions forms a rich cultural and historical backdrop to this study. With a history dating beyond 2000BC (Avalos, Melcher, & Schipper, 2007), this section of the review can only summarise the main features of its history, outlining the complexity lying beneath its practice (see Gollaher (2000) for a comprehensive history of MC).

MC is one of the earliest surgical procedures known to have been performed. Ancient Egyptian reliefs from Saqqara (2345-2182 BC) depict ritual MC, with sharp stones used as knives (Avalos et al., 2007, p. 85). Gollaher (2000, p. 3) has described Egyptian MC as representing a transition into manhood from youth. Herodotus (440 BC/2013), the Greek historian described how MC was practised for cleanliness amongst the Colchians, Egyptians and Ethiopians at this time. Gollaher (2000) argues that the ancient Egyptians' 'obsession' with purity and avoiding contamination encouraged MC as a symbol of high status. However, in Greco-Roman times there was a decline in the practice, which Hodges (2001) ascribes to Greek distaste for the practice; the foreskin covers the glans which, if displayed, was considered a sign of arousal and therefore immodest.

1.4 Judaism and Early Christianity

In Judaism, MC is known as *brit milah* and is traditionally carried out on the eighth day after a child is born (Hoffman, 1996). MC is seen as the physical expression of the covenant made between Abraham and God, 'Every male among you shall be circumcised. You shall be circumcised in the flesh of your foreskins, and it shall be a sign of the covenant between you and me.' (Genesis 17:10.11 [English Standard Version]).

Writing in the 2nd century AD, Suetonius (121 AD/1930) described the discrimination of Jewish men by virtue of their circumcision status to ensure payment of the Jewish Tax. The only other groups practising MC at this time were the early Jewish Christians and Egyptian priests (Gollaher, 2000). Even today, MC remains common among those who practise the earliest forms of Christianity, for example the Ethiopian Orthodox (WHO, 2008b). However, for most Christians, following the teachings of Paul the Apostle, MC came to be seen as something unnecessary; indeed Gollaher (2000) has pointed out that being *uncircumcised* was seen as a way of confirming the Christian identity, distinguishing them from Jews. By the time the Jewish philosopher Maimonides wrote about MC in the 12th century AD, the operation had become more extreme. The removal of the entire foreskin was mandated to prevent some Jewish men from trying to restore their foreskins to avoid persecution (Gollaher, 2000). Maimonides (1190/1963, pp. 609-610) argued that MC was necessary to keep the Abrahamic covenant and also for moral reasons, stating that it would reduce men's pleasure and interest in sex thus making them more likely to think about God.

1.5 Islam and the Spread of Circumcision

MC is known as *khitan* or *khatna* in Islam and is commonly viewed as being *fitrah* or being necessary to exhibit that a man is dignified. Its practice follows the Prophet Mohammad's recommendation of 'circumcision, removal of pubic hair, plucking of armpit hair, trimming of moustache, cutting of nails' (al-Sabbagh, 1996).

The necessity for MC is debated amongst Muslim scholars with some seeing it as recommended and others as an obligation. Those who see it as an obligation point to God's covenant with Abraham and view the Prophet Mohammad's circumcision as something to be emulated. Other reasons given are that the uncircumcised penis is unhygienic and that the circumcision identifies the faithful Muslim and marks him out as different from the infidel (al-Sabbagh, 1996). Following the global rise of Islam in the 7th century AD, MC came to be

adopted amongst many previously non-circumcising populations (WHO, 2008b), particularly in Africa.

The Prophet Mohammad is believed by some Muslims to have been born without a foreskin (aposthetic) and by others to have been circumcised on the seventh day. Rizvi, Naqvi, Hussain, and Hasan (1999) report that MC in Islamic countries is usually carried out by the age of 7. For most Muslims, MC is considered as something that all males undergo, confirming their relationship with God (WHO, 2008b). Sahin et al. (2003) report a prevalence of around 95% among Muslim men; they estimate that there is an important minority of 120 million circumcised Muslim men in India where circumcision is rarely practised by the Hindu majority.

1.6 Non-religious Circumcision

The WHO (2008b) estimates that there are approximately 200 million men alive who have been circumcised for non-religious reasons and that 85 million of these live in the USA. Many other ethnic groups practice MC for non-religious reasons. This includes the aborigines of Australasia and groups in sub-Saharan Africa, the Philippines and South-East Asia (E. K. Silverman, 2004). The rates of MC can vary considerably within countries according to ethnicity (WHO, 2008b) beyond the variation accorded by religious differences alone. The forms of MC practised among different ethnic groups has been studied by anthropologists and ethnographers since Frazer (1904) and van Gennep (1909). In many cultures MC takes the form of a ritual and is a key part of the transition to manhood, which van Gennep (1909) referred to as *rites of passage*. E. K. Silverman (2004), in his anthropological review of circumcision, describes how it has often been associated with identity, masculinity, status and belonging. He describes how MC has defied the attempts of theorists to explain it and yet remains intimately tied up with symbolism and manhood.

E. K. Silverman (2004) and other authors (WHO, 2008b) suggest that wherever MC is commonly performed, there are social determinants that

maintain the practise. MC may become socially desirable for reasons of conformity and perceived health benefits. T. Kim, Lim, Oh, and Choi (2004) reported that in South Korea, where almost all men are circumcised, 61% of men in their survey thought that they would be ridiculed if they had not been circumcised, while 78% felt that their circumcision made them cleaner and conferred health benefits.

1.7 History of MC as a Western Medical Practice

MC was not practised by Christians up until the late 19th century, when it came to the fore as a medical practice. In the UK, Hutchinson (1855), in one of the earliest epidemiological studies, concluded that the lower rate of syphilis amongst Jews was related to MC. Sayre (1872), a doctor in the USA, promoted MC for a range of health benefits, after a patient of his was 'cured' of partial paralysis following circumcision. Gollaher (2000) describes how it continued to gain popularity in the 1890s, as a 'cure' for masturbation amongst other ills. By the 1920s it had become routine and was popular with the upper classes in the UK and USA as a sign of status and faith in the benefits of medical science and hygiene.

1.7.1 **MC in the UK.** MC was first introduced as a medical operation in the UK in the late Victorian era (Hodges, 1997). MC is usually a neonatal operation in the UK. By the late 1940s, according to Gairdner (1949), between 12% and 84% of all male infants were circumcised; the highest rates being amongst the higher social classes. He described reasons as deriving from aesthetics, religion, class and personal hygiene. His paper revealed that 16 infant deaths per annum were caused by MC and this influenced the newly formed NHS to restrict MC (Gollaher, 2000). Rates fell gradually to around 20% for those born between 1956 and 1960 (Dave et al., 2003). The British Medical Association [BMA] guidelines in 1996 and 2003 recommended that MC for children should only be carried out with the consent of both parents on religious or medical grounds. Currently, around 2% of children under the age of four in the UK are circumcised for medical

reasons (Cathcart, Nuttall, Van der Meulen, Emberton, & Kenny, 2006), but this figures rises to approximately 5% once religious circumcision is included (WHO, 2008b). The latest BMA (2006) guidelines point out that MC research into the medical effects is often contradictory and subject to criticisms of bias. I consider this bias further in the literature review. The guidance warns doctors to ensure that those giving consent on behalf of children are aware of all the issues. The issue of consent is considered further in section 1.8. It is estimated that between four and six million males in the UK have been circumcised (Dave et al., 2003; Office for National Statistics, 2011).

1.7.2 **MC in the USA.** MC in the USA is more common than in the UK. It used to be a routine neonatal operation in the 1950s although since then rates have declined from around 90% to 60% (Gollaher, 2000). Darby (2005) has pointed out that the growth in MC in the USA followed a similar pattern to that in the UK and Australia, but the decline has been less pronounced.

The American Academy of Pediatrics Task Force on Circumcision (1999) concluded that although there are some medical benefits to circumcision, the risks did not warrant its use. However, in 2012, after a 'comprehensive review' they revised their Circumcision Policy Statement reversing the previous stance (American Academy of Pediatrics Task Force on Circumcision, 2012). The statement now concludes that there are medical benefits of circumcision that outweigh the risks, but that the final decision should rest with the parents, who may wish to consider their own ethical, religious and cultural beliefs. The medical benefits are said to include the prevention of penile cancer, urinary tract infections, and the decreased chance of sexually transmitted infections, particularly HIV (American Academy of Pediatrics Task Force on Circumcision, 2012).

Some researchers (Gollaher, 2000; WHO, 2008) suggest that social conformity is an important factor maintaining the practice of MC. When the majority of men are circumcised, parents often want their sons be circumcised, so

that they will not look different from their peers. Fox and Thomson (2009) suggest that aesthetic and hygienic reasons, along with an early desire for sexual restraint, have been common features in the history of the development of MC in the English-speaking world. More recently, reasons for promoting MC have evolved into new forms centred the prevention of HIV transmission. The anthropologist Leonard Glick (2005) considers that the reasons given for the practice are based upon prevailing cultural attitudes with traditions and customs being reworked and altered throughout history.

1.8 Controversy Surrounding MC and Comparisons with Female Genital Mutilation (FGM)

Male and female circumcision, referred to hereunder as female genital mutilation (FGM), is described by E. K. Silverman (2004) as the most controversial topic in anthropology. He sees circumcision as challenging anthropology's pluralistic stance at the point where it impinges upon human rights. Price (1999), a medical anthropologist, has argued that the issue is centred upon the rights of children, as they are unable to give informed consent. He considers that MC is not ethically controversial if an adult makes the decision for himself, or if there is a sound medical reason for a child to be circumcised. However, in the case of FGM, Kalev (2004) argues that there are additional concerns regarding male domination of women.

Despite the debate around FGM and neo-colonialist attitudes in anthropology, almost all researchers and commentators in other fields have come down firmly against FGM, however it is performed (WHO, 2008a). The severest form of FGM, pharaonic circumcision or infibulation, commonly involves the removal of the clitoris, inner and outer labia and closure of the vagina. It is known as type III FGM by the WHO (2008a) who estimate that eight million women have been affected globally. Around 125 million women are estimated to have been affected by all types of FGM, through either partial or total removal of the clitoris and labia, and infibulation. FGM had been outlawed in many countries, although

enforcement of the law is rare (WHO, 2008a). The traumatic psychological consequences of FGM have been extensively reported (Mulongo, Martin, & McAndrew, 2014; Stewart, Morison, & White, 2002; van der Kolk, 1999) although Berg and Denison (2012), in their systematic review, have drawn attention to the need for higher quality research about specific types of FGM, in order to develop more effective targeting of interventions.

By comparison to FGM, MC has generally been viewed as a minor procedure throughout history (Aggleton, 2007), without adverse long-term psychological consequences. Equating MC and FGM is often viewed as invidious; Martha Nussbaum (1999) makes the point that the equivalent of a clitoridectomy on a man would involve removal of most of the penis. However, recently, the debate surrounding MC has intensified, with the adherents and detractors of MC taking polemical stances. Darby and Svoboda (2007) have questioned the common discourse that vilifies FGM yet argues that MC is acceptable and may have health benefits. They have argued for greater gender neutrality when discussing male and female circumcision. The President of the UK Family Division, Sir James Munby recently commented in a ruling concerning Type IV FGM (Leeds City Council v. (1) M (2) F (3) B (4) G, 2015) that MC may be comparatively more harmful, despite the difference in legal status. Harrison (2002) has argued that the standard perspective of condemning FGM while condoning MC is an unqualified one while Fox and Thomson (2009) have shown how those opposing MC often compare it to FGM and refer to MC as Male Genital Mutilation (MGM). There are many websites that oppose MC in these terms, such as NOCIRC (*National Organization of Circumcision Information Resource Centers)* and NOHARMM (*National Organization to Halt the Abuse and Routine Mutilation of Males).* Okino and Yamamoto (2004) in their review of MC websites, concluded that those searching for information were more likely to encounter views against MC, although not that these were more representative.

The controversy surrounding MC is rarely out of the news for long. In 2011 in San Francisco, local attempts were made by activists to ban MC, but these were frustrated by the state governor, who made it a state-wide issue (Neroulias, 2011). The German regional court in Cologne decided in 2012 that MC was bodily harm, a decision that caused outrage amongst Jews and Muslims and was attacked as anti-semitic by the UK Chief Rabbi Jonathan Sacks (Sacks, 2012). The decision was rescinded when the Bundestag passed legislation permitting MC, so long as parents are informed of the risks (Chambers, 2012). Despite this being welcomed by Jews and Muslims, it was criticised by groups defending rights of the child (Chambers, 2012).

It appears that MC is at a controversial nexus in the West, where concerns surrounding the rights of the child and bodily integrity clash with religious and cultural freedom. The ethics surrounding MC have been debated in the medical profession for over 100 years. Mussell (2004) has acknowledged the strength of opposing views on circumcision and suggests that there are potential 'net benefits' to MC on the grounds of cultural integration which have to be balanced against the 'net harm' (p. 256) caused by the breach of a child's rights. The BMA (2006) leave the ethical decision up to the parents, particularly when the choice is made on religious grounds, on the basis that even though the health benefits may not justify it, the likelihood of physical harm is small. This position on physical harm echoes that of Grossman and Posner (1981) in respect of modern surgery, yet neglects psychological consequences.

1.9 Male Circumcision and the Research Literature

1.9.1 **Introduction.** MC research has given rise to debates on moral, cultural (Hellsten, 2004), ethical and medical grounds (Denniston, 1996; Svoboda, Van Howe, & Dwyer, 2000). It has been extensively researched from an anthropological, ethnological and medical viewpoint (E. K. Silverman, 2004) and there are many books that have been written detailing the history and practice of MC (Darby, 2005; Gollaher, 2000). Currently, there is increased interest in MC as a

method of reducing HIV transmission. A search of Google Scholar (January, 2013) reveals 1710 studies including 'male' and 'circumcision' in the title, published since 1994, with over 700 in the last four years; 666 of these are with regard to HIV. However, it is currently little studied psychologically. A search of PsycINFO on the same criteria as the Google Scholar search reveals 151 studies of which 62 are about HIV. A search of Pubmed revealed 521 studies of which 74 made reference to issues of identity, masculinity or psychology. However no further articles to be reviewed were found, beyond those selected via the PsycINFO and Google Scholar searches. It is claimed that MC protects against female-to-male HIV transmission by around 60% (Auvert et al., 2005). MC is being encouraged once more on health grounds, particularly in Africa, but also in the USA, which has seen the prevalence of MC fall to around 56% since the 1980s (Gust et al., 2011). It is important to consider both the psychological and medical impact of MC when MC is being newly promoted.

One strand that emerges from many studies is the link between MC and issues of male identity. Boon (1994) has written about the way MC divides men; Muslims from Hindus, Jews from Christians, and modernists from traditionalists. He emphasises the identities that are taken on in this process and that are symbolised by the circumcision. Fox and Thomson (2009), writing from a feminist perspective, point out that MC has long been used as a sign of belonging or as a cultural marker, imposing masculine ideals on young men. Therefore, I begin with reviews of selected psychological literature on identity, masculinity, and male body image that have relevance to MC.

Qualitative and quantitative studies of the psychological effects of MC are rare, particularly those that are not linked to HIV research. These are reviewed next. Following on, research papers that explore men's reports of sexual function and sensation after MC are reviewed for their psychological implications. Next, research regarding MC and HIV prevention, mostly from Africa, is similarly reviewed. Most HIV studies that have a qualitative component use a mixed

methodology. The qualitative analysis is usually limited to exploring the views of men regarding their acceptance of MC. Finally, MC in the psychoanalytic literature is touched upon.

1.9.2 **Identity theory.** Harrison (2002) suggests that the psychosexual effects of MC on male identity have been neglected by those writing from sociological or gender perspectives, who often take a medical approach. He criticises Susan Bordos's (1993) article 'Reading the male body' for discussing the penis and its role in making arousal visible without discussing circumcision. He suggests that men view their penises as uniquely important, associating them with emotional experiences. Furthermore, he argues that MC plays a key part in defining a man's body image. Psychological research has rarely considered Boon's (1994) suggestion that MC separates men into 'us' and 'them', thereby engaging men in discourses of difference and identity.

Issues surrounding personal, social and cultural identity have been raised by many writing and researching MC (Bettelheim, 1954; Boon, 1994; Gollaher, 2009; Khumalo-Sakutwa, 2013; Lee, 2006; Mshana et al., 2011; Ramos & Boyle, 2000). From anthropology, E. K. Silverman (2004) has reviewed the issues of male identity in the context of sociocultural change; however, in psychology there has been a dearth of research around such issues. Rather than review multiple areas of identity research, I will focus on those that can help to bring together the different strands relevant to MC.

Identity is a concept that has been widely researched and theorised about in psychology over the last fifty years (Breakwell, 1986; Côté, 2006). Vignoles, Schwartz, and Luyckx (2011) argue that 'identity' is a complex, sometimes obscure, term that means different things to those studying it from different perspectives. They consider it a powerful construct that allows people to gain psychological strength. I adopt their definition of identity as 'who you think you are' both as an individual and as a group member and in 'who you act as being' (p. 2) in relation to others, with a focus on distinctiveness. A broad definition such

as this encompasses the views of both social psychologists researching group identity and those who focus on personal identity. I will therefore review theories that consider identity as something which develops within personal contexts, social contexts and over the lifespan. Furthermore, I will be considering the role of body image and the impact of self-esteem on the self-concept and identity. Next, I review theories that focus on the social and psychological processes of identity, before turning to theories of masculine identity.

1.9.3 **Social and lifespan theories of identity.** For Erikson (1950) identity was a means by which the individual can gain a sense of coherence over the lifetime span. His psychosocial theory (Erikson, 1959) describes eight stages of psychological development, set within the social context. These stages covered infancy, early childhood, pre-school, school, adolescence, young adulthood, middle adulthood and maturity, although not necessarily in that order. Each stage is characterised by an identity challenge. During adolescence the challenge is identity versus role confusion. In early adulthood this becomes intimacy versus isolation and by middle adulthood it has turned into generativity versus stagnation. Erikson argued that the degree of success in resolving the identity issues at each stage could influence the ease with which the challenges of the next stage could be resolved.

H. E. Tajfel (1978) argued for the distinction of personal identity from social identity but suggested that they can lie on a continuum. The position along this continuum varies from situation to situation depending upon the degree to which the person is affected by their group affiliations. In a family situation, affiliations would trigger an individual to think, feel and behave differently than in a situation where their national or religious identity was prominent. In Social Identity Theory (SIT), he argued that individuals self-identify with their 'in-group' memberships whilst comparing themselves to the 'out-group'. When an individual is in this mode of comparison, it is the social identity that is emphasised, whilst when they are comparing themselves on an interpersonal

level, it is the personal identity that predominates. Tajfel regarded distinctiveness from others as necessary to maintain a positive sense of social identity. He originally began developing his theory out of research into the minimal conditions under which one group might begin to discriminate against another (H.E. Tajfel, Billig, Bundy, & Flament, 1971). H.E. Tajfel and Turner (1979) suggested that there are three conditions under which in-group discrimination might become particularly strong. Firstly, when individuals identify to a large extent with the in-group; secondly, where the context allows for comparisons and thirdly, where there is a perceived relevance to the comparison. Tajfel and Turner's discrimination and in-group favouritism is redolent of Lee's (2009) study of MC from the Philippines, reviewed later, which found that boys were teased for being uncircumcised. This finding is also reported by Vincent (2008) in relation to verbal and physical abuse of Xhosa initiates in South Africa.

The sociologist Anthony Giddens (1991) emphasises that self-identity exists within given historical and cultural contexts. He considers identity in the late modern era as involving 'reflexive projects' meaning 'the self as reflexively understood by the person in terms of his or her biography' (Giddens, 1991, p. 53). A project requires an individual to reflect, work on and revise their personal biographical narrative to gain meaning. When this can be done in a way that creates an ongoing narrative of the self, then a stable sense of identity will be maintained. Giddens sees self-identity in the late modern era as differing from earlier traditional societies. The dynamism of late modernity undermines traditional customs on a global scale due to the greater levels of interconnectedness in contemporary society. Giddens points out that changing kinship relationships between traditional societies and contemporary 'high modernity' have created 'tribulations of the self' or threats to identity; these are situations where individuals' sense of continuity and security are challenged due to increased fragmentation and uncertainty (Giddens, 1991, p. 243). Despite the fact that he has acknowledged the role of the body as a project, he has been

criticised by Shilling and Mellor (1996) for maintaining the dualism of mind and body by failing to account for experiences of embodiment, placing too much weight on the social and rational aspects of embodiment. Watson (2000) similarly argues for the importance of a focus on embodiment to extend Giddens' work, seeing embodiment as the focal point where the personal and social converge. MC can be viewed as a socio-medical practice that intersects the dynamism of Giddens' 'post-modern' identity and Watson's view of embodiment.

1.9.3.1 Identity Process Theory. Glynis Breakwell (1986) developed Identity Process Theory (IPT) after working with Henri Tajfel on Social Identity Theory. Breakwell (2010) proposed that the key to understanding identity is to examine individuals' responses when their identity is threatened. I have chosen to include this theory because rather than looking at identity as emerging from evaluations of social categories, IPT focuses on the psychological and social processes that form it. It may be helpful as a means of discussing the experiences of circumcised men from different social contexts in a way that does not become too fragmented. IPT posits that psychological processes maintain identity, which is then made evident through the actions, thoughts and emotional experiences of individuals. Individuals are seen as having agency in the construction of their identity, although the degree to which they exercise this may be constrained by the dominant social representations of their particular social context (Jaspal, 2011).

Breakwell (2010) does not distinguish between personal and social identity, arguing that in a person's biography social identity becomes personal, and that any split between the two dissolves over time. Universal processes of assimilation, accommodation and evaluation are posited to operate on the identity structure. New information is absorbed into the identity structure by accommodation and assimilation; evaluation is the process by which individuals give meaning and value to the contents of identity. Breakwell (2010) describes four principles that guide accommodation/assimilation and evaluation, although she recognises that these may be culturally and historically specific. The principles that she has

identified are continuity, distinctiveness from others, self-efficacy, and self-esteem. Self-esteem is modelled as varying on the dimensions of efficacious action and the social approval of others (Breakwell & Lyons, 1996). Jaspal (2011) has suggested three further principles of belonging, meaning, and psychological coherence between identities. Breakwell (1986) describes the social context as providing the source from which roles, beliefs and values are assimilated into identity. She sees assimilation as influenced by social processes, for example education or contemporary polemic. As an individual moves within the social structure, threats to identity can occur when required changes conflict with the principles that guide them. Individuals use coping strategies in order to restore the principles of the identity processes (Breakwell, 1986). These may be temporary strategies, such as denial or avoidance although she considers that engagement with others and acceptance needs to be found to resolve threats.

1.9.3.2 Male and masculine identity. Kipnis (1991) suggests that MC plays an important part in the socialisation of men in a way that affects their male identity and behaviour. From the perspective of social psychology, one's gender identity or masculine identity in the case of men, is based upon socialisation rather than the biology of sex, and consists of the self-meanings that individuals form as they develop and interact with significant others, from parents to peers. In contrast, psychoanalytic psychosexual theories of masculine identity have emphasised the role of the father (S. Freud, 1927/2013) as well as the role of the mother (Chodorow, 1978). Psychoanalytic theory will be considered further in subsection 1.9.8. Cognitive-developmental theory (Kohlberg, 1966), on the other hand, posits cognitive stages leading to gender constancy by the age of 7.

Wetherell (1996), writing from a social psychology perspective, argues that masculinity is both personal and social. From her standpoint, male identity becomes more fluid and dynamic than from the psychoanalytic and cognitive developmental perspective. She draws upon Foucauldian ideas in regarding power structures in society as the basis in which masculine identity is rooted,

ideas that have also been taken up by feminist theorists such as Connell (1995). Connell, furthermore, argues for the centrality of the male body to a man's experience of masculinity. Some (see S. Goldberg, 1973) view the male body as evidence of the role of biology in gender inequality. Connell takes a different stance towards the roles of biology and culture in the formation of masculinity. She argues that the sense of being male or female is inextricably rooted in the body, in the way we move, the shape of our bodies and how we have sex. It is key to understanding how we culturally interpret gender and how gender issues can be influenced by the power structures in society (Connell, 1995). However, taking a social constructionist viewpoint, she argues that masculine identity is essentially socially defined with the body acting in a way that either conforms or not (Connell, 2000). She argues that the body acts both as an object of social practice and as an agent of action at the behest of society. Curiously, Connell (2000) does not refer to MC despite discussing how during hazing initiation rites individuals may have their bodies marked against their will, in what she describes as an exercise of male power. However, Whitehead (2002) argues for a more nuanced view of masculinity suggesting that traditional attributes such as strength and toughness are incorrectly associated with dominant masculinity. Furthermore, he points out that many men experience problems in coming to terms with the relationship between their bodies and the dominant social representations of them, affecting their personal sense of masculinity.

Spence (1993) takes the view that masculine identity consists of multiple factors such as physical features, personality, skills and roles that are all culturally influenced in a way that makes each person's sense of their gender identity unique. While sociologists and social psychologists have emphasised social aspects of masculine identity in gender roles and attitudes (Eagly, Wood, & Diekman, 2000; Spence & Helmreich, 1979), there is a dearth of literature in psychology on the importance of physical attributes despite Spence (1993) arguing for this. However, in a recent qualitative study of penile cutting practices in Papua

New Guinea (*N* = 482), Kelly et al. (2012), reported that where MC was traditional, men reported feeling stigmatised if they were not circumcised, with a risk of being mocked. They found that MC was a determinant of men's sense of their masculine identity and was also linked to status and the perceived ease of gaining access to sexual partners. Further motivation came from perceptions of cleanliness, hygiene and fertility, which were attributed to MC. This research was carried out as part of an acceptability study into MC for HIV prevention using focus group discussions and semi-structured interviews.

H. E. Goldberg (2003), writing from a Jewish perspective, sees MC as the defining symbol of male Jewish identity, serving as a reminder of the social interconnectedness of Jewish men. However, he says nothing of the psychological impact of this. Similarly, Fox and Thomson (2009) have described MC as being 'a marker of masculine belonging' (p. 197). Ndangam (2008), writing from a sociological perspective, analysed the discourses surrounding Xhosa MC as represented in the South African newspaper media. She argues that, wherever it occurs, ritual circumcision is linked to ideas of male identity, with the ritual validating an initiate's manhood, and that his penis thus subjectively reaffirms and symbolises a man's identity in society. Drawing upon Connell's (1995) conceptualisation of hegemonic masculinity, she demonstrates how the discourse surrounding MC, and the almost exclusively privileged, male voices that make up opinion, reinforce notions of male dominance in South African society. She points out that the voices of circumcised men in South Africa are invisible in debates around MC and that they need to be brought into the foreground of research.

1.9.3.3 Body image. In James's original work on the self (James, 1890) he regarded the body as 'constituting' the innermost core of the known self or 'Me'. He described the relations between the body, the social and spiritual self and with the feelings that were aroused in the subjective self or 'I'. For Merleau-Ponty (1962, p. 71) the mind and body are 'the vehicle for-being-in-the-world' which binds and identifies one with place and time by filtering our experience to give meaning

from existence. Merleau-Ponty and James provided a foundation for expanding the concept of identity to include that of our bodily identity. Despite this early recognition in psychology and phenomenology, in mainstream psychology body image has been thought of as a separate area of study from that of other forms of identity, such as social identity. Researchers in the field of body image (Girodo & de la Guardia, 2006; Thompson, Penner, & Altabe, 1990) point out that research needs to take place within a broader theoretical frame.

Research into body image has largely focused on the relationship between bodily self-perception and self-esteem in conditions such as anorexia and body dysmorphic disorder, typically amongst females (Cash & Deagle, 1997). Dittmar et al. (2000), in their study of English adolescents, have shown how increased concern with bodily appearance makes a significant contribution to adolescent identity. Following up on this research, in a study ($N = 53$) examining the links between body image and identity formation, Kamps and Berman (2011) used the Identity Distress Survey developed by Berman, Montgomery, and Kurtines (2004) to show how identity distress was correlated with body areas satisfaction ($r = -.54$, $p < .001$) and appearance evaluation ($r = -.38$, $p < .005$).

Cash (2004, p. 1), one of the main researchers in the field, has long argued for a more inclusive view of body image as thoughts, feelings, attitudes and beliefs that one holds about one's body. This view has been taken up by others such as Altman, Buchsel, and Coxon (2000). Cash and Pruzinsky (2002) and Thompson (2004) have evidenced significant correlations between body image and a range of mental health problems.

Murray, Rieger, Karlov, and Touyz (2013) point out that, despite most of the research into body image being carried out with an emphasis on females, there is now a greater understanding that a large percentage of men experience body dissatisfaction. Gill, Henwood, and McLean (2005) argue that in an era of post-modernity, with the growth of cosmetic surgery, tattooing and piercing, there is a growing focus on the body. They noted in their earlier research (Gill,

Henwood, & McLean, 2000) that men characteristically emphasise the importance of autonomy in making decisions about their body. Yet, they do not mention MC as a body modification in this respect. Schooler and Ward (2006) have pointed out the need for more innovation in male body image research, because the dominant concepts have emerged from research into women's concerns.

Tiggemann, Martins, and Churchett (2008), in a USA study, suggest that concerns over specific body parts may be increasing amongst men and changing how they view body image. They used a measure of satisfaction with penis size, body weight, muscularity, height and hair, finding that 61% of men sampled (N = 191) wanted a larger penis and 83% wanted greater muscularity. They found that there was a significant effect of body part on worry ($F(5, 183) = 444.58$, $p < .001$) with penis size being worried about less than weight and muscularity but more than other body parts. They concluded that psychologists need to take men's specific body image concerns into account when dealing with men's mental health.

S. N. Davis, Paterson, and Binik (2012) have argued that poor body image can affect male and female sexuality and self-esteem. They reviewed the little researched area of 'male genital image' and concluded that further efforts should be made to measure 'men's satisfaction with their genitals' (p. 46) as it was correlated with sexual health outcomes. Two areas were of particular importance; penis size and deformities caused by disease. They argued that when changes occur to the penis there can be negative psychosocial and psychosexual consequences which healthcare professionals need to take into consideration. They called for more research to illuminate this poorly understood area. MC was not considered but, since it alters the overall size, shape and look of the penis, it is reasonable to consider its impact on male genital image.

A study by the sociologist, Genaro Castro-Vázquez (2013), has analysed the growing practice of MC in Japan, a country with no medical, religious or cultural history of MC. His sociological analysis is of the promotion of MC in public and

medical media. The removal of the foreskin is advertised as a way to reveal the full size and shape of the penis and to improve body image. He argues that this, along with penile performance and health, is being used to give the promise of enhanced masculinity and beauty.

1.9.4 **Studies of the psychological effects of MC.** One of the earliest studies into the psychological effects of MC was conducted by Cansever (1965). Writing from a psychoanalytic perspective, his exploratory study reported effects of psychological harm following ritual circumcision on Turkish boys (N = 12), aged between four and seven. The children were seen a month prior to MC and followed up three to seven days after. Cansever concluded that the children saw MC as an attack or 'castration', experienced confusion around gender identity and expressed more hostility. This research is frequently made reference to by other researchers (Yavuz, Demir, & Doğangün, 2011) regarding the psychological harm of MC. However, it should be pointed out that Cansever (1965) used tests that rely heavily on the researcher's subjective interpretation. The Rorschach test, for example, despite being thoroughly researched, remains controversial and is increasingly regarded as 'unscientific' by many psychologists (Hunsley & Bailey, 1999). Cansever's sample was small and the follow up period was short; Cansever should have limited his conclusions to this timeframe and those citing his work should make this clear.

Rhinehart (1999) has thoughtfully discussed the psychological effects of MC from his perspective as a psychotherapist in the USA. He used evidence from four client studies, presenting men's experiences of 'serious and sometimes disabling lifelong consequences' following neonatal circumcision (Rhinehart, 1999, p. 221). His clients showed longstanding symptoms including anxiety, distrust of others, difficulties in forming intimate relationships, low self-esteem and feeling less like men. Rhinehart interpreted these symptoms, along with memories of the circumcision, as evidence of MC related trauma. In his view, the trauma they experienced maps onto Judith Herman's (1997, p. 126) description of

'complex post-traumatic stress reaction' where the trauma is inflicted by another person. Whilst the clinical material he presents is convincing, his argument against neonatal circumcision seems to assume that all circumcised men may experience trauma and that the circumcision has caused the consequences rather than being associated with it. I suggest that this is a small clinical sample that indicates only that some men report high levels of psychological distress, which they link to their MC during psychotherapy. Rhinehart seems to preclude the possibility that the procedure could be experienced as beneficial by other men.

Ramos and Boyle (2000) have calculated that 51% of boys (N = 1577) aged 11 to 16 who were circumcised in the Philippines met the criteria of post-traumatic stress disorder (PTSD) as defined in the DSM-IV (American Psychiatric Association, 1994). In ritual circumcision the figure rose to 71%. However, information on symptom chronicity was omitted, meaning that formal diagnoses could not be made. The use of PTSD was therefore misleading. Furthermore, the authors describe MC as 'partial penile amputation', a term that is usually reserved for damage to the shaft of the penis, emphasizing their anti-circumcision stance and leaving the reader questioning whether the data may be further biased.

In a contrasting study from the Philippines, where over 90% of men are circumcised, Romeo Lee (2009) used semi-structured interview data from males aged 13 to 51 (N = 114), focusing on the rationale for MC. He concluded that MC is viewed as an 'enhancement of masculinity'. The main reasons given for MC were: avoiding being teased (67%), following tradition (41%), having a more developed body (30%) and cleanliness (23%). Lee makes the point that Filipino men undergo MC feeling a 'need to conform', perceiving it as body-enhancing and improving sexual prowess, making them more attractive to women; MC thus becomes a key feature of their 'masculine status and identity'. The methodology is not described clearly in the paper, with nothing to show how the qualitative data were analysed to generate the findings. There is a focus on statistics rather than presentation of quotes and the author does not address his epistemological stance, leaving it

unclear as to how his approach may have affected the data. There was little focus on current experience in this study as it focused on the period soon after MC. This study illustrates a gap in the literature for studies of the long-term experience of men who have been circumcised.

Ménage (1999), similarly to Ramos and Boyle (2000), has reported symptoms of PTSD in a sample (n = 8) of circumcised men that formed a small part of larger research into the effects of FGM (n = 500) in relation to PTSD. She postulates that a child's lack of choice and knowledge about MC and their experiences of pain from the operation are risk factors for the development of PTSD. Her sample was of men who had been circumcised in the first seven years of life. She found that four of the eight men showed 'symptoms of PTSD' which she reported as likely to have been caused by circumcision. However, due to the small sample size, no statistically significant result was found and the findings need to be viewed with caution. She reports a selection of the men's comments, but with no detail of her methodology. Menage's research is often referenced by other authors (Boyle, Goldman & Svoboda, 2002; Bensley & Boyle, 2000; Ramos & Boyle, 2000) without mentioning the limitations of her study.

In a preliminary survey of men (N = 313) who were circumcised as children, Hammond (1999) found that 41% suffered emotional distress affecting intimate relationships, which they ascribed to circumcision. A further 60% reported intrusive thoughts about having been mutilated, and 46% about being violated. Over half of the men had not sought help for their distress. The data was sampled from men who had contacted a USA based anti-circumcision organisation (NOHARMM) and responded to a survey. The participants were all men who were unhappy about having been circumcised. The author recognised this bias in the sample and that random sampling 'might produce different results', but nevertheless argued for the likelihood that the general trend was likely to be reflected in a random sample as well. This survey highlights the need

for studies that target all circumcised men so that bias in the data can be minimised.

Bensley and Boyle (2000), in an exploratory survey (N = 83) from Australia, reported that circumcised men were more likely to express negative emotions than uncircumcised men. The circumcised men often described feeling angry, hurt, cheated or incomplete in relation to their circumcision and many reported penile scarring, the need for more stimulation during masturbation and some dissatisfaction with their orgasms. They were more likely to report a reluctance to use condoms, which the authors linked to decreased sensitivity. However, unlike Ramos and Boyle's (2000) study in the Philippines, there were no findings relating to symptoms of PTSD. Survey questionnaires were handed out to men's groups and to those attending a health centre with a 29% response rate being reported. Of the respondents, 53 were circumcised and 30 were uncircumcised. The authors recognised that their sample was not truly representative. They pointed out that some research contradicted their findings, but generally only made reference to research that supported it. This leaves some doubt as to whether their findings may be biased.

Bollinger and van Howe (2011), in a preliminary investigation of circumcised men (N = 300), reported 20% higher age-adjusted scores for alexithymia. Individuals who show signs of alexithymia have difficulty identifying and expressing emotions in the self. Bollinger and van Howe (2011) accept that their sample may not be representative, but do not fully discuss the impact of the participants' self-selection through websites that have an anti-circumcision stance. They do not adequately discuss the possibility they may be confounding circumcision with some other factor since they present their findings as though MC may be the cause of the higher alexithymia scores.

Not all studies have found negative psychological consequences after MC. Schlossberger, Turner, and Irwin (1992) found that circumcised adolescents (n = 59) in the USA scored more highly on body image satisfaction as measured by the

SIQYA (Petersen, Schulenberg, Abramowitz, Offer, & Jarcho, 1984) than the uncircumcised (n = 14). However, the fact that the sociocultural norm for men in the USA is to be circumcised may have influenced the responses, particularly from an adolescent sample; this was not discussed. The authors called for more research into the psychosocial sequelae of MC that would include a larger proportion of uncircumcised men. The study illustrates the contrasts when studies from different cultures are compared and where the social and religious contexts differ.

1.9.5 **Research into the physical effects of MC.** There have been numerous studies of the physical effects of MC, regarding sexual function, sensation and satisfaction, mostly by urologists. D. S. Kim and Pang (2007) conducted a study on men circumcised as adults. Their study used a questionnaire to ask about changes in sexual function. Their sample (N = 373) consisted of 255 circumcised and 118 uncircumcised males in South Korea, a country with a 95% prevalence of MC. Poorer sexual lives were reported by 20% of the circumcised men, while 6% reported an improvement following MC. They concluded that MC was linked to a decrease in sexual function, perhaps related to the physical effects of the operation, but did not adequately discuss the improvements mentioned by a significant minority of the men.

A study that contrasts with the above one was carried out by Krieger et al. (2008). Their randomised controlled trial (RCT) studied the effects of MC on sexual sensation and function in a sample of 2784 men in Kenya who had been circumcised to reduce HIV transmission. Half the participants formed a control group and data was collected via questionnaires. The researchers reported that MC for adult men was not related to increases in sexual dysfunction; 64% of those circumcised rated their penis as significantly more sensitive, 54% said that orgasms were much easier to reach and 39% reported a higher frequency of sex, two years after MC. This study was well constructed and the existence of the control group meant that the effect of MC on sexual dysfunction could be more

accurately measured. However, the data also revealed that 7% of those circumcised thought their penis was less sensitive, 10% that orgasm was more difficult and 12% that the frequency of sex had declined and the data for the control group was not represented. These side effects are not analysed which raises questions about the generalisations they make.

1.9.6 **MC research and contrasts in findings.** The review of the previous two studies regarding sexual function illustrates the contradictory findings that come out of so many studies regarding MC. Morris and Krieger (2013), in their review of MC research, suggest that studies that find negative outcomes are more subject to bias, being less well constructed. However, Morris is himself a well-known circumcision advocate, maintaining a website, www.circinfo.net. Other authors (see Bensley & Boyle, 2000; Goldman, 1997) contend that research carried out by those in the medical profession, who they consider have a financial interest in MC, often does not properly evaluate the risks, nor the potential for psychological harm.

In continuing to present one side of the argument or another, researchers rarely take account of the cultural and religious context of their findings. Neither of the studies regarding sexual function consider the possibility that a participant's perception of their sexual function could be affected by whether their circumcision is the cultural norm for them nor indeed how the perceived benefits of it for HIV prevention may have skewed the results. At one level, the two studies appear contradictory, but on the other hand they both show that MC may be correlated to aspects of sexual function and can act to polarise the men's experiences. There is a gap in the literature for studies that consider this effect. It would be unusual if there were not some contradictory findings from studies originating in different countries. However, researchers seem reluctant to consider sociocultural contexts, accusing each other of bias instead.

1.9.7 **MC research related to HIV/AIDS.** There has been a surge in studies of MC for HIV prevention, following the findings of a large scale, well-constructed

RCT by Auvert et al. (2005) in South Africa. The men (N = 3274) were split into an intervention group (MC) and a control group and were followed up 3, 12 and 21 months post circumcision. The efficacy of the treatment was reported as around 60% in preventing HIV and this was confirmed in a follow up study by Auvert et al. (2013). Other researchers have conducted RCTs that support similar efficacy (see Bailey et al., 2007; Gray et al., 2012). Nevertheless, Green et al. (2010) have challenged the external validity of these RCTs. Garenne (2008) argues that there are complex economic, social, and cultural factors that influence the spread of HIV and that MC status plays a minor role. However, the WHO is using MC as a cornerstone of its HIV prevention strategy in countries where MC prevalence is low and the risk of HIV is high (Hargrove et al., 2009).

A search of PsycINFO on May 15th 2014 revealed 29 studies with 'male' and 'circumcision' in the title that used a qualitative methodology for at least part of the research. Of these, 25 related to HIV prevention with 24 based on data from African countries. There appears to be a dearth of qualitative research into MC from anywhere outside of Africa or which is not related to HIV prevention. Of the studies, 21 date from 2011 onwards. In the context of HIV prevention some studies draw attention to psychological factors. These studies all relate to voluntary male medical circumcision (VMMC) amongst adult men. Khumalo-Sakutukwa et al. (2013) looked at barriers to VMMC in sub-Saharan Africa finding that concepts of masculinity, sexuality, and social grouping could prevent acceptance of MC. Ssekubugu et al. (2013) in a study from Uganda into barriers and motivators to VMMC, found that 'peer influence', 'penile hygiene' and the prevention of sexually transmitted disease were key motivators for MC, while concerns around sexual function could act as a motivator or barrier. From South Africa, Peltzer, Banyini, Simbayi, and Kalichman (2009) found themes of peer pressure, societal norms and changes in sexual function amongst others influencing whether men underwent VMMC. Two separate studies from Zambia and Tanzania (Waters et al., 2012; Mshana et al., 2011) using interviews and focus

groups, found themes of MC as a cultural practice affecting men's identity, which could act either as barrier or motivator of VMMC uptake in the context of HIV prevention.

A qualitative study by Lundsby, Dræbel, and Wolf Meyrowitsch (2012) explored recently circumcised men's experiences of their circumcision. Thirteen men were interviewed who had undergone MC in clinics 5 to 17 months prior to interview. The men had undergone MC as part of an HIV prevention campaign in Zambia. Lundsby et al. (2012) used a phenomenological analysis of semi-structured interviews, following guidelines described by Hycner (1985). They found themes of social health, acceptance amongst men (through turning 'boys into men'), and personal hygiene. A further theme was of improved sexual performance related to the experience of reduced penile sensitivity post MC, so that mutual orgasm would be easier to reach. Lundsby carried out the interviews and all the researchers analysed the data, but differences between the researchers may have affected the analysis and were not discussed. All the participants expressed that they were proud and happy to be circumcised but the researchers questioned their snowball method of selection, suggesting that another sample may have expressed more problematic experiences. This study has a strong focus on HIV and illustrates the need for qualitative research into the experience of MC men from areas where African HIV is not the dominant contextual feature. In addition, both this study and the one reviewed earlier by Lee (2009) illustrate that there is no research that takes a longitudinal view of men's experience of MC.

1.9.8 **MC and the psychoanalytic literature.** In reviewing the literature, I have considered selected psychoanalytic authors (A. Freud, 1952; S. Freud, 1905/2003; Bettelheim, 1954; Kittay, 1995) and critiques of their theories of MC (Dundes, 1976; Hosken, 1994; E. K. Silverman (2004); Boddy, 2007) and include a summary of these in Appendix 1. They have been left out of this section as from my standpoint their theoretical interpretations have insufficient grounding in empirical research.

However, my critique of the psychoanalytic research by Cansever (1965) was included earlier as it was focused on MC.

1.10 Rationale for this Study

The literature reviewed has illustrated that, given the long history of MC and the number of men who have been circumcised, it has attracted little research interest outside the medical and anthropological fields. This is particularly true for psychology, except for researchers who have taken a polemical stand against the practice. Indeed the male penis itself has largely been neglected as a study area except by those writing from either a medical viewpoint or from a psychoanalytical stance, turning the penis into a symbol and writing about 'the phallus'. Recent research into male body image (Castro-Vázquez, 2013; S. N. Davis, Paterson and Binik, 2012) showing an increase in men's concerns with their bodies and aspects of their penis, points to a particular gap in the literature for psychological research into the experiences of MC. Dowsett and Couch (2007) have maintained that, because of the significant increase in the number of men being circumcised as part of HIV prevention strategy, there is an urgent need for broad-based research that considers social and cultural factors and the possibility of both positive and negative impacts, including psychological ones, on the individuals affected.

The research project undertaken here uses Interpretative Phenomenological Analysis (IPA) to study the experiences of circumcised men. I was not able to identify any pure qualitative research in this area, apart from the study by Lundsby et al. (2012) which was focused on an HIV context. Most of the evidence from other studies is either anecdotal (see my critique of Ménage, 1999) or in which the psychological findings may be biased (see my critiques of Bollinger & van Howe, 2011; Ramos & Boyle, 2000; Rhinehart, 1999). Fox and Thomson (2009) point out that those studying MC have mostly privileged either religion, culture, or the medical model as starting points for their findings. They argue that there is a need for research that is open to the role that MC plays in identity, masculinity

and male sexuality. It is believed that this research project is open in the way suggested by Fox and Thomson. Because of the large number of males who have undergone MC there is a broad context in which this research may be relevant (D. Silverman, 2010). It is hoped that readers may be able to relate the findings to their own personal or professional experience (Smith, 2008).

2 Methodology

2.1 Overview of Research Design

I used IPA (Smith et al., 2009) for the research. This is a qualitative research approach. I gathered data using semi-structured interviews from a sample of eight circumcised men and then analysed this in detail to draw out themes and subthemes.

2.2 Research Aims

By carrying out this research project, I wanted to gain access to the experiences that the participants have of being circumcised men. I have reflected upon my choice of research question and research methodology, drawing out my role in these choices and in the construction of 'knowledge'. Reflexivity is weaved in throughout this Methodology chapter with further thoughts and a summary at the end (section 2.9).

Taking an open, balanced and exploratory approach seemed to be in keeping with the spirit of Counselling Psychology and IPA. I hope that this exploratory approach will lead to some understanding of the phenomenon of being a circumcised man and may inspire others to take an interest in further research as this is an area that has been largely neglected. I also hope that it will help professionals reflect on their therapeutic practice, where an understanding of the experiences of circumcised men may give insight when difficulties arise for clients.

2.3 Rationale for a Qualitative Research Approach

A qualitative methodology seems to fit well with stage of my development as a Counselling Psychologist and stands in contrast to my earlier preference for

using quantitative methodologies. My therapeutic practice, relating to clients at interpersonal depth, seems far removed from the quantitative approach and I wanted to approach my research question similarly. In the future I may well return to quantitative research as a pleasant diversion from this interpersonal intensity, but for the moment it is a natural fit. The outcome of my initial literature review pointed towards a lack of psychological research around MC. It was clear that there was no body of research that could be built upon, despite there being no lack of strong feelings on the subject of MC from both a pro and anti-stance. Studies, in general, make *a priori* assumptions that are dichotomous regarding the benefits of MC. Thus, the exploratory nature of this study pointed towards an inductive approach, which is by its nature exploratory and more open-ended. It is reasonable to assume that the nature of the participants' reality with regard to their experiences of circumcision was likely to be multi-layered and subjective and, therefore, that a naturalistic approach to collecting the data would be appropriate, making a qualitative approach a valid choice (Morse, 1994). I had no intention to make predictions or test hypotheses, and this precluded taking a hypothetico-deductive approach (Popper, 1959). I tend to take the view that the 'scientific method' has held back research into the areas that really matter to psychology, such as meaning. Others may take the view that this approach lacks the rigour of a 'real science' by studying areas that cannot be accurately quantified. I believe that both can co-exist in a symbiotic relationship that reflects the metaphysical nature of the world. I believe the qualitative approach can be rigorous and scientific. As Giorgi (2009) has suggested with regard to phenomenology, the approach represents a different philosophy of science. Furthermore, I value the way an idiographic approach respects each participant and their data, while the nomothetic approach to psychology, as pointed out by (Smith et al., 2009), only makes group-level claims based on statistics and sidelines the individual. Thus both the research question and my preference for an idiographic approach provided a rationale for using a qualitative methodology.

2.4 Epistemological Reflexivity and Position

Willig (2008, p. 10) discusses the need to reflect on one's epistemological position in research by answering the question 'What kind of knowledge have I aimed to produce?' She states that there are three main kinds of knowledge that a qualitative researcher might try to produce; realist knowledge, phenomenological knowledge and social-constructionist knowledge (Willig, 2008, p. 15). My research question was 'What are the experiences of being a circumcised man?' I aimed to produce phenomenological knowledge. I wanted to know what it was like being a circumcised man by 'walking in their shoes' as Spradley (1979, p. 34) describes it.

I started by thinking about the assumptions I make about the world, particularly by trying to answer the ontological question 'What is reality?' in relation to human existence or as Willig (2008, p. 13) has put it 'What is there to know?' I do not see reality as only consisting of an objective set of facts that can be discovered and measured, nor that there is a clear cause and effect relationship between them. In this sense, I eschew the strong positivist position that there is a 'direct correspondence between things and their representation (Willig, 2008, p. 3). However, neither do I see reality as solely existing in others' claims of it, an extreme relativist position. In this sense, I am somewhere between the poles of realism and relativism. This position can be described as a 'critical-realist' one. I can accept a person's subjective experience reality unless it clashes with objective reality to cause overt problems. However, I do not consider that only concrete reality is worth studying. My position on this has been confirmed by my therapeutic practice; I realise that some clients' approach towards the world can be self-defeating and unhelpful, but accepting *their* reality can help to strengthen the therapeutic alliance and move them towards change. As far as the research is concerned, I have not made any assumptions about whether the experiences that the participants related directly to an external 'reality'. I believe that they themselves do not have full access to this 'reality' but will interpret it in their own unique way. One consequence of this is that I was of the opinion that participants

in my research could have very different experiences of the 'reality' of being circumcised, depending upon how they interpreted it. Since I believe that our senses are filtered so that we can never be fully conscious of an external 'reality', a further consequence is that I accept that the participants' data is not a self-evident reflection of what is going on in the real world. As Snygg and Combs (1949, p. 21) indicate, people act on how things appear to them and not on how they actually are. This leads me to the conclusion that as a researcher, a level of interpretation is needed (Willig, 2008, p. 15) in order to throw more light on the phenomenon of being a circumcised man.

However, I also see social constructivist processes at work, through the discourses that research participants draw upon when engaging in their accounts of their lived experience. I have been influenced by Eatough's (2008) position on IPA in this respect. She maintains that discourse and sociocultural context impact the way we attribute meaning to experience, tell our life stories, and come to understand them. Madill, Jordan, and Shirley (2000) have described the 'contextual constructionist' viewing all knowledge as based in a context that may be local, conditional and time-bounded in a historical sense (also see Jaeger & Rosnow, 1988). I feel closer to this position than to Eatough's, who leans more towards discourse. Larkin, Watts, and Clifton (2006, p. 104) have elaborated on contextual constructionism seeing the need to position phenomenological accounts 'in relation to a wider social, cultural, and perhaps even theoretical, context'. As a researcher, I believe that it is important to pay heed to the underlying cultural beliefs of both myself and my participants. Nevertheless, as Madill et al. (2000) have suggested, I intend to ground my contextual constructionist leanings firmly in the research data, essentially using my 'critical realist' position to guard against moving towards an extreme relativist position.

On the poles of realism-relativism, I would therefore position myself somewhere between critical-realism and contextual-constructionism. In my

analysis I have particularly drawn attention to cultural influences on meaning and how that is entwined with participants' lived experience.

2.5 IPA Methodology

2.5.1 **Overview and background of IPA.** IPA aims to illuminate the detailed personal experiences that participants have of important life events and states, exploring how they make sense of their lifeworld, both personal and social (Smith & Osborn, 2003). There is, therefore, an emphasis on the meaning that participants make of their experiences.

Jonathan Smith (1996) first presented IPA as a bridge between the social constructionism of discourse analysis (DA) and the positivism of the experimental approach to social cognition at that time (Smith et al., 2009). IPA takes a broad view of cognition as including layers of reflexivity, awareness, hot cognition and sense and meaning-making. This resonates with my sense of the complexity of cognition and my scepticism of taking a polarised approach to epistemology.

As the name suggests, IPA is both phenomenological and interpretative. Hermeneutics, as the theory of interpretation, is therefore an important foundation. IPA also takes an idiographic approach with a focus on the particular. I consider these three influences below.

2.6 Phenomenology

Phenomenology is a philosophical approach that underpins a group of qualitative research methods used to study subjective experience (Langdridge, 2007). It is concerned with how things are perceived in an individual's consciousness, varying according to context and time (Willig, 2008, p. 52). Phenomenology emerged from Husserl's (1900/2001, p. 2) proposal that there should be a 'return to the things themselves', with a focus on the phenomena of human experience. He stressed that to study psychical experience, it was necessary to step out of our *natural attitude* and develop a *phenomenological attitude* through a process of reflection. He suggested the necessity of 'bracketing' our ordinary assumptions about the world in order to reflect on our perceptions of it.

Heidegger, a student of Husserl, questioned the extent to which the phenomenological attitude could elicit knowledge of the 'essences' of experience. He saw that the context of 'being-in-the-world' or Dasein, whereby individuals are *thrown* into a world of objects, relationships, languages and cultures, was an inevitable part of experience (Heidegger, 1962, p. 56). He considered that interpretation would always be part of the phenomenological process. Heidegger's approach is one that matches mine; I do not feel that I can completely 'bracket' my assumptions, but I can question them and make them transparent to the reader.

Merleau-Ponty's (1962) contribution to phenomenology comes from his focus on the *embodied* nature of human experience. First we are *body-subjects* and the body is the vehicle through which we experience the world, isolating others from our perceptual experiences. Smith et al. (2009, p. 19), follow Merleau-Ponty, suggesting that the 'lived experience of being a body-in-the-world … must not be ignored' in IPA. Merleau-Ponty has further inspired my phenomenological approach to men's experiences of MC. MC history and research reflects an embodied sense of the penis permeating the layers of meaning, both personal and cultural, that overlie it.

2.6.1 **Hermeneutics**. IPA, as an interpretative endeavour, draws upon hermeneutics, particularly through the work of Heidegger (1962), Gadamer (1975) and Schleiermacher (1838/1998). Through interpretation, IPA distinguishes itself from other phenomenological approaches in psychology, such as the descriptive phenomenology of Giorgi (2009). Smith et al. (2009) draw upon Schleiermacher's view that, in a comprehensive analysis of a text, the end result may be 'an understanding of the utterer better than he understands himself' (Schleiermacher, 1838/1998, p. 266). They take the position that interpretation in IPA can move beyond what participants explicitly state. Heidegger (1962) emphasised our subjective inter-relatedness to the world and the hidden meanings of 'appearances' as well as the surface ones. He felt that these hidden meanings were

ones the phenomenologist could uncover. He accepted that in doing this, 'fore-conceptions' (Heidegger, 1962, p. 141), which are one's assumptions and pre-understandings, would reveal themselves and needed to be worked through in relation to the phenomena, rather than just accepted. IPA, following Heidegger, embraces the researcher's dynamic role in an interpretation of the participant's world (Willig, 2008, p. 57). As Smith et al. (2009) argue, Heidegger's hermeneutic stance indicates the importance of reflexivity in IPA and taking a more nuanced view than that of Husserl's bracketing, with the realisation that it can only ever be partly achieved.

As discussed above, Gadamer did not agree with Schleiermacher that it was possible to understand the author better than he understands himself. However, he did agree that someone reading a text could add new interpretations. In this process, he, like Heidegger, stressed the importance of maintaining a reflective openness to one's prejudices and bias while engaging with the text. He believed this could avoid meaning being imposed on a text by a reader's preconceptions.

Wilhelm Dilthey (1900/1976) has written of the interpretative process as a hermeneutic circle.

> Here we encounter the general difficulty of all interpretation. The whole of a work must be understood from the individual words and their combination but full understanding of an individual part presupposes understanding of the whole. … the whole must be understood in terms of its individual parts, individual parts in terms of the whole (Dilthey, 1900/1976, p. 259).

Smith et al. (2009, p. 28) stress the importance of the hermeneutic circle in IPA, and particularly that analysis should involve a 'back and forth' iterative process, as meanings emerge and are considered. I felt comfortable with the concept of the hermeneutic circle when approaching the texts but was surprised at the frustration and feeling of wanting to give up on the

process at various points. My struggle with the *level* of interpretation to take throughout the research was at the forefront of my mind and then moved back and forth in what at times felt like an endless hermeneutic circling; in essence I was trying to interpret my internalised Gadamer/Schleiermacher debate. At other times my approach to interpretation has been like a dance, a careful back and forth, trying to keep the right balance between being fully grounded in the text or moving beyond it. I reflect further upon these issues in the Discussion.

2.6.2 **Idiography**. Smith and Osborn (2003) have described the influence that idiography has on IPA. Idiography is an approach which explores individuals in depth and in personal detail to reveal what is particular about them. Smith et al. (2009) suggest that a commitment to idiography in IPA underlines the need for in-depth analysis, with an openness to the unique view that individuals can offer of their experience of phenomena. At the same time they point out that phenomenology encompasses the embedded nature of the individual in contexts that influence them. They suggest that IPA's analytic procedures are able to maintain an idiographic commitment while also developing more general themes and commentary. They go on to argue that the idiographic approach does not mean that more established generalisations can never be made in IPA, but that they would emerge gradually as more studies in a research area are carried out (Smith et al., 2009, p. 29).

2.7 Rationale for the choice of IPA

IPA seems to fit well with my epistemological stance as it does not prescribe any particular position as a qualitative approach. As a methodology it can be rigorously scientific, although taking a different view of this to that of mainstream quantitative research (also see subsection 2.8 below). Jerome Bruner (1990), one of the founders of the cognitive revolution in psychology, emphasises that cognitive psychology was originally formulated as having 'acts of meaning' (p. 3) as a focus. He is disillusioned with the way cognitive psychology has largely

only used quantitative methodologies for research. Eatough and Smith (2008) have called for a wider view of cognition, promoting IPA for the analysis of the subjective meaning-making process. They acknowledge the role of language in the inter-subjective development of the self. This reflects my position towards IPA IPA in this research study, although I perhaps put less weight on the discursive role of language.

I considered using other methodological approaches to my research question. Foucauldian Discourse Analysis (FDA) (Arribas-Ayllon & Walkerdine, 2008), Grounded Theory (GT) (Glaser & Strauss, 1967) and the possibility of taking a descriptive phenomenological approach (Giorgi, 2009) were explored along with IPA. FDA privileges the role of language in the way discourses are structured by power and made available for use. While this is important, my epistemological stance meant that it was too constructionist and inappropriate for the experiential focus of the research question. GT has been criticised by Langdridge and Hagger-Johnson (2009) for the absence of consideration of the participant's internal world. Willig (2008, p. 47) has critiqued the preoccupation of GT for uncovering social processes and its lack of emphasis on reflexivity. I felt that the participants' internal world was at the heart of my research question and that IPA would be a better fit. A descriptive phenomenological approach would have met some of the aims of my research question but I considered that the interpretative approach of IPA and its emphasis on meaning was more appropriate. As a circumcised man, I considered that IPA's attention to the double-hermeneutic would facilitate further reflection on my role as researcher throughout the research process (see sections 2.8.1, 2.9 & 4.3.3). IPA fits well in terms of the focus on participants' lived reality and individual experience. I hoped that, by reflecting on the symbiotic role of language and experience, I could avoid making interpretations that went too far, a problem that Willig (2008, p. 67) sees as a challenge for IPA.

2.8 Evaluating the Research

In quantitative methodologies, validity and reliability are well accepted constructs by which to begin evaluating research. However, in qualitative research, as Finlay (2006) points out, there is a greater divergence of views on how research should be evaluated. Seale (1999) has warned against using strict criteria to judge qualitative research and also against extreme relativist positions that challenge attempts to judge validity. I am aligned with attempts to evaluate qualitative research by using broad guidelines to stand in for the validity and reliability used in quantitative methodologies as Smith et al. (2009) recommend. They suggest that this approach to quality avoids stifling creativity and subtlety in IPA. To this end, I have used Yardley's (2008) suggestions for demonstrating qualitative research validity. Yardley defines four principles that I will consider in turn.

2.8.1 **Sensitivity to context.** As Yardley suggests, I have set out to demonstrate sensitivity to context by engaging in extensive reading of empirical and theoretical literature throughout the research process, over fields including psychology, anthropology, sociology and medicine.

In the interview process, I aimed to be sensitive to the participants' perspective, for example by using open-ended questions in a semi-structured format. Furthermore, I endeavoured to maintain an awareness of the participants' sociocultural context and also of my influence as a researcher and a circumcised man (see Personal Reflexivity, section 2.9).

2.8.2 **Commitment and rigour.** I committed myself to IPA training seminars and to read IPA papers and philosophical theory. I have further aimed to demonstrate commitment and rigour by engaging my supervisor and fellow research colleagues in cross-reading to give feedback. Feedback during the analysis helped me to step back from the data when I had become too close to see the bigger picture, reengaging me in the hermeneutic circle.

Smith et al. (2009) suggest that the sample is carefully selected and homogeneous as an example of demonstrating rigour. I have tried to show rigour

in this regard in an alternative fashion. The research literature often mentions controversy surrounding MC, with opposing views being stated with equal conviction. To be sensitive to this context of controversy, I felt that I had to be rigorous in aiding the self-selection of a sample without pre-judging their experience. Therefore, I deliberately courted a sample that would allow men with *any* experience of circumcision to come forward.

In conducting the analysis, I used *negative case analysis (*Lincoln & Guba, 1985*)*. As initial themes began to emerge one by one, I would look for participants' experiences that were contradictory, going through repeated cycles of adjusting, expanding or abandoning themes. There were many times when the image of the clockwise arrows on depictions of the hermeneutic circle felt as though they were running in reverse. The process brought to mind the image of Prochaska and diClemente's (1983) image of the Cycle of Change with relapse, or backward steps as an integral part of the process.

I have set out to develop an analysis and interpretation that has sufficient depth and insight to add to MC research. I have tried to develop an empathic understanding of the participant's experiences within their sociocultural context and to ground and re-ground my findings and interpretations in their experiences.

2.8.3 **Transparency and coherence.** I have outlined my epistemological stance and methodological choices earlier. In section 2.10 below I describe how I selected the participants, the way that I developed the interview schedule, carried out the interviews and the steps I took in doing the analysis and write-up. The aim of this is to make it transparent to the reader how the study was conducted. By including the participants' own words throughout the Analysis, I am aiming to illustrate transparency as to the inductive approach taken. Through engaging in personal reflexivity and in the use of a research diary (see Appendix 2), I intend to clarify how my experiences and thought processes are inevitably part of the research and how I am involved in a double-hermeneutic process. I have tried to create a

coherent analysis through attention to my epistemological stance and by presenting the research clearly.

As suggested by Smith et al. (2009), I have kept all my notes throughout the research process, from developing ideas about the research question, keeping the interview and transcript notes, to development of themes and drafts of the final report. I have used these to go back at various points to check the coherence of my thought throughout the research process. However, the final arbiter of this reports' coherence will be the reader, of course.

2.8.4 **Impact and importance**. Yardley (2008) makes the point that an evaluation of qualitative research needs to consider the impact and importance of what is presented. I have aspired to choose a challenging subject matter that has been little researched psychologically and which has potential impact and importance by virtue of the large numbers of men who have been circumcised. I expand on this further in the Discussion when considering the relevance of the findings for Counselling Psychology.

In the Discussion (section 4.3) I will further reflect upon my efforts to demonstrate the quality markers of this research.

2.9 Personal Reflexivity

This section was written prior to interviewing participants. In the Discussion subsection 4.3.3, I will return to further consider personal reflexivity.

I find Willig's (2008, p. 10) description of personal reflexivity a useful starting point when considering this research project.

> *Personal reflexivity* involves reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research. It also involves thinking about how researchers shape the ongoing research and how the research may have affected and possibly changed us, as people and as researchers (Willig, 2008, p. 10).

As Marshall (1986) suggests, I consider it important to make my position as a researcher clear so that the reader can properly evaluate how the research contributes to knowledge. My reasons for selecting this research topic are two-fold. One of my first clients, 'John' [1] had experienced MC at the age of 7. The medical procedure itself was uncomplicated, but his experience of the aftermath was traumatic, leading to preoccupation and fear around his penis, particularly a fear of having an erection in changing rooms both as a child and an adult. He never felt himself to be a man.

However, my own experience of MC has been benign. I had the procedure when I was six and although I have memories of having a reaction to the anaesthesia afterwards, I have never experienced any regrets nor any strong positive feelings associated with it.

Following the advice of Hill (2007) on transparency in circumcision research, I identify myself as coming from a White British background and coming from a culture in the UK that no longer promotes circumcision. Despite being circumcised myself, I have four sons who are not. My reasons for not having my own sons circumcised are that it was never suggested when our sons were born, and that since my own circumcision was only undertaken to relieve tightness of the foreskin (phimosis), it never occurred to me. Furthermore, I state that I do not profit from circumcision and my true motives for this research are as set out herein.

My period of reflexivity around this has led me to realise that MC is something that deserves more attention from the viewpoint of psychological research. Nevertheless, I realise that my own experiences and attitudes about MC will influence this research and that I will need to reflect upon my own assumptions and attitudes during the research. To this end, I have begun a research diary in which I will note down my thoughts and feelings and reflect on

[1] Name and identifying details omitted for purposes of anonymity

the way these may influence my interpretation of the research. I have chosen MC as an area of research that I am interested in, but I am trying to maintain a stance of curiosity towards how the findings emerge. I am now aware, in a way that I was not before conducting the literature review, that MC is a very controversial area where the tendency is to fall strongly towards one side or the other. Indeed, I have felt myself pulled in multiple different directions as I have engaged with the research material. I will endeavour to consider both sides of the argument but am aware of my limitations in attempting this. I can see that, for cultural, aesthetic and other reasons, some people have a preference for MC and others are opposed to it. I aim to keep in mind that my changing assumptions during the research can influence how I formulate the interview questions, how I interpret the data and how I write up the findings. I aim to present my findings in as transparent a manner as possible.

I have thought about my role as researcher-subject of this IPA study in the light of the double-hermeneutic process described by Smith and Osborn (2003). As a researcher-subject, I am making sense of my participants' sense-making - the research-object, and cannot remain apart from it. This is particularly relevant since I am a man, have a relationship to my penis and I am circumcised. Bunge (1993) has pointed out that in the critical-realist epistemological approach our perception of facts is influenced by our beliefs and attitudes and therefore subjectivity is a necessary part of understanding and the production of knowledge, requiring personal reflection.

2.10 Data Collection

2.10.1 **Sampling.** IPA, due to its idiographic and qualitative nature, utilises small samples. It makes little sense to talk of representativeness and random sampling in similar terms to those in quantitative studies. I consider non-probability sampling to be a sound ethical approach to finding out whether a subject, such as MC, is worth further examination since a smaller number of participants undergo the research process unnecessarily.

Smith et al. (2009) indicate that researchers should aim to recruit a homogeneous sample representing their area of study for whom the research question will have some meaning. Smith and Osborn (2003) and Yardley (2008) suggest homogeneity as a way of containing some of the variation between participants that arises in other ways than that suggested by the research question.

The issue of homogeneity and in-depth analysis vexed me. I could see that potentially there was a large pool of participants. The 2000 British National Survey of Sexual Attitudes and Lifestyle reported 15.8% of 16 - 44 year-olds were circumcised, (Dave et al., 2003). As a rough guide, with approximately 20 million men in the age category 15 – 64 (Office for National Statistics, 2011), this gives a pool of around three million males from which to find volunteers for research. However, when it came to deciding how to make the sample more homogeneous, I came up against my own ideological stance. I found it unjustifiable to privilege one group or to exclude any particular person an opportunity to come forward through methods of selection that might be biased and not justified by prior research. I decided to allow space for any male with something they wanted to say about their experiences of MC to come forward. I am not suggesting, however, that the sample is representative of all circumcised men, as the sample is small and self-selected.

Therefore, by keeping my research question open and drawing from a broad pool of participants, a more heterogeneous sample was generated than in many IPA studies (see Table 1 and Appendix 3 for thumbnail sketches of the participants). I took encouragement from Smith et al. (2009) who maintain that the final judge of the effectiveness of an IPA study is the extent to which throws light on the wider context; I was concerned that a more homogeneous sample might just play into one side of the circumcision debate and end up limiting the readers ability to make connections and judge transferability, something which Smith et al. (2009) suggest is important.

In line with the Smith et al. (2009) recommendations for IPA professional doctorate sample sizes, I recruited eight participants. I placed an advertisement in a London-wide newspaper, seeking men over the age of 18 who would be willing to be interviewed about their experiences of MC.

2.10.2 **Semi-structured interviews.** When deciding on the data collection method my primary goal was to settle on a method that would elicit the most in-depth and detailed data regarding each participant's personal experience. I was following Brocki and Wearden's (2006) advice for IPA researchers to think carefully of the pros and cons of various data collection methods. I wanted to choose a method that would allow the participant to freely relate what they considered to be the most important facets of their experience. I did not want to pre-judge experiences by settling on using a more structured approach. I rejected diaries as I wanted to collect data from a longer period of time. I considered using personal accounts or questionnaires. However, I decided that written personal accounts might put off or disadvantage many participants while questionnaires would inevitably pre-judge and constrict the data collected.

I therefore decided to interview each participant once, a method of data collection that fits well with my skills as a Counselling Psychologist, relying on interpersonal communication skills and rapport to gather data (Hargie, 1997, p. 205). A single interview was a feasible and pragmatic choice within the time constraints of the research. Interviews allowed me to take note of non-verbal communication both during the interview, in order to guide it, and also afterwards, during annotation of the transcription to aid analysis. The design of the interviews was semi-structured as I hoped this format would allow participants to flexibly recall key experiences that would allow me to identify relevant meanings (Reid, Flowers, & Larkin, 2005) and even for new concepts to emerge (Dearnley, 2005).

As Smith and Osborn (2003) suggest, the importance of establishing rapport so that participants could talk about meaningful experiences would

inevitably create more pressure on me as the interviewer. However, on balance, I felt that my training and experience as a Counselling Psychologist put me in a strong position to be able to gather the data successfully from one interview.

2.10.3 **Preliminary interview schedule.** My preliminary interview schedule (Appendix 4) consisted of a series of questions covering areas of MC experience. These questions grew out of a multi-disciplinary review of MC as there was little peer-reviewed psychological research. As Smith and Osborn (2003) recommend, the schedule was guided by my research question and I scripted the questions using language that could be readily understood in an interview context. At this stage, I carried out a reflexive interview, since I myself am a circumcised man, and I used this opportunity not only to reflect further on how this might impact the research, but also to guide a reappraisal of the interview schedule. The result of this was that when I listened to my responses on an audio-recorder, I was aware that I was talking of experiences that occurred over a great part of my lifespan. As I considered this more, I realised that there were certain areas that I had neglected, and some of these justified inclusion in the schedule. I therefore, reworked my interview schedule to include questions on how participants felt about the way their MC looked and about health effects. I realised that having questions that followed a lifespan timeline might help elicit areas of experience to aid later comparisons and contrasts between participants. However, despite doing this, I was committed to using it more as an aide-memoire during the interview rather than as a way of rigidly structuring the interview along a timeline format. This new schedule was then used for the pilot study.

2.10.4 **Pilot interview and revisions to the interview schedule.** I decided to undertake a pilot interview as I this was my first research project utilising a semi-structured interview and IPA. I was keen to gain feedback on my style of interviewing, how the interviewee had felt, and whether the pilot participant felt that their experiences were fully explored.

A colleague on my training course who had taken an interest in the research volunteered for the pilot interview. He identified himself as a circumcised man and therefore fitted the research sampling criteria. Since I was keen to use the pilot interview as a rehearsal for the actual interviews, I followed the pre-interview procedures, the consent procedures and the post–interview procedures as closely as possible.

The feedback I received was positive. I reviewed the data and found it to be sufficiently nuanced and deep for the most part. I noticed some opportunities that I had missed to 'go deeper' and resolved to stay closer to the participants' experience in future. My pilot participant reported that the interview had prompted him to think about other areas of experience that he remembered, such as masturbation as an adolescent and how that related to his MC. From this, I made further changes to the interview schedule (Appendix 5). I realised that many of the questions in the schedule asked for an account of past experience and this raised some issues about the phenomenological validity of experience remembered over the lifespan. However, returning to my epistemological position, I considered that their experiential memories were valid as an object of a phenomenological research study, even if they had been mediated by later understanding and life experience.

2.11 Procedure

2.11.1 **Recruitment.** A flyer (Appendix 6) was prepared and handed out at various locations in London (a large railway station, a health club and at Covent Garden). However, due to a lack of response, I then placed an advertisement in the classified research section of the London Metro newspaper (Appendix 7). This method yielded sufficient responses which were selected from in the order to which the participants had responded, as I wanted the selection to be transparent.

2.11.2 **Initial telephone contact.** The advertisement included an email address, and a dedicated research telephone number with an invitation to respond to that by text as well as voice. When a telephone contact was made, I used a pre-prepared telephone schedule (Appendix 8) which was designed to give further information about the research to enable the respondent to decide if they wished to participate further. At the end of the initial telephone contact, I arranged to send those who were interested in pursuing the research further a 'Participant Information Sheet' (Appendix 9). This gave them written information outlining the research so that they could make a considered and informed decision to take part.

2.11.3 **Pre-interview discussion.** For six participants, interview rooms were pre-booked at the university; for the remaining two, rooms were pre-booked in a business centre and a members' guild respectively as they requested a location close to work or home. Upon meeting the participants and after checking that they were comfortable and had all they needed in the way of refreshments and rest breaks, I asked them to read through the Participant Information Sheet (Appendix 9) allowing time to answer any questions they had. A couple of them asked how long the interview might take and about how confidentiality would be maintained. Since this report is to be published and confidentiality at that stage cannot be maintained, it was emphasised that their name would be substituted with a pseudonym and that any identifying details would similarly be altered in the study, to preserve anonymity at all times. I explained that I had allowed time

for a debrief, during which they could discuss how they had felt about participating in the interview and ask further questions. Following this information, I gave each participant a consent form which they were asked to sign (Appendix 10). I also signed this form.

2.11.4 **Background demographic data collection.** After signing the consent form and before the interview began, I invited each participant to complete an optional background demographic data collection form, which they all agreed to do (Appendix 11). The purpose of this data collection was to give readers of the study an idea about the background demographics in order to contextualise the sample. I also wanted to be transparent about the diverse backgrounds of the participants. I included several items on the basis that they were implicated in the literature review of MC. Therefore, questions regarding faith, culture, ethnic origin, sexuality, and relationships as well as age, education and employment were included. I tried to make the form as inclusive as possible but the downside of this was that in some parts the form became somewhat unwieldy. I had to point out areas that had been missed while also making it clear that there was no need to fill in these areas if they did not wish to. In future I would spend more time on the design of such a form.

2.11.5 **Interview.** The interviews ranged from approximately one to two hours in length with the average being around one and a half hours long. Each interview was recorded on an Olympus digital voice recorder, with the data being transferred onto an SD card and stored in a locked cabinet at my home address. This recorded material will be destroyed once the evaluation and appraisal of the research is complete.

I found that adopting a relaxed and open attitude from the moment I met each participant, yet showing that I was conducting the research in a thoughtful manner, meant that it was generally easy to build rapport. The only time my relaxed demeanour was tested was when I had inadvertently spilt a cup of coffee down my shirt moments before meeting a participant.

Asking about their reasons for participation was usually found an easy question to answer, and in those cases the initial answer tended to form the basis for the rest of the interview. In the first interview, I felt slightly stilted initially in the way I asked for more details about experiences. However, in subsequent interviews, when my confidence grew, I was able to go with the flow better and revisit points in a more flexible manner. Of course, each interview took a different form, and for some participants it was useful to dip in and out of their developmental timeframe with regard to their experiences as this often built up the context of their later experiences. Indeed, for a couple of the participants, the interview itself made them realise something about their experience that they had never been fully aware of before.

In a couple of the interviews, I noticed a tendency for the participant to check with me whether he was giving the 'right' answer or whether the information was 'useful'. It positioned me in the role of expert which was not what I intended. In future research of this kind I would put greater emphasis, from the very first contact with participants, on my interest in any of their experiences of the subject matter whatever their view.

In a couple of the interviews, particularly where a lot of depth was covered on aspects that were not included in the schedule, I referred to the schedule as a checklist to ensure that we had not 'missed out' any areas. On some occasions, I found this slightly awkward as it seemed to break the flow of the interview somewhat. Nevertheless, further experiences were uncovered that would have been missed. In future, I would like to memorise my interview schedule, so that I can maintain a more natural flow throughout interviews from the beginning.

2.11.6 **Post-interview debrief.** At the end of the interview a verbal debrief was given to each participant, asking them how they had found the interview and inviting them to ask further questions. All the participants responded that they had found the experience positive, some markedly so, remarking that they had not previously had the opportunity to share feelings about their experiences in

this way. Two of the participants asked questions about my circumcision status, which I answered, and another two asked questions about getting psychological help for issues that were either tangential to or unrelated to the study material. The resource pack provided to all participants was useful in signposting these participants towards further help.

2.11.7 **Post-interview reflexivity.** After the completion of each interview, I made notes on the impact the interview had had on me, how the participants had reacted and what they evoked in me. I also made notes on my thought processes and summarised my initial impressions of them and what they had told me. If any ethical concerns arose, I thought about how I had handled these. I tried to treat each interview and my post-interview reflection as part of a learning process. I revisited these notes during the analysis and write-up as a way of reflecting on my emerging understanding.

2.11.8 **Transcription.** I used Express Scribe Pro Software with an Infinity foot pedal to transcribe each interview. I listened to each interview in full before beginning transcription. I aimed to keep a level of detail in the transcriptions that reflected significant non-verbal behaviour along with any pauses and inconsistencies in each participant's speech (see Appendix 12). I did this to keep the data as rich as possible for the analysis stage. Once each transcription was completed the recorded interview data was removed from the computer.

2.11.9 **Analysis of data.** As I began the analysis stage, I was mindful that I was inextricably part of the research process and would need to maintain reflexivity to ensure that the analysis remained grounded in the data. Interpretation in IPA has been described by Smith and Osborn (2003, p. 53) as involving a 'double hermeneutic' as I sought to make sense of my participants' sense making. Moving from the particular of an individual participant's experience to the experience that is shared between participants is a further part of the process of analysis. It involved a number of iterations, as I analysed transcripts one by one and emergent themes gradually became grouped into superordinate themes (see

Appendix 13). Then I repeated the process across all participants' superordinate themes and slowly developed a set of master themes that attempted to capture the essence of the shared experience, while allowing for divergences to remain. My further description of theses stages of the analysis below tends to oversimplify this process and make it sound linear or smooth. In reality, I found it to be messy; themes were explored and then cross-checked with the original transcripts to ensure that they were grounded in participants' accounts. I consider my resultant analysis to be only one of many possible ones but that what is important, as pointed out by Reid et al. (2005), is that it should hopefully be plausible to those who read it.

2.11.9.1 Reading the transcripts. The first stage of the analysis began by looking at one interview in detail, as suggested by Smith and Osborn (2003), before analysing further interviews to build up master themes. To begin, I chose an interview that seemed to contain a rich articulation of the participant's experience, as I felt that this would make a good starting point that would help to build my skills for the subsequent analyses. The following procedure was adapted from Smith and Osborn (2003) for the analysis stage.

2.11.9.2 Initial notes. Before making initial notes, the transcribed text was read while listening to the audio recording to re-familiarise myself. I re-read my impressions of the interview that I had noted on the day and reflected on how these might influence my understanding. I then read through the interview transcript again, making notes on the right hand side as I read through it line by line. My notes consisted of initial ideas, impressions and insights. I tried to keep initial comments were close to the text, while on further readings I would generally add linguistic and conceptual comments, using different coloured pens to distinguish these. Where comments became more abstract in nature, I would return to them the following day, sometimes rejecting them if I felt that they were not grounded enough in the transcript.

2.11.9.3 Developing themes. I read through the interviews again, this time using the left hand side to develop themes that might capture some of the essences of the notes made during the prior reading. When I found two headings that seemed similar, I would try to combine them and reuse that if appropriate. I would return to the text many times and progress was often circular rather than linear.

2.11.9.4 Cross-linking of themes. The emergent themes were listed separately and cross-linked, where possible, into clustered themes, which were checked for sense against the transcripts. Smith and Osborn (2003, p. 70) suggest 'you imagine a magnet', whereby some themes will tend to be drawn together as you make sense of the data. Initially, I did the clustering on my computer. However, I found it difficult to create the clusters so I printed out selected quotes together with an identifying paragraph number and a theme and cut these into individual labels. I found that I could easily move them around into clusters or reform them into new ones. Using this more embodied way of data manipulation helped me to sense connections between emergent themes and to subsume them into other themes. When the clustering process could continue no further, the themes became superordinate themes and the subthemes were listed beneath them.

2.11.9.5 Selection of the next participant for analysis. Each participant's transcript was analysed as described above before moving on to the next. As pointed out by Smith et al. (2009, p. 100), I found that my 'fore-structures' had been changed by the previous analyses and I was inevitably influenced by this to some extent. However, by following the steps in the procedure, and reflecting on my assumptions about what might follow, I noted that new themes could emerge from subsequent transcripts, rather than being imposed by what had come before. To check out my themes, I asked a peer researcher to review them for plausibility. Even though this did not constitute validation by triangulation (Madill et al., 2000), it was useful, as time could be spent exploring divergences and

misunderstandings. I reviewed the themes further with my research supervisor. At this stage there were between three and six master themes for each participant.

2.11.9.6 Developing themes across participants. The next step in the analysis was to develop the themes across participants. Superordinate themes were compared one by one across participants in a similar manner to the way theme clustering was described above, with much of the work being carried out in a multi-sensory way on a table. Once a master theme had been identified, it was again checked back both to the quotes that had been subsumed into it and also, at various points, to the original transcripts. I continued the analysis to the point of 'saturation' when I felt that the themes could not be further integrated, as recommended by Willig (2008). A table of master themes and subthemes was created (Appendix 14 and Appendix 15) together with the quotes that best illustrated those themes and this table was used as the basis for the write-up of the analysis (chapter 3 below). Some reworking of the structure and particularly the names given to themes took place at these later stages. For example, one participant seemed to have a theme that could not be accommodated, but then it became clear that it was just a different aspect of one of the master themes.

During the write up process, further refinement of what was to be included took place. In a sense, the analysis structure was not fully complete until the write-up was well progressed and I would still find myself checking back to the original transcripts on some occasions.

2.12 Ethical Considerations

This research study was subject to approval granted by the Ethics Committee of the Department of Psychology at City University. A copy of this approval is attached in Appendix 16. Ethics were considered at every stage throughout the research process and I found it useful to refer to the Code of Human Research Ethics (British Psychological Society, 2010). My main area of concern was to avoid causing harm to the participants. Others areas of concern were to gain fully informed consent, to maintain anonymity, and to make clear

the rights to withdraw, whilst undertaking the whole project in a way that maintained respect towards participants and avoided prejudice. These points are further discussed below.

2.12.1 **Throughout design and implementation.** Respect towards participants was an ethical consideration that underlies this research project in a fundamental way. I had reflected on the circumcision research previously carried out and the way the topic is discussed in the media as a polemicized debate. By keeping the research question open and not focusing upon trauma, I have aimed to respect all experiences of what it means to be a circumcised man and to avoid prejudicing one aspect of experience. I have aimed to maintain this stance throughout the analysis and write up of the research

I decided not to offer any financial inducement for taking part in the interview as I did not want this to be a possible motivation for taking part, ensuring as far as possible that participants had experiences they wished to share. I also felt that it would make it easier for a participant to withdraw later if they had not been paid.

Having considered the design of the research, I did not think that it would involve participants in any more danger, physical or psychological, than they might experience in their day to day lives. However, because of the sensitive nature of the topic, I reflected that it was possible that participants might find this process more difficult than anticipated. I wanted to remain sensitive to this and planned to use my interview schedule in a way that was flexible, allowing them to take the lead in what they discussed.

Just before each research interview, I conducted a pre-interview discussion based around an information sheet (Appendix 9) that each participant was invited to read. I asked them if they had reason to believe that they might be harmed in any way by taking part in the interview in order to give pause for further thought. I felt that this was important in order to minimise the potential for harm and did so before asking each of them if they still wished to continue by signing the

consent form (Appendix 10). The form explained that an audio-recording of the interview would be made and that they had a right to withdraw from the research at any point prior to the write-up.

During the interview I occasionally used the schedule to prompt for further experiences. I did this tentatively, letting each participant know that there may be questions they might find not relevant or would prefer not to talk about. I also allowed for a post-interview debrief so that time could be given for the participants to discuss any difficulties they might have experienced from the interview. During the debrief, most participants said that they had valued the opportunity to talk about their experiences in depth. This included Ahmad, who had mentioned his abusive childhood and how this made him question his circumcision. I paid particular attention to his debrief to ensure that he felt grounded before leaving and was not distressed. I had prepared a debrief information pack (Appendix 17) for each participant. This contained contact numbers of organisations that might prove helpful for professional advice should any of them later experience distress.

I paid attention to my own personal self-care as well as that of the participants. I decided not to interview participants in their homes to avoid risk of physical harm and, therefore, the interviews were carried out in pre-booked rooms at City University or in other official meeting rooms. I chose to continue my personal therapy throughout the research process, finding the research stressful whenever progress seemed elusive.

It was a key concern of mine to ensure that identifiable personal information remained confidential. During the transcription process, I anonymised their personal information. A pseudonym was given to each participant and used within the transcript. Other details (age, employment etc.) were also anonymised so that the true identity of the participant could remain confidential. The transcripts and my analysis were kept on a password protected computer to which only I had access, while the consent forms, audio recordings

and key to the pseudonyms were kept in a separate, locked filing cabinet. Handwritten documentation or printouts from the computer were kept in another locked cabinet when not being worked on. All interview recordings and forms will be destroyed once the write-up and appraisal stages of the research are completed.

2.12.2 **Write-up.** During the write-up stage I am aware of the need to engage closely with the material and to let meanings emerge. I consider this a prerequisite to my ethical as well as methodological stance. Willig and Stainton-Rogers (2008) advise against imposing meaning on participants' accounts. I will use my research diary to reflect on how meaning emerges from the data. When writing the Discussion, I am conscious that the 'I' in IPA is for Interpretative. I will be looking to reveal another level of meaning in a tentative and exploratory way; this represents an ethical challenge for me. I want to keep my participants' voices in mind during this process and to test the evolving meanings by putting myself in their shoes, as if they were reading this research. I reflect further upon this in the Discussion.

3 Analysis

3.1 Introduction to the Analysis

The respondents who were interviewed were aged between 30 and 80 years of age and all reported being circumcised. There were no requirements for the participants to have English as their first language, but all demonstrated a high degree of fluency, including those for whom English may have been a second language. A summary of the participants' background information is set out in Table 1 below; see Appendix 3 for thumbnail sketches of the participants. This illustrates the heterogeneity of the participants' demographic backgrounds

Age at circumcision	At birth: 4 Pre puberty: 1 Age 20-30: 2 Age 40-50: 1
Age at research interview	Mean: 48 Range: 30-80
Ethnic origin	Pakistani: 2 Indian: 1 White British: 2 White (other): 2 East African: 1
Nationality	British: 4 N/A: 4
Religion	Muslim: 3 Jewish: 1 Christian: 2 Hindu: 1 Buddhist: 1
Religiosity	Very important: 1 Quite important: 1 Average importance: 3 Not that important: 1 Unimportant: 1 N/A: 1
Education	University level: 4 HND level: 2 GCSE level: 2
Sexual orientation	Gay: 2 Bisexual: 1 Heterosexual: 5
Geographical Location	Inner London: 1 Outer London: 7

Table 1: Summary of participants' background information

I took the decision to avoid referring to theory throughout the Analysis. I wanted it to present a close reflection of the participants' voices with a focus on their lived experience, rather than risking it being clouded by theoretical discussion. However, the Discussion in the light of theory will follow the Analysis. In presenting quotes to illustrate the themes I have tried to choose those that best reflect individual participant's core experiences and to represent each participant's voice.

Three main themes emerged from the analysis (see Appendix 15 for a table of master themes and subthemes and Appendix 18 for a 'model' of how these fit together). The first master theme is 'Who am I? Circumcision and my Self' which includes the subthemes 'In or out?' describing experiences of group belonging, 'Feeling different?' relating to their personal sense of self and 'Perceptions of others', exploring how they experienced others views of their circumcision. The second master theme, 'Perceptions of the physical experience. Circumcision and my body' includes four subthemes. These comprise the men's 'Reflections on appearance', their 'Experiences of sensation', how they experience 'Representations of health and hygiene' and lastly their 'Memories of the operation'. The third and final master theme is 'Reflecting on the decision' which has two subthemes. The first, 'Did I have a choice?' explores their experience of choice in the original decision, while the second 'Reviewing the decision', looks at how the men feel about their circumcision when they look back at it over the passage of time.

The Analysis uses direct quotes from the transcripts and are referenced following each quote in brackets as follows - (participant pseudonym and line numbers). Pseudonyms have been used to protect participant's anonymity and identifying details have either been altered or omitted thus _____. The quotes include grammatical errors and pauses as heard in the recorded data. The pauses are shown in the text by the use of a double full stop .. while the use of bold text within [] is used to describe body language or details of intonation. The use of

italicised text within [] is used sparingly to provided missing words when essential to aid the reader. Italicised text on its own is used where the participants emphasised certain words. In a few cases the use of [] on their own indicates text that has been omitted where, being taken out of its full context, it might add confusion for the reader.

One feature that runs through each participant's narrative is the importance of culture and context in understanding how they make sense of their experience. However, due to the divergent cultures represented in the sample, I felt that highlighting culture and context at a thematic level risked losing the richness of experience that was common between the men. I have therefore woven the culture and context into the Analysis at each point where it will help to inform the reader of the background to the experience being described. This is particularly relevant in the first theme. I will further consider the role of culture and context in the Discussion.

3.2 Master Theme 1 – Who am I? Circumcision and my Self

This master theme illustrates the way circumcision has led to participants' feelings that their sense of self had been changed or confirmed in some way, and what this change meant. For each participant, the focus of these experiences was different and this is reflected in the three subthemes. 'In or out?' explores the changes to feelings of being in either the in-group or the out-group and how that related to their circumcision status, along with the connected experiences of acceptance and rejection. 'Feeling different?' looks at how difference is considered by the men at the individual level of their personal identity and how that difference impacts their personal world and sense of self. The third subtheme, 'Perceptions of others – 'It's a bit of a concern isn't it?' illustrates how the men experience the views of others and what that is like for them.

3.2.1 **In or out?** Most of the men described how being circumcised made them feel as if they belonged to a particular group. For those who saw circumcision as

their cultural norm, this appeared to create strong feelings of acceptance and a new group identity.

For example, Hari described his experiences following a tribal circumcision in Kenya aged 7, where the emphasis of the ritual preparation was on becoming a man.

> You feel, wow, I'm accepted. I'm a real man now. I have grown up and I'm no longer the little child of yesterday. (Hari, 349-351)

Hari's vivid recall of passing through this rite of passage shows how he marvels with some surprise at being accepted as one of the group of men. The use of 'now' seems to emphasise his experience of this transition as sudden, as does the juxtaposition of 'I have grown up' with 'I'm no longer the little child of yesterday'. It is as if he paints an image of himself as a child, who physically remains a child, but for whom the experience of circumcision seems to mark a transition to manhood.

> To, to be like my father, so I have become him and I have become grand great grandfather so and so. (Hari, 1776-1778)

Hari's sense of acceptance and entry into the group of men seems further compounded by his description of 'becoming' his father and ancestors. His language suggests that he feels not just one of the men but bonded to them.

Hari's sense of belonging contrasts with Micky, who was not circumcised, despite being Jewish, until he was twenty. He talks of his feelings prior to his circumcision.

> You're a boy, you want to have friends, you want to look cool, and if you're not cut and you're Jewish then you're not cool. (Micky, 927-929)

Micky describes being circumcised and Jewish as synonymous with being 'cool' and by linking this together with the desire for friends, suggests that his experience prior to circumcision is that he feels more of an outsider, towards the

edge of the group. In his repeated use of 'you' rather than 'I', he is perhaps distancing himself from the concept of not being 'cool', locating it away from himself. However, when he is circumcised later for medical reasons, he talks of the change he feels afterwards, when he no longer feels the need to avoid using the urinals in the synagogue. An Orthodox Jewish friend recognises his circumcision when he is in the urinals and starts clapping.

> And that was quite a jubilation you know, so you know y'know, it was nice so .. The feeling was like 'Oh my god yeah', you know, 'I'm one of you now', so to speak. (Micky, 1068-1070)

Micky describes his sense of triumph and joy at this recognition and links his experience of 'jubilation' to his sense of being 'one of you now', being newly circumcised. It is as though his experience of his previous uncircumcised status meant that he had not felt properly Jewish. The transition, marked by the experience of circumcision, seems to have profoundly impacted his sense of being a Jew and his sense of belonging. It is as if he previously had a sense of diminished Jewishness in not being a 'fully-fledged Jew' (Micky, 1168) and as shown by his previous avoidance of the urinals. This now seems to have been replaced by a sense of pride, 'Oh my god yeah', in his new, self-confirmed Jewish identity.

However, for Soona, who was circumcised for medical reasons in India as one of the Hindu majority for whom circumcision is not part of the religious identity, such feelings of belonging are nowhere to be seen.

> S: Once my friends were trying to pull my trousers down and I was very, very uncomfortable, thinking that was that was to actually happen I would have been very conscious of ..
>
> *I: What do you think you would have been conscious of?*

> S: Conscious of the fact that I'm different and I'm sure there are probably not many people, circumcised people in India, so I would probably have looked out of place. (Soona, 1332-1342)

Soona describes intense and uncomfortable feelings; it is as if he is afraid of his circumcised penis being revealed in front of his uncircumcised Hindu peers. The sense is that he has kept this well-hidden to date and would like his circumcised status to continue to remain hidden from his friends. Here, the experience of being a circumcised man is suggestive of a risk that he could be construed as belonging to the wrong group, as he 'would have looked out of place'. Indeed, he points out earlier that in some parts of India it is believed 'that if you have a circumcision you become a Muslim' (Soona, 1238-1239), the principal religious minority. It is as though he still remains conscious of this difference, undiminished over the passage of some twenty years, as he switches from the past to the present tense when he says that he is 'conscious of the fact that I'm different'.

In contrast to Soona's childhood in India, Anik grew up in the north of England as a Pakistani Muslim, having been circumcised as a baby in Pakistan, before moving to the UK. His circumcision was the expected 'norm' for his religious and cultural background. In this quote he talks about the differences in the circumcision status between the Asians and White British that he noticed in the school changing room.

> I: So this gave you a feeling .. So when you were in the changing room this time, you noticed for the first time that you were different from the other boys?
>
> A: I noticed that there was two different groups. You had um like most people in my class when I was in school were either Asians, like Pakistani or Indian Muslims, or British white people. There was no Chinese or African people. Because I grew up in _____ um which is near _____ and I only moved to London a couple of years ago, so ____ is my home town. And I noticed that the Indian Muslims, Pakistani people, look the same and the other British people look different. (Anik, 157-165)

Anik's experience of circumcision within his local cultural background is as if it marks him as being 'the same' as other Asian Muslims, the group that he feels he belongs to, and it was the White British who looked 'different', despite them being the national majority. His sense of 'sameness' seems to emphasise his belonging to the Muslim group.

Two of the participants, Bob and Ron, talked of strikingly similar encounters with uncircumcised boys in changing rooms at school. Both being 65 and 53 and of White British origin, their experiences at 12 and 11, hark back to an earlier era in their childhood.

> I went to Catholic school y'know a secondary modern .. And there wasn't many in my year um then who were circumcised .. And I had a bit of the mickey taking because a lot of the boys weren't circumcised. (Bob, 54-58)

Bob describes an experience of his circumcision as marking him out as being in a minority group, an outsider in a Catholic school where the 'norm' was to be uncircumcised. Furthermore, 'the mickey taking' suggests that his experience is one of being disparaged by the others who were in the in-group.

> And they were alloc-[*sic*], to Jewish things, you know, like "Are you Jewish?", and you can imagine.. I can remember coming out of the showers and a couple laughing and calling me like a little Jewish boy or something, and that type of thing. And that's when I first sort of like, it made me feel that I was different. It set up a feeling that there was something wrong with me, with your penis sort of thing. (Bob, 67-75)

It is as if, by being asked "Are you Jewish?" in the context of being in a Catholic school, Bob experiences a further distancing from his peers, placing him in a minority group that he does not belong to. His experience is of emerging from the showers and being called names by two boys who draw attention to his circumcision. By his calling on me to use my imagination, I sensed embarrassment and awkwardness at this during the interview. His experience is as if he is being ridiculed for belonging to an outsider 'Jewish' group, and this seems to have a

cascading effect; on his sense of his embodied self, feeling that there was something wrong with his penis, and on his personal self, feeling that there was 'something wrong with me' as well.

Ron tells of his similar experience in a school changing room.

> R: And I was getting dressed and putting my vest on and he came over and made an issue of it [*his penis*] and starts referring to it in a particular way. So that's why you don't forget it and of course to be honest I sort of thought.
>
> *I: And it sounds like he was quite derogatory?*
>
> R: Yes.
>
> *I: What sort of thing?*
>
> R: Well I can tell you he was going "Oh Yid" you see. So obviously he had awareness and I was like.. you know (Ron, 58-67)

He later refers to this experience again.

> He's highlighted "Look at him, look Yid" and all this sort of thing. I thought "Hey this isn't good." And I had no awareness of the Jewish faith and that Jews are circumcised. (Ron, 1100-1103)

Ron's experience is of being 'highlighted', naked in a changing room with other boys around him as though he and his circumcised penis had been put in a spotlight for all to 'Look at him'. He appears to have had no sense of exactly why he is being called a 'Yid', generally used as a derogatory term. It is as though, despite his confusion, he realises from the undertone that the way his penis looks suggests that he belongs to a different group that he does not recognise. For him 'this isn't good'. His use of understatement here perhaps reflects the depth to which this experience has remained with him, 'you don't forget it', as well as his reluctance to go into too much detail, just referring to 'all this sort of thing'. The

reader should bear this in mind as the Analysis proceeds and more of Ron's experiences are presented.

These experiences of changes in the men's perceptions of group identity reflect the way that the cultural context of the circumcision impacts their identity forming process. For some, as seen in Bob's experiences, this also impacts on their sense of their own personal identity, and this is explored further in the next subtheme.

3.2.2 **Feeling different?** This subtheme explores the varying extent to which the men's circumcision gives rise to experiences of being different from others, in ways that influence their sense of personal identity, as expressed by Ron.

> I'm different, there's something wrong. (Ron, 1153)

It appears that the very experience of finding out he was circumcised at the age of 11 seems to have led him to conclude that 'I'm different'. It is as though the sense of 'I'm different' is enough on its own to conclude that 'there's something wrong'.

Bob describes how he noticed, as a teenager, that he masturbated differently to his friends as a result of being circumcised.

> It just felt a bit freakish. I couldn't get my head around it. I just felt like a bit inferior. (Bob, 299-300)

Bob's description of not being able to get his 'head around it' suggests that there was an attempt to understand this experience, but that it couldn't be resolved.

He later describes his experience of using sex workers in Austria because of his fears of entering long-term relationships, where he felt his penis might be criticised.

> I was fighting within myself, there's not something wrong with you, there's not something wrong with your penis, this battle was going on. (Bob, 1364-1366)

Bob appears to be describing an identity struggle as he says 'I was fighting within myself'. He uses the metaphor of a battle and a fight in a way that suggests he is emphasizing how difficult this was for him and the depth to which it affected him.

Ron and Bob had these experiences at 11 years of age, pre-puberty, at a time when they were exploring their newly *developing* sexuality. It is as though the unwelcome attention on their circumcised penis in the changing rooms set up a conflict in how they saw themselves at this developmental stage. By contrast, Anik and Ahmad talk of their experiences of difference without the struggles that Ron and Bob experience. For example Ahmad said:

> To me it's been natural, yeah, it's more or less what I'm born with, but not, if you know what I mean? (Ahmad, 88-90)

Ahmad's experience of his circumcision is that it is 'natural', as if it is a part of him and that the difference is of no consequence. He emphasises this sense that it is 'natural' by his experience that it feels as though he was born with it, having been circumcised as a baby in Pakistan.

Likewise, Anik remembered:

> When I first knew I was circumcised 10, 11 years old, once I knew I was different and then as I went into my teens and everything I didn't really think of you know anything more of it. (Anik, 188-191)

Anik tells of his experience of knowing that he was circumcised at a similar age, pre-puberty, to Ron and Bob. This discovery also appears to have led to an experience of feeling 'I was different'. However, my understanding is that, in contrast to Ron and Bob, he seems to have found this easy to accept, being something that he did not think 'anything more of' at this age. While he does not link his experience here to his status as a circumcised Muslim living in the UK, there is an overlap here between this subtheme and the previous one, 'In or Out?'

Rudy's experience of a change in his sense of himself following his circumcision in the 1970s when around the age of 40, contrasts with all of the above participants. He had a long-standing desire to be circumcised from a childhood age and chose to be circumcised around the same time he realised that he was gay.

> Yeah, well sort of you've gone through a stage. Just like .. when you sort of you know you start to grow hair .. you know, it just kind of a .. but to me it's a kind of a .. state, or from my personal view, you're more of a man and that's it, you know. (Rudy, 1534-1538)

Rudy describes the experience of circumcision as if there is a transition that involves change. He seems to compare this experience with the onset of puberty and maturity, when a boy becomes a man. It is as though he experiences his circumcision as making him more mature and as a result he felt 'more of a man'.

Hari, like Rudy, also seemed to describe feeling more of a man, although the change for him happened at the age of seven in Kenya. Here he seems to describe his experience of feeling as if he had matured soon after his circumcision.

> You look at your friend Rob and you laugh at Rob and say, 'Wait till you get it [*the circumcision*].' Because you are a little kid Rob [**laughs**]. I'm a guy now. (Hari, 351-353)

Hari describes his experience after circumcision in terms of a transition to being a 'guy now', despite his young age. It is as if being circumcised has made him feel more mature and superior to Rob, as suggested through the use of the diminutives, 'little' and 'kid' and by juxtaposing this with being a 'guy now'.

> At the time you feel all mature, a man, I got to act in a mature way, no more kiddie nonsense, like, I don't know "Let's go throw stones", something like that, climb up a mango tree and pick up some mangos. (Hari, 677-680)

His experience of 'feeling all mature, a man' seems to suggest that he has passed through a stage in how he feels about himself, which is marked by the circumcision. With this maturity though, Hari seems to have experienced an imperative to act differently and to leave behind childish behaviour. However, it is as though the thoughts of 'kiddie nonsense' that he draws upon evoke memories of having fun and eating mangos from someone's tree. In his interview, Hari talks at length about wishing that he could have had his circumcision in his teenage years like the Maasai tribe as he would then have been able to enjoy his childhood to the full. Here he describes what he missed by his early circumcision.

> I missed the mischievousness of it. Of being a child. (Hari, 714-715)

For Hari, the differences he noticed following his circumcision appear to have marked the end of his childhood. He describes this as a loss, missing the 'mischievousness' of it, even though he is still only seven at this time.

The aspects of this subtheme have illustrated how the participants varied in the way they experienced difference as symbolised by their circumcision and how this was then felt to influence how they felt about themselves. In the final subtheme the focus is shifted to participants' sense of self with regard to ideas of what others think about their circumcision.

3.2.3 **Perceptions of others – 'It's a bit of a concern isn't it?'** For most of the participants, what others thought about their circumcision was something that they referred to on many occasions throughout their interviews. It often seems as though they imagine others looking at them and judging them in some way. For some this was in the context of sexual relationships, while for others it was in terms of being mocked. Ron describes his concerns around a sexual relationship.

> Yes, because obviously you know you get on with somebody and everything else but you're sort of thinking in the back of your mind "What's she going to think when she finds out?" You know, what's going to be .. It's a bit of a concern isn't it? ..

> Yeah um you know, it's like "Oh what happened to you?" You don't know, as it happens it wasn't an issue. (Ron, 576 – 583)

Ron highlights the concerns he feels as he approaches the point in a relationship when his girlfriend will find out that he is circumcised. It seems as though there is an underlying fear attached to the concern about 'What's she going to think?' In his mind, it's as if she will be surprised by his circumcised penis as he imagines her saying, 'Oh what happened to you?', and this perhaps echoes his previously discussed sense that there was something wrong. Bob similarly illustrates his thoughts of others within sexual relationships.

> Perhaps she might think there is something wrong with your penis, 'Oh, it's been cut', 'It has been cut', 'It's been .. mutilated.', you know, that sort of like thing .. No woman has ever, ever said it but if it was an intelligent person it would probably really set me back donkey's years .. That's why I've never been in any long-term relationships because I've always felt .., I've had casual sex. (Bob, 1522-1528)

This quote goes to the very heart of Bob's experience of being a circumcised man, describing the way he has never had a long-term relationship, because of what appears to be a fear that a woman might tell him that his penis has been mutilated. For him, this possibility would seem to have profound implications, as he says it would 'set him back donkey's years'.

In contrast to Ron and Bob, Anik had a direct experience of a partner's thoughts about his circumcision as a teenager.

> So she just questioned, you know, why Muslim boys have it. Um she said she prefers it. Yeah, because it's a different .. it made me feel good about myself. (Anik, 263-265)

For Anik, hearing that his girlfriend preferred his circumcised penis to an uncircumcised one led to what appears to be a boost in his sense of self-esteem. Throughout the interview he comes back repeatedly to the question of what

women think. Here he describes his thoughts around a time in his 30s when he had a Brazilian wax to remove his pubic hair.

> So what are their views on the circumcised penis from like a waxer's point of view? I was quite curious. (Anik, 1076-1078)

Throughout the treatment he said that he wondered what the female waxer thought as she would have seen many different penises. His curiosity about women's 'views' is made clearer further on.

> So them not liking it wouldn't affect me but them liking it would affect me by making me feel better. (Anik, 1141-1443)

Anik's experience seems to be one of persistent curiosity about what women might actually think, almost as though he hopes he could increase his self-esteem again.

Whereas the above participants had experiences related to what others might think, Micky describes the impact of receiving an opinion about the difference in his penis post-circumcision. This seems to trigger off a cascade of thoughts about the perceptions of others.

> An ex-partner says, "Oh your cock looks much nicer now since it's been cut." Like, "What do you mean looks nicer?" "There was nothing wrong with it before, it just looks nicer. No you never had a manky willy before, it just looks nicer now." .. "Oh my God, what does he mean? Nicer?" I said to him, "Have I got a manky willy?" "No you haven't." I said "Well you just .. looks nicer? Elaborate." "No I don't need to, it looks nicer." I said, "Okay" and never saw him again. (Micky, 1204-1213)

He tells of how an ex-partner, who had known him before his circumcision, expresses his preference for the new, circumcised look. Micky's experience of this overt compliment is as if it can *only* mean that his ex-partner thought previously that he had a 'manky willy'. Micky's shock at this is revealed by 'Oh my god,

what does he mean?' In the way he juxtaposes this with never seeing the man again it is as if this experience may have ended their relationship.

Several participants spoke about their perceptions of being teased or mocked by others. There is some overlap with the 'In or Out?' subtheme, where mockery was evident, although here the men's experience indicates how they kept thoughts about others in their minds and took precautions to avoid being mocked. Micky describes his withdrawal by not letting other boys see his penis, as an uncircumcised Jewish boy.

> It wasn't any issues or self-confidence, I just didn't, um .. I expect I didn't want to be picked on I suppose, you know. "Oh he hadn't got his done. Micky, blah, blah, blah", so I withdrew. (Micky, 894-897)

Micky denies having self-confidence issues, and at several points in the interview he reiterates his confidence in his penis before his circumcision. He seems to struggle here, though, to reconcile his confidence with his withdrawal. In reconstructing his experience, through the use of 'I expect I', he tentatively explains that it was a desire not to be picked on that drove his withdrawal. He seemingly draws upon perceptions of others being critical of his uncircumcised status in order to make sense of the way he describes his 'self-confidence' and withdrawal from others.

Soona also described his perception of others as potentially mocking him, although for him, in contrast to Micky, it was his circumcision that he did not want to reveal. He finally had to have a circumcision for medical reasons when he was in his early twenties, after suffering numerous infections due to balanitis which can lead to a tight foreskin. Here he describes how he made sure that his circumcision remained a secret, arranging to have it when his friends were on a trip away from university.

> They would probably .. probably make fun of that, I wasn't sure, you know this is like you know when you are getting into adulthood where, where there are no

> stops, I mean they would have probably used that to mock me, which I didn't want, in jest. (Soona, 1364-1369)

It is as though, in his mind, others would make fun of his circumcised status and that somehow this mockery might have no end, 'where there are no stops'. Soona described later being aware of the way circumcision could be mocked; as a Hindu boy he remembered, along with others, making fun of circumcised Muslim boys, calling them 'You incomplete bastard'. (Soona, 1405)

> I was part of them .. I was actually making fun of them so obviously it would stick back, so that's what I was worried about. (Soona, 1416-1418)

Soona's worries about being mocked, in my interpretation, seemed to go along with thoughts of 'what goes around, comes around', that his own mockery of other boys will 'stick back' to him, as in karma.

This master theme has explored participants' sense of self in being circumcised men by looking at the subthemes of 'In or out?', 'Feeling different?' and 'Perceptions of others'. There is rich contrast and divergence in the accounts within these themes. As mentioned in the introduction to the Analysis chapter, the sociocultural context of the men's experiences forms a backdrop within which their accounts are embedded. This is not meant to suggest that the experiences are determined by this, but rather that the context needs to be understood for the reader to gain a better feel for the rich contrast in what it is like for these men. The next master theme sees a similar pattern being followed.

3.3 Master Theme 2 – Circumcision and my Body.

In this master theme the men reflect on their experiences of the physical aspects of being a circumcised man. Some of them, who remember what it was like when they were uncircumcised, reflect on the changes they have felt, comparing the experience before to that afterwards. Others lack the prior experience and wonder what it might have been like.

Four subthemes are explored. In 'Reflections on appearance. 'Oh, that looks nice', most of the men reflect upon their contrasting experiences of how the circumcised penis looks while in 'Experiences of sensation – 'That's quite important' some of the men explore their sexual sensations and how they perceive them to have changed. The subtheme of 'Representations of health and hygiene – 'It's much cleaner' illustrates how most of the men experience their circumcision in respect of talking about health and hygiene. In the final subtheme, the way the men talk about the experience of their circumcision operation is illustrated in 'Memories of the operation – 'Do you remember it?'.

3.3.1 **Reflections on appearance – 'Oh, that looks nice.'** Most of the men described how the circumcised penis looked. Some of them talked about this from the point of view of what they thought about other men's penises, both circumcised and uncircumcised, while for others their experience was focused on how they thought their own circumcised penis looked.

Here, Micky describes how he felt when he saw naked circumcised men in the changing rooms and showers at his local gym before he was circumcised.

> Comparing mine when it wasn't cut to one that is cut, I'd think, "Oh, that looks nice." (Micky, 294-295)

Micky's experience in the presence of other circumcised men in the gym is one where he seems to be comparing his uncircumcised penis to other men's circumcised penises. In thinking that theirs 'looks nice' it is as though he is hinting at a preference for the way the circumcised penis looks although a little later he seems to clarify his thoughts about this.

> I'd never really gone down the route of, "I'm going to have circumcision because it's nice". No, no. Not that. (Micky, 300-302)

He seems to be emphasizing, by use of 'No, no. Not that', that even though he liked the way the circumcised penis looked, he never felt any desire to have a

circumcision himself. Later on, he returns to reflecting about his experience of often comparing his penis to other men's in the past, now that he is a circumcised man.

> But since then I really I don't really compare anymore because I don't need to. .. Maybe it was subconsciously looking at other people's to compare mine against but now I don't need to because my penis is nice. (Micky, 560-564)

Micky appears to reflect that somehow he needed to compare his penis to others before he was circumcised, but that now it is as if this need has disappeared. By describing doing this as 'it was subconsciously', he suggests he wasn't aware then of thinking about why he did this. In using the word 'against' he suggests that there is something that seems almost evaluative or measured about this 'need' to compare. By suggesting that now he doesn't need to because his 'penis is nice' it is as though he felt his penis was not nice before. Here he later describes how he feels about the way his penis looks now.

> Beautiful. It looks beautiful. Like a flower. (Micky, 1239)

Micky illustrates through the use of simile and description, just how strongly he appears to feel about the way his penis looks now. To him it appears beautiful, like a flower. In this choice of simile it is almost as though he is comparing his circumcised glans to a flower; something beautiful that has been revealed or has flowered through the removal of his foreskin.

Anik also reflected on the beauty of the circumcised penis. Here he is describing experiences around being a circumcised man when he and his friends watched pornographic films. In these films he explained that there were only uncircumcised actors, whereas the group of friends, being Muslim, were all circumcised.

> Like the foreskin itself it like covered um .. the beauty of it, I guess. (Anik, 413-414)

It is as though he feels, when he saw images of uncircumcised men, the foreskin hides something beautiful underneath. A little later he explains.

> Because half of it, well not half, a proportion of it's hidden, you know. And .. we as the group of friends thought .. being sort of fully exposed looks better, you know. (Anik, 419-422)

It is like Anik feels the removal of the foreskin has revealed and exposed the head of the penis and that the circumcision represents an improvement in how it looks. In describing this as a shared experience with his group of Muslim friends, he suggests a bond with others in respect of how it looks that emphasises the view that, to them, it looks better.

Rudy, who was circumcised in his 40s and earlier told of his preference for the look of circumcision from childhood, similarly describes his thoughts around physical appearance.

> You know it's just an aesthetic thing all the time with me. I just think the circumcised penis is a thing of beauty, of beauty, and uncircumcised is ugly, especially if they've got long, droopy, overhanging foreskins, elephant trunk type and these ones that come to a point and you know the glans have never seen the light of day since they were born, that sort. I think they're awful. (Rudy, 1062-1069)

Rudy appears to emphasise the aesthetic nature of his preference for the circumcised look. He seems to objectify the beauty of it as a 'thing' rather that owning it for himself and this contrasts with Micky's more personal experience seen earlier. By the way he juxtaposes his experience of beauty with 'uncircumcised is ugly', it is as if the 'beauty' is emphasised through being the opposite of the 'awfulness' he feels towards the foreskin. His use of 'elephant trunk' seems to imply that for him the foreskin is unwanted as a human part, particularly if it prevents the glans seeing the 'light of day'. However, he seems to relate this to the view of other men's penises rather than his own.

However, not all the men felt that their circumcised penis looked good. Soona here reflects upon a different experience of how his circumcised penis looks, after telling of how he feels that the wrong technique was used and that maybe he should have his operation revised, which he thinks may improve the evenness of the scar. He returns repeatedly, to this theme throughout his interview.

> .. or have the scar even, not like jagged or puckered edges where the stitch marks are pretty much looking ugly or kind of like dog's ears on one side. (Soona, 543-546)

For Soona it does not just look ugly, but is described in terms that are barely human, reminding us of how Rudy, in the previous quote, described the *uncircumcised* penis. It is as though 'dog's ears on one side' have spoiled the symmetry and are something that do not seem to belong. His use of 'jagged' and 'puckered' is suggestive of something rough and uneven and in this he seems to experience the hand of another, as he makes it clear he is talking about stitch marks, evidence of the surgeon's work. Later Soona reflects further on the physical appearance.

> I think my prime thing is that the cosmetic effect of that is not ideal, that's my main concern. (Soona, 859-861)

It is as if Soona's concerns are centred on the physical appearance as he describes it as 'prime' and 'main'. In this concern it is almost as though he compares his penis to an 'ideal' circumcised look, which his does not attain. He seems to be using 'cosmetic effect' in a dual sense, not only as something that is about appearance, but also as in a procedure that in his experience should have improved how his penis looked and not left it looking 'like dog's ears'.

Like Soona, Bob appeared to be concerned with the way his circumcised penis looked. He tells of how he would feel better if a woman in a long-term relationship, which he has never experienced, reassured him about how it looked.

> It would make me feel better and .. you wouldn't feel that it looks ugly, you know, the actual like butchery job you know, that's the thing. [**laughs**] You know that's the thing, it's been butchered. (Bob, 2564-2567)

The ugliness he feels seems to represent an experience of his penis having been being butchered by someone else. It is as if he thinks his penis has been treated no better than a piece of meat, and not with the care that surgery requires. He laughs at calling this a 'butchery job' as if he is trying to distance himself from what he has just described. However, in returning immediately to reiterate 'it's been butchered', it is as though he makes it clear that this is no laughing matter for him.

While in this subtheme, the men have described their contrasting experiences of the physical appearance of their penis, in the next subtheme, the men reflect upon physical sensations and their circumcised status.

3.3.2 **Experiences of sensation – 'Is this because of that?'** Most of the men described the sexual sensations they received from their circumcised penis, and used this to tell themselves something about being circumcised men. For Ron and Bob, who had no memory of their circumcision, this was something that involved imagining what the sensation might have been like if they had not been circumcised. Here Ron is describing his experience of difficulties coming to orgasm when using a condom, after later reading an article that proposed a loss of sensation following circumcision.

> I think about what I've read about the sensitivity you see and I'm thinking "Is this because of that?[*the circumcision]*" Because a Durex is a no, no for me, yes okay it has happened, but it's a lot of work so you can imagine now why the thought process is "Maybe there's something in this". (Ron, 337-342)

In thinking 'Is this because of that?' he appears to link his experience of difficulties around sensation to his circumcision from what he has read, as though he is comparing his penis to a representation of a more sensitive uncircumcised

penis. It is as if the added barrier of the condom appears to reduce sensation during sex, and although sometimes he has reached climax when 'it has happened', it would seem to be more like work than pleasure. Ron's statement of 'now why the thought process is' seems to hint that this is an ongoing concern as he makes clearer later on.

> Of course if there's been a loss of sensitivity then that's *quite important* [**slowly and emphatically**]. (Ron, 889-890)

Ron's slow emphasis of *'quite important'* seems to underline that a possible loss of sensitivity after his circumcision would be significant for him. However, by his use of 'if', it is as though sensitivity loss is something he is finding difficult to form a clear opinion about.

Here, Bob talks about the consequences of the skin on his circumcised penis being 'hard', for reasons he later explains as being, 'Where it's always open to the elements, it's, it makes that skin less sensitive, you know.' (Bob, 2448-2450).

> With the skin being hard, when you put a normal Durex on .. It is like putting a sock on it and you haven't got the feeling like someone, I should imagine, of not being circumcised. (Bob, 797-800)

Once again, it is as if the condom in 'like putting a sock on it' is an extra barrier that prevents sexual sensation and Bob seems to imagine, by comparison, that the feeling would be different if it was not for his circumcision, which he perceives as reducing his sensitivity.

Here he is describing further experiences during sex of the loss of sensitivity he perceives.

> You could go for a long while sometimes and sometimes you, you couldn't ejaculate and it's you know quite um, [**overtalking**] traumatic .. and again it could make you feel like in sex like you know "Oh, it's too much pressure", you know. (Bob, 431-435)

It appears that sometimes Bob experienced delayed ejaculation, but that when he could not ejaculate at all it was a deeply distressing experience. His use of 'you' throughout seems to emphasise how he would like to keep these uncomfortable memories at some distance from himself, and in feeling that 'it's too much pressure' it is as though he was struggling to balance sexual pleasure against the pressure and trauma he felt when he could not ejaculate.

He revealed how he had made many visits to Thailand to have sex without condoms to gain more sexual sensation. This was mostly prior to the AIDS epidemic, although here he describes what it was like even when he was aware of AIDS and of the risk he was taking.

> In the end it was such, I was literally taking like a gun to my head and having sex without [*condoms*] .. with prostitutes, because you couldn't get no feeling otherwise. (Bob, 2487-2490)

Bob describes having risky sex as being like 'taking a gun to his head'. It is as if he is playing a game of Russian roulette, with the reward being the sexual feelings he gets from unprotected sex which he seemed to balance favourably against the risks of sexually transmitted disease.

Whereas Bob and Ron have described perceptions of losing sensation, Soona's experience suggests a more nuanced view. Here he reflects on the sensations during masturbation, after he was circumcised in his twenties.

> The tell-tale difference is there is, you touch and obviously masturbate, the feeling of skin coming over, then skin coming over, now is different .. I think it is not as good as it used to be with that, but then there is the other sensation of not having the skin that also is good so I am coming in under the point that I'm pretty much in good territory. (Soona, 840-846)

Soona seems to compare previous memories of sensation during masturbation with how it feels now. He describes this as a 'tell-tale difference' and 'not as good as it used to be' and appears to be underlining that this involves

a loss in his estimation. However, he also describes the 'good' sensation from 'not having the skin' as if it was a gain. He seems to use these comparisons as points or indicators, as a way of judging the outcome in terms of sensation as being 'in good territory'.

In contrast to the above participants, some men described increases in penile sensations after being circumcised. Micky, who earlier in his interview described difficulties with climaxing when he was uncircumcised, here describes the difference afterwards.

> M: I never really had sensation, um never - before I had a cut penis um it wasn't so intense, the feeling when I used to wank, it wasn't .. intense. I never used to get um like tingling in my penis at all or when I was going to come I never got that .. like, "Ah"; no.
>
> *I: You never got a feeling that -*
>
> M: No, I never got a jubilation inside, you know it's like you shake a ball and it explodes, I never got that before I had my cock my cock cut. But after .. literally it was like a vol-volcano, it was like the ceiling, and the tingling is amazing. (Micky, 386-396)

Micky suggests that the sensations he now experiences, since his circumcision, have become much more intense, by comparison, as though they were muted before. It is almost as though he feels he had not experienced orgasm fully before, 'I never got that .. like, "Ah"; no.' He repeatedly uses the word 'never' and it is as if this emphasises the new world of sensation that he has entered which he links to being circumcised. Micky describes the sensations using metaphor and simile such as 'explodes' and 'like a volcano', to emphasise the strength of the sensations he now feels. These feelings seem to go beyond physical sensations as his 'jubilation inside' suggests that he experiences something almost akin to ecstasy.

Like Micky, Rudy also reflects similarly on differences in sensation after he was circumcised in his forties, following a lifelong desire to be circumcised.

> I think once, I think, I think you know, once I was circumcised the first ejaculation I had I thought I'd hit cloud nine, the sensations and all that. I don't know if it was actual sensations or the fact that in my mind I knew that I was circumcised and it just seemed you know 100 times better than the feeling that had been before. (Rudy, 1341-1346)

Rudy's description of his sensations being '100 times better' suggests that they were very different from those he remembers before circumcision. With his illustration of hitting 'cloud nine', it is as if the improvement in sensation during orgasm was something that made him feel extremely happy. However, Rudy seems to be doubtful as to whether his elation was directly related to the sensations or whether it was knowing 'I was circumcised', suggesting he feels something more psychological may have enhanced this experience.

While the first two subthemes have explored the contrasting ways participants experienced the appearance and sensations around being a circumcised man, the next subtheme reveals more consistent experiences around representations of health and hygiene.

3.3.3 **Representations of health and hygiene – 'I can see the cleanliness bit.'**

Most of the men talked about their circumcision in terms of health and hygiene. For some this was experienced by comparison with what they thought about the hygiene of the uncircumcised penis, while for others it was related to information that they learned from other sources.

Here Ron describes how he understands the foreskin and cleanliness, as he has no knowledge based on his own experience, having been circumcised as a baby.

> I do understand and I'll be very basic, with the hood [*foreskin*] over there maybe you get more moisture underneath which obviously you don't if you don't have the hood and so I can see the cleanliness bit and that's a plus point.
>
> *I: What's a plus, that it's cleaner?*
>
> R: Yes, whereas with a foreskin you might be more damp and wet underneath all the time and you probably gotta be more cleaner than ever er because of that. (Ron, 313-315)

Ron appears to imagine a place under the foreskin which in his mind is maybe permanently more moist than in comparison to a circumcised man. It is as if this environment is one that could be dirty as he indicates the possible need to be cleaner with 'gottta be more cleaner than ever'. He describes the 'cleanliness bit' of circumcision in comparison as a 'plus point', in a way that suggests he uses this as one way of weighing up his circumcision, as if he does this point by point.

Rudy describes similar views of the foreskin and cleanliness, when observing men in public showers.

> I always sort of considered that the circumcised ones were much cleaner because a lot, the majority of men never pull their foreskins back. I mean I've been in public like baths where there have been showers .. alright they have every kind of shampoo, deodorant, everything, but not one pulls their foreskin back and washes it; not one. (Rudy, 1149-1155)

It is as though Rudy has formed an opinion about the cleanliness of the circumcised penis, through his experience of how he observes uncircumcised men who seem to fail to wash their penises properly by retracting the foreskin. Rudy seems to experience these men, in 'never' and 'not one' of them pulling back their foreskin as being neglectful of their penile hygiene, even though they have all the necessary cleaning products; it is as if he experiences being circumcised as a way that avoids these problems, being 'much cleaner'.

Hari, as described earlier, was circumcised in Kenya and was sexually active at the time that AIDS became a public health issue. In the interview he talks at length about 'scientific research' he read that showed reduced HIV transmission in circumcised men. Here he describes his thoughts about being circumcised regarding these perceived benefits in sexual hygiene.

> It made me realise er it sort of made me kind of thankful also to be circumcised. Well, in that way. But then I knew why it was done, it wasn't just spiritualism, be a man, it was also there was a scientific reason behind it. There was a hygienic reason behind it. (Hari, 1180-1184)

It is as if Hari draws upon the discourse of medical science as giving a reason that can help him to make sense of his circumcision. 'But then I knew why it was done' appears to show that he felt he had been previously missing an explanation that he could make sense of, as though the 'spiritualism' and 'being a man' he experienced in the tribal rites of passage were not enough. His understanding of the scientific 'hygienic reason' seems to have made him thankful to be circumcised, as far as hygiene is concerned, in a way that he seems to use to justify his circumcision to himself. Anik reflects upon similar experiences of health regarding circumcision.

> Infections, things like that [] ..could be prevented. Because um .. like the foreskin, bacteria can like multiply and maybe grow at a faster rate than someone who has been circumcised. And then when you understand these things, then you think you know it's a good thing, not from a religious point of view .. from a health point of view. (Anik, 731-741)

Anik suggests that in his experience circumcision is something that may prevent infection and it is as though he represents the foreskin, by contrast, as a place that allows bacteria to thrive and is less healthy by comparison. It seems that Anik's understanding of this is something that he uses to make a judgement

about his circumcision as being 'a good thing', that he experiences as separate from any views he holds from the religious point of view.

In this subtheme we have seen that most of the men perceive being circumcised as conferring physical health or hygiene benefits and that in doing this they often appear to compare their circumcised status to the uncircumcised. In our final subtheme, the men explore their memories of the physical experience of the operation.

3.3.4 **Memories of the operation – 'Well that must hurt.'** Most of the participants, who had a memory of the operation, spent time describing the physical effects of this. For some of the men, who were circumcised in childhood and had no memory of it, their operation was something that they appeared to imagine. Ron, who has no memory of the operation, describes his experience of this.

> I think that with the procedure of a circumcision I think, as men, we're fully aware of "Well that must hurt." (Ron, 1709-1711)

It is like Ron feels his view, of the operation as necessarily being painful, is shared with all men. In being 'fully aware of' this it is as if he is appealing to knowledge 'as men' of the sensitivity of the area of the penis that is circumcised, and as though this is how he makes sense for himself of what it must have been like, as he can only imagine this.

Elsewhere, Ron reflects on a memory of discussing circumcision with his wife that adds a further dimension to his experience of the operation he had as a baby.

> I said "What's your view then on the trauma the baby goes through?" So she said "Do you remember it?" But I don't subscribe to that. (Ron, 166-168)

Ron appears to be refusing to subscribe to the view that, without a memory of circumcision, there can be no trauma. Through his use of point and

counterpoint, it is as though he feels that he was debating his views on circumcision with his wife. He seems to imagine that circumcision for him as a baby may have been traumatic, even though he has no memory of it, but feels others may not want to believe this.

Anik, circumcised as a baby in a village in Pakistan, imagines how the operation was for him. He describes thoughts and feelings that follow seeing his baby brother crying after his circumcision when he was around 10 years old.

> I felt, I felt for his pain, you know, once my mum told me you know he's going to be circumcised and then he was crying. So I felt you know bad, and I also felt that maybe how it must have been for me. I must have been crying. Maybe the pain for me was worse because I wasn't taken into like a fancy hospital and things like that like my brother did. (Anik, 904-910)

The way Anik reiterates, 'I felt, I felt for his pain' it is as if he found it easy to empathise, emphasising how close it was to a feeling for him. It appears to have triggered thoughts that he must have experienced circumcision in a similarly distressing way. He seems to contrast the 'fancy hospital' where his brother was circumcised with his own circumstances, suggesting that he perhaps feels his brother's medical care was better and that this may have reduced the pain for his brother, making his own pain worse by comparison.

Hari remembers how he felt both before and after the operation at around the age of 7. Here he describes what it was like before.

> I thought it [*the surgical knife*] would be like a big chopper, like a butcher's chopper and they were going to chop it [*his penis*] like that. And you are going to cry out or hold it in, an' blood will gush out, and things like that. (Hari, 519-522)

It appears that Hari anticipated his circumcision as though he might be afraid he was going to be butchered and that this was something that would be horrifying and painful, involving a bloody wound, almost as though he feared the penis might be chopped off. It is as if he felt powerless, under an attack from a

'big chopper' and the use of 'they' seems to further a sense that he felt outnumbered. However, he reflects upon the operation very differently afterwards.

> I mean the circumcision, when it really comes to the practise of it, the practicality, it's like .. a tiny graze isn't it, like someone who like chopping onions. You cut yourself, ooh blood is coming out and then later on you put a band aid "Oh I feel alright". It is finished. It takes a moment. (Hari, 273-278)

He seems to emphasise that what he 'really' experienced from the operation was something minimal, 'a tiny graze'. By comparing this to an accident 'chopping onions' he seems to further minimize his experience of the impact of the wound and that it was as if any bad feelings were short lived and that there was nothing really to be afraid of, apart from the tears.

Rudy shared some similar feelings about the operation, which he said he only realised he could choose to have when he was about 40.

> I must admit I probably early on I would have been scared of the operation earlier on, you know. But when I got to .. when I knew I could actually have it because the doctor he assured me, he said there would be absolutely no pain whatsoever, I did it I did it under a local [*anaesthetic*], you know, did it in a lunch hour, came home and went to drove to work the same evening .. with a big bandage around it. (Rudy, 1221-1228)

Rudy describes the operation as if it is something to be feared, particularly when he was younger. It is as though the doctor's assurance of 'no pain' assuages his fear and he describes the actual operation in a way that suggests it was experienced as minimal, being 'in a lunch break' and had few after effects, as he 'drove to work the same evening'.

Micky talks about his operation in his twenties, because of a medical emergency following an infection, and of what the doctors told him.

> And I had it done. "And later it will be quite painful." It wasn't at all. I don't know why people think it's pain, painful, you know; it's not. (Micky, 57-59)

Micky juxtaposes being told to expect pain after the operation with his own experience that 'it wasn't at all' and repeats this juxtaposition with 'it's .. painful .. ; it's not' as if to emphasise that he felt no pain. In appearing puzzled about other people's view, it as though he is extrapolating from his own experience and suggesting that the operation is never painful, and that he feels others are mistaken about this.

In this subtheme, the men's descriptions of their operation suggests that it can be anticipated or perceived as something painful or feared. However, for those who remember their circumcision, they seem to minimize this afterwards.

This concludes master theme 2, 'The physical experience – circumcision and my body'. In the third master theme, the participants explore the meaning of the decision to be circumcised, their choice in it and how they feel about MC when they look back upon the decision.

3.4 Master Theme 3 - Reflecting on the Decision

Most of the men seemed to reflect on the decision in two ways, firstly over their choice in it, secondly, on whether it was right for them. In the first subtheme, 'Did I have a choice?', the culture and context within which the men's circumcision took place is important to bear in mind, in order to understand how they made sense of the choice. For instance, the participants who were circumcised at birth or when very young had no choice in their circumcision and this forms a backdrop to their experience. Similarly, in the final subtheme, 'Was it right?', the culture and context need to be taken into account to understand their experiences of whether the circumcision was right for them and of its impact.

3.4.1 **Did I have a choice?** Hari talked about how he felt too young when he had his ritual circumcision in Kenya, at the age of around 7, and felt, as discussed earlier (subsection 3.2.1, In or out?), that he had missed out on part of his

childhood. He describes how at the time he wanted to put the circumcision off until later.

> You can't tell your father or your grandfathers, they are all the men, you can't say to them "Hold on. I think I'd really like to put it off till next year or three years later", because there is no ifs. (Hari, 280-283)

By repeating 'you can't tell' and 'you can't say' it is as though Hari is describing something that restrains him from expressing how he feels to 'the men'. Hari's comment 'because there is no ifs' suggests a lack of choice for him over the timing of his circumcision and as though he feels powerless to decide for himself, against the men's wishes, that he is not yet ready to be circumcised.

Soona described a similar reticence to be circumcised, recalling that he had suffered many painful infections over a period of years and had put off making the decision many times, despite receiving medical advice that it was needed.

> So, I was always in doubt and I .. unless it was absolutely necessary I was not going to say I would do it. (Soona, 242-244)

The way Soona talks about absolute necessity, indicates what appears to be a strong reluctance to be circumcised and that the choice of resisting saying 'I would do it' was heartfelt. In the next quote he reflects on his choice in making the final decision, when it became medically essential.

> At the end of the day it [*the circumcision*] was my decision but at the end of the day it was a medical decision but the outcome [*the circumcision*] wouldn't have been different if I went in for the first time and my parents had been deciding for me or that I decided, the outcome was the same, it was a question of time. (Soona, 821-826)

Soona begins by describing how, in the final analysis ('at the end of the day') he made the choice ('it was my decision') to be circumcised. However, his double use of 'but' suggests that this choice felt qualified or restricted as he emphasises that it was a 'medical decision', rather than what he wanted on

broader grounds. He also seems to highlight that the outcome of becoming circumcised was the same as if his parents had made it, when he would have had no choice anyway. It is as if Soona experienced ambivalent feelings regarding the real freedom of choice that he had in becoming circumcised, and that he possibly feels that it was a forced choice that he made.

Micky also described needing a circumcision on emergency medical grounds, following an infection. As a Jewish man, his cultural norm was to be circumcised and he recalled being given a choice by his parents before his Bar Mitzvah at 13, but had chosen to say no. He describes how he reacted to what he remembers as the doctors telling him in his 20s that 'When it goes, the infection, you're going to have an awful-looking penis.' (Micky, 203-204)

> I Googled deformed penis online and there's like wonky, bits missing, chunks off, no, I don't want that so .. (Micky, 225-226)

Micky appears to have been making a choice between remaining in his chosen uncircumcised state, but with the risk of it looking disfigured ('bits missing, chunks off') or of being circumcised. It is as if by comparing his future uncircumcised state with the images of 'deformity' on the internet, he realises that he does not want to risk this and decides to go ahead with the circumcision.

> After I researched it and I saw the pictures I said [*to the doctors*], "Do it [*the circumcision*]; do it.." (Micky, 249-250)

It is almost as though the pictures have made Micky afraid of what might happen if he does not have the circumcision and he feels this influencing his choice ('Do it. Do it'). Similarly to Soona, Micky seems to be describing a situation when he felt that his choice was forced, when the doctors tell him of the medical necessity.

> "We have to [*do the circumcision*] because of complications, and if we don't.."
> Because I literally couldn't, it [*his penis*] was like a bottle like this, wider and I

> couldn't even wee. I had to .. have a catheter down and they said, "Look we just have to do it." So they done it. (Micky, 88-93)

Micky seems to have experienced that the circumcision could not be avoided with the doctors saying 'We have to' and repeating later 'we just have to do it'. In the way his recollection of the alternative 'and if we don't ..' tails off it is as though it confirms there was not really any other choice. He expresses this from the third person perspective of the doctors again emphasising his distance from this choice. Micky's experience of his swollen penis and not even being able to urinate seems to position himself as both helpless and feeling in the hands of doctors ('I had to .. have a catheter down'), as though he feels the circumcision was their choice at some level, and not his own as he described earlier.

Rudy stands somewhat in contrast to the men above in his experience of having a choice over his circumcision. He was the only participant who made a free choice, unconstrained by parents or medical advice of the necessity. He repeatedly talks during his interview of his desire to be circumcised from an early age. Despite this seeming preference he was only circumcised when he was in his 40s. He describes what it was like for him in the 1950s and how he thought about his choice in the decision, before he was circumcised.

> You couldn't just go to a hospital and say, "I want to be circumcised." You could ask your doctor .. that was about the only way you could do it. He would have probably said no. (Rudy, 852-855)

Rudy describes an experience that suggests he felt that his freedom to choose to be circumcised was restricted. It is as though Rudy is expressing a wish that he could have just asked for a circumcision at hospital but that he felt that his options were limited to asking the doctor. The doctor seems to be felt to have been an obstacle ('He would have probably said no,') that stood in the way of Rudy's choice at this time. The way Rudy uses 'you' is as if he feels that these restrictions

in choice did not just apply to himself but were something that others would have felt too.

In contrast to the above participants, Bob experienced his circumcision not as a forced or restricted choice but more as though it had been forced upon him. As we saw earlier on, Bob was circumcised as a young child in the 1950s for 'health reasons' and could not remember his operation, but always appeared to associate it with sexual and relationship difficulties throughout his interview. He talks of his feelings of having no choice over being circumcised.

> You just feel that you have been, some, some something like, you know like someone say like a woman has been raped, that feeling you know, that someone has done something to you and you have no say in it .. You are violated. (Bob, 2122-2125)

Bob draws a powerful comparison between being circumcised without a choice and being raped; sexual intercourse without consent. By drawing on the analogy of female rape it is as if he thinks that, without the freedom to choose, his circumcision was a violent attack on his penis and as something that makes him feel powerless and possibly less masculine. Furthermore, by repeatedly using 'you' as in 'You are violated', Bob seems to distance himself from the pain of feeling violated. It is almost as though he feels this not just at a physical level, but as if his self has also been violated.

Similarly, Ahmad also reflects on his lack of choice over his circumcision and how he makes sense of this.

> You're getting carved up basically, you know what I mean, having parts of your genitals sort of like chopped off, without consent. (Ahmad, 100-102)

Ahmad uses metaphorical language, 'carved up' and 'chopped off', suggesting that in not consenting to his circumcision, he feels that he may have been butchered, and as though his genitals have been partially removed. Later on in his interview he reflects further on having no choice and calls his circumcision

a violation. He makes sense of this by linking it with later experiences in childhood of being 'very badly beaten' (Ahmad, 893).

> If you put it [*the circumcision*] together with all that I've experienced then it is like a violation. I'll just give you a brief idea. I come from parenting that was very, very violent .. that's why I'm using the words that I do, so I understand all that because I was violated as a child. (Ahmad, 881-887)

It is as if he is comparing his circumcision by putting it together with 'all that I've experienced'. He seems to strongly suggest this other experience is of feeling violated by the physical abuse he endured as a child, attacks on his body, which he did not consent to. He seems to tie the two experiences of violation together ('that's why I'm using the words that I do') as though the circumcision itself, in which he had no choice, is also felt as a violent attack on his body.

Ron, who was circumcised as a baby, was also not given any choice in the decision. He reflects about what the lack of choice means when he thinks about the circumcision of babies.

> Nobody knows how it [*the circumcision*] can affect somebody, what they've chosen to have done to someone. They might have said "Oh that's only a little bit of skin," but what I've read it's a very delicate piece of skin, there's no other skin on the body like that in its texture and everything else and somebody decides *on your behalf* that they're going to remove it. (Ron, 474-481)

Ron appears to suggest that there may be many ways that one can be affected ('Nobody knows..') and, as no one else can predict, that it should not be another person's choice. It is as though Ron feels the others who are involved in the decision are experienced as not taking adequate consideration of the consequences of circumcision, minimising the loss of the foreskin as 'only a little bit of skin'. Ron describes the foreskin as 'very delicate' and as if it is special. By his emphasis of *'on your behalf'*, he suggests that he finds it difficult to comprehend

how its removal could be in the best interests of someone if they are not involved in the decision.

In drawing the various strands of this subtheme together, it appears that the participants' experience of restrictions in choice were interpreted in ways that have profound implications for some of the men and less for others. For those who were following medical advice this could mean that they felt their freedom of choice was restricted, whereas for Bob and Ahmad, their lack of choice in the decision is experienced as akin to abuse and the circumcision itself as something violent.

In the final subtheme, the men explore their thoughts and feelings as they review the decision to be circumcised.

3.4.2 **Reviewing the decision – 'Is it right?'** In this subtheme all the participants appear to review the circumcision decision by summarising their experience to date about how they feel about it. Some of them appear to have worked out contrasting positions on this for themselves while for others, such as Ahmad, it still appears to be a work in progress.

As described in the previous theme, Ahmad experienced his circumcision as a form of violation, having no choice in it as a baby. Throughout his interview he talks about not having spent much time thinking about his circumcision in the past and that this is a new area of interest for him. He reflects on the reasons behind the circumcision.

> If I know the religious ideology behind why they [*his Muslim parents*] did it and then I can see if I agree with what they did and if it was right and whether it was actually something that should have been done. (Ahmad, 289-292)

Ahmad seems to be describing a personal journey that he has begun towards self-discovery in which it is as if he needs to review the religious ideas around circumcision, in order to see if he can find a reason for it. He appears to feel that he lacks the religious knowledge ('If I know') to see if he agrees with the

decision to circumcise him and that, by repeatedly using 'if', he suggests that he has not decided whether it was right and has some doubt about it. He talks about what the religious meaning of circumcision would mean to him as a Muslim.

> If there is a religious meaning to it then, obviously, I have to abide by that to some extent, by the religious side, but even then that is questionable. If it doesn't make logical sense to me, then I'll have to question "Is it right? Is it right?" (Ahmad, 405-409)

As a Muslim, Ahmad seems to feel that a religious meaning to circumcision is something that he needs to take into consideration but this is something that he suggests he is sceptical about ('even that is questionable.'). It is as though he feels ambivalent about what weight he would put on finding 'religious meaning'; in one sense he seems to be seeking for logic in the meaning, but if it is not there, it is as if nothing will be resolved as the question of persistent doubt will remain ('Is it right? Is it right?'). By positioning this in the future, Ahmad indicates that he feels this journey towards meaning lies ahead of him but that he suggests he will use it to retrospectively judge how he feels about the decision.

Similarly to Ahmad, Soona still appears to be working out how he feels about the decision in a way that has persisted from when he was uncircumcised. He describes the period before his circumcision on medical grounds, when he was suffering repeated infections in his penis.

> Whether it should be done, whether it should not be done or rather, I was unsure, put it this way, I was unsure and what I saw at that time, again wasn't convincing enough to have an altered body er .. firmly by any point in time. So I always had a doubt whether it was good or bad. Should have been or should not have been? That, that is still there. (Soona, 211-217)

Soona's use of 'Whether it should be' or 'should not be' suggests ambivalent feelings around a decision about whether a circumcision would be right for him. His doubt ('I was unsure') further suggests a conflict in his attitude

towards having a circumcision, as though 'an altered body' was not something he desired or could be convinced of. The doubt over 'whether it was good or bad' suggests he feels as if was struggling to decide whether his circumcision would be right or wrong for him. He further illustrates how these feelings seem to have persisted to the present day when he says, 'That, that is still there'. Furthermore, Soona talks about the current possibility of revising his circumcision to remove a remnant of his foreskin.

> I'm in two minds whether I should have a revision which would probably cut back that [*a remnant of foreskin*] but if you do the revision then if it goes wrong it is going to complicate the issues further. (Soona, 677-679)

Soona's ambivalent feelings extend to considering the major step of revising his circumcision. He seems to relive the dilemma of his circumcision as a young man in his preoccupation with this twenty years later.

In contrast to Soona and Ahmad, Ron appears to have made up his mind about whether the circumcision was right, when considering his role in making the decision.

> I also read that the sensitivity of the head of the penis changes. It's not right that somebody should decide they're going to do .. have that [*the circumcision*] done to you. (Ron, 197-200)

As seen to some extent in the previous subtheme of 'Did I have a choice?, it is as if Ron feels that his circumcision was not right by linking his parent's decision and his lack of choice over it to something he has read about sensitivity change. It is as though he feels that a decision that involves the potential to change his penile sensitivity is one that ethically only he should make.

Ron's sense that the circumcision was not right for him appears to be compounded by his experience of having never been given a reason; 'Why was that done? I don't know.' (Ron, 1447). In the absence of reasons he uses his imagination.

> So what was his [*father's*] take on this? Had I done something bad, was it something I'd done? (Ron, 919-920)

Ron describes wondering what his father thought about his circumcision. It is as if, in wondering this, he felt that his circumcision may have been a punishment handed out by his father.

> I don't think it [*circumcision*] is necessary, I had that experience [*of being teased in the changing rooms at school*] which I've never forgotten. (Ron, 1050-1052)

Ron describes circumcision in general terms as being something he suggests does not have good reasons behind it. He juxtaposes this with what appears to be the persistent memory of being teased as 'Jewish' when at school, as described in the first master theme. It is as if he is judging his own circumcision as not being necessary or right for him, by virtue of this aversive experience.

Bob seems to describe similar experiences of feeling that his circumcision impacted him negatively.

> I feel I would have been a bit more confident if I had been not circumcised [] Looking back now, if I could have my life over again, I would have preferred not to be circumcised. (Bob, 971-976)

In 'looking back' Bob seems to be reviewing all the experiences which he links to being a circumcised man. It is as though he sees himself as lacking confidence and that this is something he regrets. He appears to blame being circumcised for his lack of confidence and hints that he may be resigned to what this has meant as he poses an impossible scenario ('if I could have my life over again'), as though nothing can ever be changed. Later he talks about his unhappiness.

> The unhappiness it's [*the circumcision*] caused me over the years, er, er.. when I get down feelings, you could blame it on a lot of things but that [*the circumcision*] is the root cause, the root cause. (Bob, 2319-2322)

Bob describes his unhappiness over many years as being caused by the circumcision as though this is something he feels has persisted. He suggests that he see his low moods as something which could be blamed on many things but he seems to distance himself from these 'things' by using 'you' rather than 'I'. By contrast, his experience of circumcision as a 'root cause' suggests that he feels it has nurtured his unhappiness and continues to feed it.

In contrast to all the above participants, the others seemed to have come to a more settled view of accepting their circumcision, although with varying experiences of emotion.

Anik, who was circumcised when very young in Pakistan as a Muslim, describes coming to a retrospective decision about his circumcision in his thirties after reading about purported health benefits.

> I wanted to know like why God said all boys needed to have it done. I wanted to know like why, you know, and then I read that by doing so would prevent certain like diseases or infections, so it's a benefit for your health. And then, because it was a good reason, then I accepted it. (Anik, 785-790)

Anik describes wanting to know the reasons behind the religious edict for circumcision. It is as though the religious reason alone was not enough for him to decide if it was right. However, once he had found out a 'good reason' that was to do with physical health and disease prevention it appears to have shifted his experience of the decision towards acceptance.

Hari was living in Kenya when AIDS first became a health issue and learned from research that MC could reduce HIV transmission. He talks of the impact this had on understanding his circumcision.

> When this thing came up, the AIDS thing and I said 'That's why!', then it struck me and then I realised the beauty of all this culture. The tradition is still going on, it hasn't died out, hasn't been obliterated, so I could understand why it is, it exists, you know even today. I could understand that it was on the scientific part of it, the hygienic part of it. (Hari, 1623-1629)

It seems that when Hari perceived what he saw as the hygienic and scientific part of circumcision in preventing sexually transmitted disease, it triggered a review of his ritual circumcision. It is as if it provided a reason for him that made sense of the cultural tradition of ritual circumcision. It is as though only at this point when 'it struck me', he realised the value of his circumcision as something he could make sense of and that had been lacking earlier. He seems to confirm this later.

> I like it [*being circumcised*] now, I liked it when I knew about the hygiene side of it and was happy that I had done circumcision ritual. (Hari, 2092-2094)

Hari describes liking his circumcision at the point in time when he learned about 'the hygiene side', and that this feeling has continued to the present day, suggesting by contrast that, before that, he had not liked it. It is as though not understanding the reasons for it earlier may have caused some emotional difficulty, as only since then he feels 'happy' to have been circumcised.

> That [*the hygiene*] is the reason and that is how I survived [*the outbreak of AIDS*] and 'Okay thank god for that.' (Hari, 2100-2101)

Hari's understanding of his circumcision appears to have evolved to the point that he believes it saved his life from AIDS. By thanking god for this I construe that this period of surviving was one in which he felt he had lost some sense of control of his destiny, and that he now feels glad to be alive.

Similarly to Hari, Rudy and Micky both seem to review their decision to be circumcised in ways that suggest they feel good about it. Rudy describes his thoughts after finding a doctor who agreed to circumcise him when he was around 40.

> I knew I wanted to be that way [*circumcised*] I wanted to be that way all my life .. I thought, "Well now I'm going to actually going to be that way." (Rudy, 802-804)

Rudy's reiteration of his desire to be circumcised and that it had lasted 'all my life' seems to emphasise how strongly he felt about this, as if he wished for it. It suggests that the decision he takes to 'actually .. be that way' is felt as a fulfilment of a wish. He adds to these thoughts later.

> I've often said it's [*the circumcision*] the best thing I ever did in my life. (Rudy, 835-836)

Rudy appears to be emphatically stating how the decision to be circumcised felt right for him and as if it was the most momentous decision of his life. Similarly, to Rudy, Micky looks back at his decision to be circumcised.

> I love my penis now. I wouldn't ever go back to having an uncut cock because I just um like it; I'm a convert. So .. I converted to the other side. (Micky, 267-270)

Micky describes loving his penis *now*, as though his feelings were not so strong before. It is almost as if he is describing having a relationship with his penis and the decision appears to be something he has no regrets over, never wanting to revert to his previous uncircumcised state. In calling himself a convert and saying 'I converted' he suggests that he sees the decision as an alteration not just to his body but also as if joined another group, reflecting what he also described in the first master theme, when he described finally feeling that he had become a fully-fledged Jew. Micky later elaborates on how far his love for his penis now extends.

> There's a picture on my fridge; I've never had a picture of my cock before on the fridge, you know. So I think that speaks for itself, um .. I don't know .. confidence in my penis, I suppose. (Micky, 1345-1349)

Micky describes having a picture of his penis on the fridge as though this is something that he never could have done before he was circumcised. Furthermore, he suggests that in speaking for itself, it feels as if he hardly has to explain how much his confidence has increased compared with before.

> If all the world had circumcised cocks it would be a better place to live in. (Micky, 1274-1275)

It is as if the strength of Micky's experience of personal benefits from circumcision culminate in him advocating that all other men should be circumcised. He appears to emphasise the strength of these feelings by extrapolating from his own experience to that of everyone else.

4 Discussion

> 'This flesh of my body is shared by the world, the world *reflects* upon it, encroaches upon it and it encroaches upon the world' (Merleau-Ponty, 1968, p. 248).

4.1 Introduction to the Discussion

In this section, I will take a view from above to summarise the key findings of the research describing the way the participants make sense of their experiences of being circumcised men. This will elaborate upon Merleau-Ponty's (1968) sense of reflection and encroachment on the flesh. I will critically appraise the research in terms of quality markers and transferability, reflecting upon the methodology and procedures and also personally reflecting upon my role as a male, circumcised researcher. I will then consider the main findings in terms of how they relate to existing literature and theory before considering the implications for therapeutic practice. Lastly, I will suggest areas for further research.

4.2 Overview of the Analysis

I have included a diagrammatic representation of the analysis structure in Appendix 18 and a summary of the master themes and subthemes in Appendix 15.

The diverse sociocultural backgrounds of the participants (Asian/Muslim, African/Muslim, Hindu, White British, and Jewish) and the different reasons and timings of their circumcision (from birth to the age of 40) in a range of countries has contributed to the diversity of the men's experiences. Nevertheless, as illustrated by the master themes, there is much that they describe that is similar at an abstracted level, even if the individual experiences are contrasting. I will give an overview of these contrasts for the three master themes while touching upon the links between them (see Appendix 14 & Appendix 15).

Issues of identity, specifically male identity are implicated in the master theme of 'Who am I?' A pattern is revealed where the men describe experiences of their circumcision status as either enhancing or compromising male identity. Experiences of belonging and acceptance for Micky, Hari, Anik, and Ahmad, as a Jew, a Kenyan Muslim, and an Asian Muslim respectively, are linked to the sociocultural norm of circumcision. Most of these men did not describe personal difficulties, although Micky, who was Jewish, recalled experiences of stress and preoccupation during the time when he was uncircumcised. Most of these participants felt, after circumcision, that they had matured as men or could easily accept their circumcision.

In contrast, experiences of rejection or not belonging arise for other participants, Soona, Bob and Ron, whose circumcision was not the social norm. As a Hindu in India, or as White British men, their circumcision identified them as belonging to an out-group, Muslim or Jewish. At an interpersonal level, most of the men who felt that their circumcision status was not the 'norm', described difficulties with how others might perceive their penis. For example, Bob described this as preventing him from ever having a long-term relationship. Most of these men described feeling 'something wrong' or 'inferior' in relation to other men, adding to a sense of compromised masculinity.

An exception to this pattern was Rudy, who described always wanting to be circumcised from early childhood despite this not being the cultural norm for him in the UK at the time. It is as though for him the male identity he most desired was that of 'being a circumcised man'.

In the master theme of 'The Physical Experience' similar contrasts among subgroups of participants are revealed as they reflect upon their penile body image: how the penis looks, feels, performs and also in terms of health and the operation.

I suggest that there may be a link between aspects of this and the masculine identity issues of the first master theme, both directly and via links

with the sociocultural context, and perhaps in how they feel their penis matches to an ideal of how it 'should' be (see Appendix 18).

Micky, Hari, Ahmad Anik and Rudy, for whom circumcision was the desired status or sociocultural norm tended to refer to an enhancement of their penile body image. Most of them described their circumcised penis as looking better or beautiful and some that their sexual sensations had been dramatically enhanced.

In contrast, Bob, Ron and Soona, who had experienced difficulties relating to their sense of male group identity, described their penile body image being compromised. They were discontent with the way their penis looked or felt less sensitive. Some perceived that this had led to symptoms of delayed ejaculation.

With regard to the men's experiences of the health and hygiene of their penis, most of the participants felt that being circumcised was cleaner and more hygienic. Hari felt that the removal of his foreskin had helped to protect him from HIV. None of the men experienced or thought of the uncircumcised penis as healthier. For some, such as Hari and Rudy, health and hygiene were an important feature of their penile body image, while for others, although considered, it was less of a feature.

All the men seem to be invested to some extent in maintaining a view of their penis as healthy, vigorous and free from disfigurement. The participants' experiences suggest that the circumcision itself is neither traumatic nor a 'disfigurement' or an 'enhancement'; rather it is the context within which it occurs that means that it may come to be seen as such. The men's experiences of the effects on their penile body image is linked, to a greater or lesser extent, for nearly all the participants according to cultural norms regarding circumcision.

When participants looked back at the operation, a pattern emerged. Hari, Anik, Ahmad and Rudy, for whom MC was the cultural norm or desired, described a more complete resolution of any fears, describing the operation in

minimal terms. In contrast, fears and preoccupations often persisted for Bob, Ron and Soona whose circumcision was not the cultural norm and was undesired.

However, before having the operation or if they imagined it, all the participants remembered it as something unpleasant, dreaded, painful or in ways that suggest they thought that their penis would be disfigured. Bob, Ron and Hari used words such as 'hurt', 'trauma', 'pain', or described that the penis would be chopped like a butcher.

In the master theme of 'Reflecting on the decision' contrasts arose between the level of choice the participants had over their circumcision status and whether it was the sociocultural norm or desired status. Difficult body image related experiences could complicate this issue of choice. The choice that the men had over their circumcision decision appears to be linked to a sense of autonomy and self-efficacy. A lack of choice regarding MC status was reported as problematic by all participants but to varying degrees. For Bob and Ahmad the lack of personal choice made them consider their circumcision as a violation whereas Rudy complained that he had not been given the choice *to be* circumcised early enough. Deciding to be circumcised for medical reasons was a constrained choice for Micky and Soona, who both found it difficult. However, in reflecting upon the decision, the choice seems easily accepted for Micky, whose sense of group belonging as a Jewish man and of penile body image were enhanced. On the other hand, Soona, for whom circumcision was not the norm, seemed to be ambivalent about having the operation revised and in whether it had been the right decision in the first place. In this theme, all the men illustrated the ongoing process of reflection in continuing to make sense of their circumcision status over their lifespan and in reviewing whether it had been right for them.

The penis is the male organ, along with the testicles, which define men as physically male. I suggest that it is male identity and pressures to conform to dominant cultural or personal ideals of masculinity that operate together with issues of autonomy and self-efficacy, binding them to the physical experience (see

Appendix 18). These issues will be discussed further below in relation to literature and theory.

4.3 Transferability and Quality

Before further discussing the findings as they relate to literature and theory, I will revisit issues of research quality and consider the limitations of this study. Next, I will make further personal and epistemological reflections.

4.3.1 **Evaluation of research quality.** Yardley's (2008) guidelines in evaluating qualitative research validity, were set out in the Methodology (subsection 2.8). I review here how my demonstration of her four principles has evolved during the research process.

4.3.1.1 Sensitivity to context. Emerging from the participant interviews was a sense that the sociocultural context was intimately tied up with their experiences of being circumcised men. I have tried to demonstrate this sensitivity by grounding the analysis in the context and including participant's quotations together with contextual information. When writing the Discussion, I have felt a constant to-and-fro between remaining sensitive to the varied contexts of the men's experiences, while trying to develop a sufficient depth of interpretation. I consider this further below, under Personal Reflexivity.

4.3.1.2 Commitment and rigour. My commitment to a more heterogeneous sample than usual in IPA was set out in the Methodology chapter. Reflecting on this throughout the research, I realised that the sample had at times made the analysis more difficult, as I seemed to find myself in an endless cycle of trying to make sense of what the men were making sense of. I knew that qualitative research required commitment and rigour, but I was stretched in ways I had not imagined. To maintain an approach to the data that could allow tentative subthemes and themes to be developed, rejected and refined was time-consuming and frustrating at times. This cycle of sense-making continued through to the write-up of the Discussion; I will leave the reader to decide as to whether sufficient insight and depth has been demonstrated.

4.3.1.3 Transparency and coherence. My research diary has been a valuable aid and I have maintained and reviewed it during the research process (see Appendix 2). Reviewing it has shown me how I slowly made sense of the men's experiences and how my feelings towards the research literature and the data evolved. At different times, I brought different perspectives to the data and the diary helped me to reflect on how this might be influencing the research process. An example of this occurred when I realised that I had not sufficiently paid attention to ethics, especially regarding circumcision for children. I expand upon this further in subsection 4.3.3. At other times I felt I was in a dialectical process being positioned within a continuum of the pro/anti circumcision debate. Striving to remain open to all views, I could feel myself being moved one way and the other, and this made me question what it was that was moving me.

I have included sketches of each participant's story in Appendix 3 so that the reader can better appreciate each man's personal narrative and can explore how the data could have been approached differently.

4.3.1.4 Impact and importance. My sense of the impact and importance of this research has grown progressively. As discussed in section 2.9, clinical experience with a past client attuned me to some of the difficulties that MC can be associated with. I was surprised, however, at the strength of the beneficial feelings experienced by some men. The response to my advertisement seeking participants was unexpectedly robust; I received well over 100 culturally diverse contacts within two days. This suggests that there may be a large number of men who feel that their circumcision status has strongly impacted their life, even if the percentage is low. The impact of MC appears to be cross-cultural and could be an issue for men that arises in therapy, or may remain unspoken. This emphasises the importance of looking beyond narrow definitions of hegemonic masculinity and towards a broader understanding of diversity amongst men as suggested by Nieminen (2013).

4.3.2 **Limitations and strengths of the study.**

4.3.2.1 Methodological reflexivity. My reasons for choosing IPA were previously discussed in the Methodology chapter. Using IPA allowed for an idiographic approach that privileges the participants' subjective experience, taking into account their 'cognitive, linguistic and physical being' (Finlay, 2006, p. 15). The emphasis in IPA on meaning making and on the double-hermeneutic process of interpretation has been echoed throughout this report. The men's individual voices have been given attention in a way that would not have been possible if a quantitative approach had been taken. However, IPA has come under scrutiny for having limitations that are not often reported by researchers (Brocki & Wearden, 2006). As Willig (2008) points out, it relies heavily on the validity of language in texts to describe the phenomena under investigation, whereas social constructionists would argue that it is language that comes first and constructs this reality. I agree, however, with Eatough and Smith (2008), who argue that, even if participants are engaged in cultural discursive acts, the use of IPA allows for a sense of their personal and emotional world to remain at the heart of the research. Willig (2008) suggests that, by using IPA, a limitation of this study may be that it does not pay sufficient attention to the way language and discourse have shaped the men's experiences. Notwithstanding Willig's critique, I feel that IPA can still pay attention to discourse and I discuss this further in the theory section (4.4) of this Discussion.

Willig (2008, p. 67) suggests that IPA relies upon participants being able to articulate the 'rich texture of their experience', and that the degree to which they can do this is questionable. There was some variation in the men's ability to express their experiences, which may in part have been because, although fluent, English was the second language learned for half of them. However, on balance, I feel that the data gathered reflected the depth of their experiences. Ahmad, for instance, sometimes found it difficult to articulate his experiences in detail. I was aware of this during the interview and, as Smith et al. (2009) recommend, I remained curious and interested, asking further questions to elicit an elaboration

of his experiences. Ahmad described his experience of violation, being circumcised without consent, and linked it to the childhood abuse he had suffered. For him, this appeared to be the focal point of his experiences as he continued to question the reasons behind his circumcision. I feel that, whatever the experiences each man shared during the interview, those experiences should be given equal weight, even if some appear richer in textural detail than others.

IPA's focus on participants' perceptions of how the world appears has been challenged by Willig (2008). She argues that this limits IPA to a mere sharing of experience rather than towards further understanding and explanation of phenomena. While this report can be said to be limited in this way through its very emphasis, I noticed that for most of the men the interview provided an opportunity to gain further understanding of their experiences. Sometimes, they had spontaneous insights that amounted to self-explanation as they reflected upon being a circumcised man. The nature of the research question involves experiences over the lifespan. In the interviews there were many points when participants reflected upon and recalled memories over time, often making links between them. Thus the men's sense making is something that *has* moved 'far beyond the moment and location of the experience itself' (Willig, 2008, p. 68).

4.3.2.2 Procedural reflexivity. Sampling presents some further limitations and strengths of this research. The sample was self-selected, via an advertisement in a London free newspaper that offered no incentive, meaning that the participants were highly motivated to take part. The findings show that men with contrasting views of MC were represented.

I selected from the respondents in the order to which they replied to the advertisement in order to ensure that I was fair and did not unconsciously or otherwise bias the sample. However, it is likely that there are many men for whom circumcision is neither experienced as problematic nor beneficial. This, combined with the small sample size of 8, means that transferability of the findings may be limited to other men who share key features of my participants.

It is not clear whether themes suggesting issues of male identity and the physical experience were particular to this sample or not, despite the fact that they resonate with the literature.

However, a strength of the self-selection sample is that only men who had something to say came forward and that they did not feel that they had taken part unnecessarily, as shown by the value many of them placed on the process during the debrief. Conversely, in terms of IPA research, the sample is quite large. Smith et al. (2009) have called for smaller numbers of participants to be used to increase the richness of the data gathered and the depth of the analysis. It is certain that a smaller participant sample would have altered the depth of the analysis, the themes and the findings.

Whilst the sample is homogenous in terms of the men all being circumcised, it is heterogeneous in terms of age at circumcision, sociocultural background, and current age. Such heterogeneity added to the diverse experiences of MC and ran the risk of complicating the analysis. However, on reflection, I feel that any extra depth of analysis that may have been obtained by choosing a more homogeneous sample or by using a smaller sample is more than offset by the fact that there was no research data to support choosing a particular sample. I particularly wanted to leave open the question of whether men found their circumcision benign or not (also see Personal Reflexivity below).

I would consider the use of participant validation (Lincoln & Guba, 1985) in a further IPA study. While Finlay (2011) argues that a participant's insight might be limited and that their responses to validating the research should be treated cautiously, I suggest that it could have added a further layer of transparency to this research. I would in future consider participant validation at the stage of analysing participants' transcripts, once interpretative themes emerged. I would report my reasons for divergences from participants' validation so that the reader could evaluate my role in the research more clearly.

4.3.3 **Personal and epistemological reflexivity.** Being a trainee has inevitably affected the outcome of the research. My choice of IPA is one that sits well with the ethos of Counselling Psychology, with its therapeutic focus on the client.

I have reflected upon sameness and difference in Counselling Psychology research in my diary (see Appendix 2). Hurd and McIntyre (1996) have warned of the 'seduction of sameness' that can block critical reflection and analysis just as much as blind assumptions about difference. I am a circumcised man, interviewing circumcised men. While I was cautious not to prejudice the interviews by revealing my circumcision status unless I was asked afterwards, it was of course implicated in the very research topic I had chosen.

I discussed my relationship to MC in section 2.9. However, as the research has progressed, I have reflected further on the dynamic interaction between the research process and me 'as a man' and on how I think about my penis. Suffering over many years from successive bouts of depressed feelings has, at repeated junctures, left me feeling ineffectual and disempowered as a man. Nevertheless, one part of my masculinity that I have always been able to rely on is my penis; form, function, sensitivity and procreativity have never given me much concern. Surprisingly to me, some functional issues have arisen in the last two years and I thought 'My 'manhood' is letting me down!' In thinking in this way, I relate to my penis is as though it is a separate part of me, with a life of its own. This is where my dynamic interaction with the research has played a part in changing my response. I have read theories of male identity (see subsection 1.9.3.2), immersed myself in the participants' lifeworlds and considered Annie Potts' (2000) 'The Essence of the Hard On'. This has brought 'me the man' closer to both my depressed feelings and to my penis; 'we' are all one and the same, me. In the past, I have only compounded my sense of disempowerment by trying to hive off various parts of my Self and by buying into ideas of male hegemony. The research has helped me to reflect differently about this.

As a trainee I have tended to work clinically in a person-centred way, sometimes utilising cognitive behavioural methods. I have learned the benefits of staying with the client's experience and slowing down to allow for exploration, whereas before I would sometimes be too hasty. When reflecting on my role as a fledgling researcher, I have had to revisit this tendency with regard to my interviewing technique. In the initial interviews, I feel I could have explored participants' experiences further in certain places as, on occasion, I prematurely used the schedule when the participant had paused and possibly could have been encouraged to say more.

As I come to the end of this research project I have reflected on the kind of phenomenological knowledge that I set out to create. Having spent time reading examples of IPA before I started the research, I was aware of differences in the emphasis between description and interpretation within IPA and phenomenology in general. However, as a novice researcher, it sometimes felt as though I was seeking a middle road that I could safely follow between the two. I aimed to develop rich descriptions of my participant's lifeworld, having a feel for my part in that description and hoping that insightful interpretation would follow. I had read Ashworth (1996) who, following Husserl, talked of the need for 'bracketing' in phenomenological research by putting aside assumptions based in theory, knowledge, personal experience and concerns about external truth. I felt I understood why 'bracketing' or Epoché was not seen as possible by those taking a more Heideggerian hermeneutic approach to phenomenology. Halling, Leifer, and Rowe (2006, p. 366) stress the importance of coming to an awareness of pre-existing beliefs and re-examining them as research unfolds, rather than bracketing. However, as my personal research diary reveals, I occasionally experienced confusion about this. Sometimes I used the words 'set aside' when thinking about what I brought to the research and how I handled that, rather than re-examining my presuppositions. At other times, it seemed I was concerned that the data might not really show 'what it was like' to be a circumcised man. It is as

though I hankered to create powerfully descriptive phenomenological knowledge using Husserl's 'reductions' to get to the essences of experiences, whilst espousing a more hermeneutic approach through my use of IPA. This mirrors tendencies within me as a therapist over the last four years to move between wanting to remain curious in the here and now of a client's immediate experience and clearing a space for meanings to emerge between us, in order to promulgate therapeutic change.

On a personal level, I have periods when I have felt 'at one with the world' and living more in the moment; at others times I have moved into a more structured, enquiring mode, curious for meaning. There is no inherent reason why my experience of this should feel dichotomised. Indeed I have come to a more fluid position, both within the research and my personal life. I mention this here so that the reader can reflect further on my role in this research, as for most of the post-analysis part of the project I have felt in the more interpretative mode of my being. This undoubtedly has influenced the extent of my interpretations. Acknowledging this helped me to 'step back' frequently, and to look again at how I viewed the emerging findings, and to re-examine my thoughts about MC. This was noticeable when I felt challenged by the research findings to re-examine and extend my thoughts on the ethics surrounding the circumcision of children. This involved questioning the extent of my embrace of multi-culturalism within the continuing flux of often fragmenting views within society and went beyond the research question. As the research process continued it has become clearer how my approach to the research subject, my research question and the questions I asked from the interview schedule have all shaped the co-creation of this research with the participants.

How I think about my epistemological stance has evolved. In the Methodology chapter it is a though I drew a line between the poles of realism and relativism. I positioned myself between critical realism and contextual constructionism. Whilst this well describes the position I brought to the research, I

have also latterly been influenced by the writing of Vermeulen and van den Akker (2010) in cultural theory. They described the contrasting modern and postmodern positions of theorists in terms of realism and relativism, seeing oscillations that they believe should be moved beyond. They coined the term meta-modernism for this. In similar terms, Finlay (2012, p. 31) calls for a move in phenomenological research to a position beyond 'modernism and postmodernism embracing both and neither'. In this Discussion chapter I have attempted to move 'beyond' such a fixed position by incorporating theoretical ideas from different perspectives in the service of developing insights into interpreting what has emerged from the data. I do not pretend to have reached a new, pluralistic 'meta-modern' position of neither one position nor the other, but I have tried to embrace aspects of both, while reflecting upon my epistemological stance.

An important area for personal reflection has been my unease in the final phase of the research process when being interpretative. I have keenly considered that my interpretations could feel like unwarranted impositions on the participants, whether they read this research or not. This has been a burden, as I consider what little I 'know' against the ocean of 'unknown' and as I weigh that in an ethical balance of responsibility to my participants. I trust that should they read this and disagree with aspects of the findings, they can rely on this research as exploratory and tentative in the way it has been presented. My hope is that further research may be stimulated that can shed light on the multi-faceted experiences of being a circumcised man, in ways that may help some men to live fuller lives.

4.4 Significant Findings and Contributions

MC has largely been ignored by psychological research and Counselling Psychology. The findings suggest that the experiences of being a circumcised man are of deep psychological significance to all of the participants in one way or another and, because of the large number of circumcised men, there is a likelihood that many other men may also be impacted.

In describing how the findings link to the literature and theory, I will first discuss the psychological literature on MC and then the men's physical experience in the light of literature on body image. Next, in discussing the impact on male identity, I will suggest that Connell's (1995) concept of hegemonic masculinity illustrates how many of the participants drew upon social representations and discourses of what it means to be a man when describing their experiences. Next, I will explore how Breakwell's (1986) Identity Process Theory (IPT) provides a useful framework to discuss the findings through the impact on male identity, by considering how circumcision status can act as a threat to male identity. As viewed through the lens of IPT, the men's diverse experiences of MC are conceptually clarified.

4.4.1 **Theory and literature.**

4.4.1.1 Circumcision literature. The findings illuminate many aspects of the extant research and literature regarding circumcision, particularly regarding contradictory findings. Much of the generally poorly researched psychological studies have indicated negative sequelae following MC. In contrast, the HIV research, some with a qualitative component, generally assumes MC to be universally beneficial, with dissenting voices seen as a barrier to saving lives. What the two strands of research appear to lack is a full understanding of the sociocultural and personal contexts from within which their conclusions are made.

The themes that have emerged from this research study have a common feature in that the experiences of the men appear to be somewhat polarised and contrasting. At one extreme, the men could feel that MC was the best thing they had done in their life and on the other a possible violation or mutilation. At a broad level, the themes resonate with those found in the phenomenological research by Lundsby et al. (2012), whereby MC was seen as a matter of social health, better personal hygiene, improving sexual performance and promotion of acceptance among men, in an HIV prevention context in Zambia. However, the

contrasting experiences of the current study are not reflected in the themes in their research study, suggesting that perhaps the cultural and HIV prevention context are playing a part in the beneficial view of MC. My findings suggest that the sociocultural and individual context should be considered in *all* circumcision research and that MC can lead to divergent experiences when men reflect on the decision. Similarly, the findings suggest that the generally negative conclusions of the limited psychological research (Bensley & Boyle, 2000; Hammond, 1999; Ramos & Boyle, 2000; Rhinehart, 1999) need to be considered as only looking at one side of MC. My findings show that some men are happier, more satisfied, and experience enhanced sensation after MC or that being *uncircumcised* may have been related to difficulties. Nevertheless, the findings concur with Hammond (1999) in so far as some men may feel emotional distress and that they have been violated, or with Bensley and Boyle (2000) in that some experience dissatisfaction with orgasm following MC.

This research makes a contribution towards understanding the debate around MC by presenting the voices of the men themselves and by interpreting these voices in a way which contains rather than provokes the debate. My research further contributes to the debate by showing that apart from differentiating between circumcised and uncircumcised men, circumcised men can become differentiated from each other by their experience, leading to polarised views of circumcision. There are thus groups of circumcised men (as well as uncircumcised men) who feel strongly about MC, both for and against, that reflects not just the physical experience, but also who they feel they are as men, and how they feel about the decision to be circumcised. This study illustrates the gulf between some men's experiences that becomes incomprehensible to either side and yet which can be understood when the themes of identity (Who Am I?), body image (The Physical Experience) and autonomy (Was it the Right Decision?) are considered within sociocultural and personal contexts.

4.4.1.2 Theory of body image. Cash (2004, p. 1) has conceptualised body image holistically, as being any thoughts, beliefs or feelings that a person has about their body. He calls for an expansion of the area of body image research beyond a narrow focus on shape and appearance. In the master theme of 'The Physical Experience', the men are exploring their penile body image in the way Cash conceptualises it, describing feelings and thoughts around how their penis looks, feels, is related to their health and how they felt about having their foreskin removed. Some of the participants described experiences that fit in with the view that their body image was diminished in some way, experiencing preoccupations with the effect of circumcision, whereas others felt it had been enhanced.

Those participants who described experiences as if their body image had been diminished used language such as 'dog's ears' and 'ugly' (Soona), 'it's been butchered' and getting 'no feeling' (Bob). It is as though they felt that their penises had been damaged or disfigured by the circumcision. These men's experiences resonate with Rumsey and Harcourt's (2004) findings that discuss the psychological impact of disfigurement through effects on body-image and self-esteem operating within a sociocultural milieu. For those participants who were circumcised for urgent medical reasons, thoughts about the damage to the penis or that they might have been disfigured by *not* being circumcised suggest that the fear of disfigurement and a changed penile body image can also encourage circumcision.

Cash (1996) models body image disturbances as occurring within cultural contexts that values certain attributes of appearance. His model of diminished body image proposed that there are often precipitating events, such as an individual being bullied or teased and these events can set in motion a cognitive and emotional focus on negative body image that then operates as a schema. The schema can then be triggered by thoughts that others may be looking at the body which may lead to compensating behaviours. Cash's (1996) model resonates in many ways with the experiences that are described by some of the circumcised

men. Some described precipitating events, such as being teased in changing rooms about the look of the penis, which appears to have led to a focus on the broader effect of the circumcision on their body image. This entailed negative images that go beyond appearance, with compensating behaviours such as hiding the penis from view, supporting Cash's idea of a schema. It was clear that the penile body image was important to all the participants. For some of them, it appears that it was enhanced by circumcision, in the way they felt the look, sensations and health of the penis had improved. These findings show that Cash's model can be usefully expanded to consider body disturbances as 'body changes' that can also *enhance* body image and self-esteem.

Patrick, Neighbors, and Knee (2004) have suggested that contingent self-esteem measures the extent to which an individual's basis for self-worth depends upon meeting standards and expectations, such as how you look or whether you gain peer approval. My findings show how circumcision status, within the cultural context, is something that can affect self-esteem in a similar way and in a way that may be highly contingent for some men. However, the participants' experiences contrast with Cash's (1996) model in respect of the implied sociocultural determinism of the valuation of certain attributes. In the current findings, personal context can override the cultural attributes; Rudy's aversion to the uncircumcised penis as 'awful' and looking like 'elephant's trunks' is an example of this. While Cash's model was mainly developed from studying women, this research suggests that more consideration of male body image is warranted as Copperman (2000) has argued. Circumcision is neither a 'disfigurement' nor an 'enhancement'; rather it is the context within which it occurs that means that it may come to be seen as such.

It is surprising that there is very little literature on body image related to the penis. S. N. Davis et al. (2012) have argued that negative body image related to penis size, deformity and disease of the genitals may affect male sexuality and have called for better measures of male genital image and more research. The way

that the penile body image was linked to sexual functioning for many of the participants is also in general agreement with the research of Malekjah (2009). He found a link between male genital image as measured by the Male Genital Image Scale (Winter, 1989) and sexual functioning in a non-clinical population. Lower scores were related to erectile dysfunction and premature ejaculation and higher scores to greater sexual self-esteem. However, the MGIS does not measure features related to circumcision status. The current findings show that circumcision status is an important feature of penile body image, and that, as a subset of male genital image, it needs to be taken into consideration in further research. The findings further extend the research of Tiggemann et al. (2008), in their study of male body image. They included the usually neglected features of hair, height and penis size, finding concerns surrounding the penis, but omitted consideration of MC. The current findings suggest that circumcision status has been a neglected area of male body image and male genital image research.

I will next discuss how the concept of hegemonic masculinity is linked to that of the penile body image.

4.4.1.3 Male identity and masculinity. As the overview of the findings illustrates, the participants' experiences of circumcision impacts the way they think about themselves as men and on their male identity. While male identity is often used in discussions of male gender identity formation, I am using it here in a way that describes the impact on the sense of what it means to be male. It therefore has much in common with the way 'masculinities' is used in feminist literature (see Blanchard, 2014; Connell, 1995; J. M. Davis & Liang, 2015; Duncanson, 2015). The emphasis at this juncture is on the meanings and symbolism inherent in being a circumcised man within diverse sociocultural contexts and its impact on male identity. I consider that circumcision *status* has the potential to threaten elements of identity that are core to being a man, as embodied by the penis and through what that symbolises in the social and personal context.

Connell and Messerschmidt (2005, p. 832) have described hegemonic masculinity as 'the currently most honored way of being a man', requiring 'other men to position themselves in relation to it'. For those participants who were circumcised as a Muslim or Jew, MC is a symbol, engraved on the penis, which represents this form of ideal or hegemonic masculinity. In this way MC can be understood as creating a socially constructed penis, with society taking some control of an individual's masculinity.

For the participants in this study who were Hindu (Soona) or White British men growing up in the 1960s (Ron and Bob), the hegemonic masculine form of the penis was uncircumcised; in positioning themselves in relation to the hegemonic ideal, these men may have found themselves in a threatened position where they could be 'dishonoured' or teased by virtue of their circumcision. It is what MC symbolises that is significant to the individuals concerned. The boundaries formed by the circumcision status, representing the hegemonic ideal, seem to create insider and outsider positions for the participants. In so far as their circumcision status matches the cultural norm, the insider position may be a comfortable fit. Those who are outsiders, however, may find themselves inhabiting a subordinated masculinity.

Thus the appearance of the penis is imbued with connotations of masculinity for the men both when they consider their circumcision personally and when they consider what others may think about it. However, as Connell and Messerschmidt (2005, p. 836) discuss, masculinity is not something that is fixed in the body or personalities of men. 'Masculinities are configurations of practice that are accomplished in social action' and which can vary according to the social context. Masculinity in relation to the penis is accomplished through the social action of sex or masturbation. Thus it is not just the look of the penis, but also how the participants understand the performance and enjoyment of sex that comes to define important elements of their masculinity. These expectations for sex seem to be somewhat limited for the participants. Describing the physical experience, they

draw upon discourses of penile sensitivity, relating that to the duration of sex and ease of achieving and power of orgasm, and penile appearance and health. It is as though all the significance of sex is vested in a sense of their masculine performance, focused on the circumcised penis, without consideration of partners, the role of the mind, emotional connections or alternative ways of having sex. The hegemony that is being heeded by these views appears to be that of the ideal male penis; one that looks good and is sensitive enough to maintain an erection for the requisite amount of time before ejaculation and orgasm.

The findings show that the participants value penile sensitivity and that lack of sensitivity may cause problems related to delayed ejaculation. This contrasts with recent findings from Africa (Lundsby et al., 2012) and Japan (Castro-Vázquez, 2013) where a perceived loss of sensitivity was seen as helping to prevent premature ejaculation and therefore beneficial. What is clear from my findings is that MC can be experienced as either enhancing or diminishing sensitivity, suggesting that whenever this is seen by men as being linked to either premature ejaculation or delayed ejaculation, their views of MC and their own masculinity will be challenged.

The findings show many of the participants drawing upon a medical discourse of the circumcised penis as healthier and cleaner with the foreskin seen as something that is dirty. In Hari's case the 'healthier' circumcised penis was described as saving him from HIV/AIDS. In using this discourse, MC is constructed as a potential bolster of masculinity, with implications that it protects the penis from infection and disease, maintaining the hegemonic sense of a virile, healthy and procreative penis. However, other experiences, such as loss of sensitivity could outweigh this view.

Notably, the men's positions as insiders or outsiders to their circumcision status, seems to be related to their position vis-à-vis the hegemonic masculine discourse of sex and the physical experience. A defective or potentially defective

appearance can challenge a participant's sense of masculinity as much as having a culturally mismatched penis, as seen previously regarding the penile body image.

Rudy's experience challenges this view of insider and outsider positions, however, as his personal preference for circumcision, not his cultural norm, meant that this was the group of men that he felt he belonged to. This illustrates that it is the identification with other men that MC can symbolise that may be key, rather than the norm of cultural practice; MC simply makes it more likely that men will identify the hegemonic form as the desired one. Rudy also exemplifies the position Connell and Messerschmidt (2005, p. 835) take; that hegemony can always be challenged and resisted and that subordinated masculinities can become stabilised. The stabilisation of gay and lesbian alternatives to heterosexuality in many western societies is an illustration they use. These findings show that the circumcision status norm can also be resisted, successfully by Rudy, but less so by Micky who resisted circumcision until finally linking it to his sense of becoming a Jewish man.

Elements of the men's masculinity are symbolised and engraved on the penis by MC. This concurs with Connell's (2000) view of masculinity as stemming from the male body, although not in an essentialist biological way. Despite Connell never discussing it, MC is a perfect example of what she describes as 'body practices' by which society produces bodies according to its own ideals.

The findings suggest that when MC as a social practice, either medical or cultural, is out of step with a man's sociocultural milieu or where his physical experience is out of step with the hegemonic ideal, then issues around masculinity may arise. Conversely, the opposite is also true, when masculinity may be enhanced. It may seem entirely unsurprising that male identity is related to MC. After all, in common parlance the penis has been referred to as 'the male member' (Lopate, 1994, p. 211), 'manhood' and 'man muscle', indicating the importance of it to men's male identity. However, it came as a surprise, in working with the texts, both the way these issues persisted for the men over many years, and how

their experiences drew upon discourse and were reformulated in the light of new discourses. Discourse appears to have shaped their understanding and can help to frame the findings.

The findings describe how participants became focused on the function and aesthetics of MC and how it affected their sexual health. This links to research by Castro-Vázquez (2013), who has shown how the recent uptake of circumcision in Japan has been accompanied by the commercialisation of the procedure. MC is promoted as enhancing masculinity, boosting sexual confidence and prowess, reinventing reasons for MC in a Japanese context. The current findings suggest that MC remained important as new discourses reframed the participants' understanding of it. However, dominant ideals of masculinity are fluid over time and not fixed; the findings link to research by Flowers, Langdridge, Gough, and Holliday (2013). They have shown how the growing 'biomedicalisation' of the penis and the commodification of its function and aesthetics seem to pathologise what was previously normative with the promise that men can take control of their bodies for themselves, as in the use of Viagra. At the same time they argue that biomedicalisation reinforces hegemonic masculinity and creates new discourses of penile aesthetics and erectile quality to complement those of sexual health, and which are increasingly visible via the media. However, they did not consider MC in such terms.

However, the current findings contrast with those of Flowers et al. (2013) as regards to the issue of men being able to control their bodies. For all the participants, excepting Rudy, there was a lack of choice and self-autonomy. Flowers et al. (2013) argue that emerging discourses emphasise the possibility of being able to more closely match the hegemonic ideal. They discuss muscle size, penis size, and erectile quality. By contrast, the same discourses may leave some circumcised men feeling more disempowered as they did not have a free choice over an 'irreversible' operation; foreskin reconstruction, as Kennedy (2015) points out, is rarely considered and may be impossible for many circumcised men. The

lack of self-autonomy for some participants, combined with difficulties relating to the cultural norm or physical experience, could exacerbate the sense of inhabiting a subordinated masculinity, as with Bob and Ron. Ahmad linked his lack of choice over MC to his later history of physical abuse, an extreme form of denying self-autonomy to another's body. The hegemonic view of men as being potent, autonomous and in control of their lives may have been challenged by circumcision and the permanence of MC is a constant reminder of this. The way the participants use old, new or adapted discourses suggest both persistence and fluidity in dominant sociocultural views of MC and masculinity. This links with the findings of Flowers et al. (2013) and Castro-Vázquez (2013) as discussed above.

Bullen, Edwards, Marke, and Matthews (2010) found a relationship to subordinated masculinities and lack of self-autonomy in men who had suffered from penile cancer, involving extreme changes to their penis. The current findings, nevertheless, show that even the lesser change predicated by MC may undermine some men's sense of masculinity, whilst enhancing others', depending on context.

Even when the participants conform partially to the hegemonic ideal as a result of MC, there may be a psychological cost involved, such as Hari's experience of a lost childhood. However, when some participants described inhabiting a body that feels as though it does not conform, the consequences can be persistent concerns around what this means to their masculine identity over the lifespan. Connell (2000) argues that it is mostly women who have been subordinated by hegemonic masculinity, and men who benefit from it, while acknowledging the existence of subordinated masculinities. The findings illuminate this by emphasizing how men experience MC in relation to hegemonic masculinity, creating a pressure to conform to ideals of masculinity that few of the men can match. It is as though some of the men have been subordinated by these ideals with consequent experiences of disquiet over masculine identity.

However, the findings of this study do not suggest that the body and the penis is a mere site for symbolism. The participants' circumcised penises have statuses as agents of action, performing through sex, influencing their sense of hegemonic or alternatively, subordinated masculinity. This links to Connell's view of the male body, as both an object and agent of social practice, in what she describes as 'bodily-reflexive practices' (Connell, 1995, p. 65). The men are at the heart of this, engaging with their experiences on a personal and social level in terms of their circumcision and how it affects their body.

Connell (1995, p. 162) views the hegemonic form of masculinity as being exclusively heterosexual. However, two of the participants, Rudy and Micky, were gay and their experiences of MC in relation to hegemonic masculinity do not appear significantly different to the other men. At a fundamental level, for this group of men, sexual preference did not appear to be closely linked to the experience of circumcision and hegemonic masculinity.

Connell discusses bodily reflexive practices through examples such as male contact sports, but the findings here suggest that the core bodily practice for men in regard to their masculinity may be that of their penis related to sex, including masturbation and coitus. I tentatively suggest that a more fundamental level of hegemonic masculinity is that of sex and the role of the penis in that, excluding sexual orientation.

Masculinity can be viewed as being a core part of a man's identity. Within that, the penis in regard to coitus and masturbation may have a core status as a bodily-reflexive practice. This is a potential explanation for why the issues raised for the men were of a longstanding nature and of such significance.

4.4.1.4 Identity Process Theory (IPT). The research findings link with Identity Process Theory which provides a framework for integrating the social and personal aspects of male identity related to circumcision. IPT elucidates the processes that may underlie MC as compromising or enhancing masculinity. Of key note are the identity principles of continuity, distinctiveness, self-esteem, self-

efficacy (Breakwell, 1986, 1993), belonging (Vignoles, Chryssochoou, & Breakwell, 2000), and psychological coherence (Jaspal & Cinnirella, 2010).

I will first discuss how circumcision status relates to threats or enhancements to male identity, before then considering the various coping strategies that the men seemed to use to allay the threats.

One point when a threat to male identity may arise is illustrated by the time the men first became aware of their circumcision status as distinguishing them from other males. For Bob and Ron, as young men, it was as though they were being called the 'wrong kind of male' when they were called Jewish for being circumcised. This may have threatened their masculinity through the principles of self-esteem, distinctiveness and belonging. While distinctiveness is generally seen as something sought by individuals, Jaspal and Cinnirella (2010) have pointed out that when it comes with a predominantly negative evaluation, it can threaten self-esteem and identity. This echoes Bob and Ron's realisation that their circumcision marked them as being different from most White British boys. They felt as though there might be something wrong with them.

It seems that for some participants, who were unable to make a choice, MC may contradict the self-efficacy principle of IPT. MC may be seen as something undesired and over which they had no autonomy, when reflecting on the decision. In contrast, for Ahmad and Anik, circumcised at birth as Muslims, there was no threat when they later became aware of their difference from other boys. Their identity as circumcised males was readily assimilated into their identity as Muslim men, which was more salient. However, in Ahmad's adult reflections, linking MC to physical abuse, the self-efficacy principle becomes salient once again.

The findings link to Jaspal and Cinnirella's (2010) principle of psychological coherence, a guide that structures identity elements. The participants described how they subjectively felt about elements of their penile body image and how coherent they felt that was with other aspects of their male

identity and masculinity, such as male belonging and difference. Threats to male identity from the coherence and continuity principle could also arise at the time the operation was considered. For Soona, as a Hindu, the circumcision was something that he resisted until it became medically essential. The continuity of his identity as an uncircumcised man and Hindu male was threatened by the operation and he sought to maintain this identity as long as possible, describing circumcised men as Muslim which was not 'coherent' for him as a Hindu. Amiot and Jaspal (2014) have argued for the psychological coherence principle as leading to opportunities of identity enhancement as well as threat. For Hari the transition to manhood represented by his ritual circumcision was in accord with the identity principle of belonging to the dominant group of men and was psychologically coherent. Nevertheless, the continuity principle was challenged by the loss of his boyhood and fears of his penis being butchered, creating a threat that was alleviated by the increase in self-esteem when he joined the 'club' of men, in accord with the coherence principle.

Jaspal (2012) has used IPT as a lens through which to understand the challenges of disfigurement for identity. There are links here between IPT and some of the men's experiences, as also discussed in subsection 4.4.1.2 as regards to male body image. Jaspal argues that the continuity principle is threatened in individuals who are disfigured later in life because of the unwelcome and often unanticipated change that needs to be assimilated and accommodated within the self-concept. He suggested that the coping strategy that was most successful for individuals coming to terms with disfigurement was to join a self-help group as this helped to promote acceptance.

Breakwell (1986, p. 96) argues that strategies will be used to cope with threats and that once acceptance and changes to identity are made, a threat will fade away. The findings here suggest that acceptance of circumcision status may often only be partial and that some threat remains, for potential rework later. For instance, Hari seemed to re-evaluate the premature 'loss of his childhood' in light

of the enhanced image of his circumcised penis as healthy and protecting him against HIV/AIDS. This appeared to justify his circumcision and improve his sense of self-efficacy.

Those men whose male identity appears to have been threatened by their circumcision status used coping strategies. Circumcision status is something that is easy for males to hide from others, except during sex, medical examination or where men may congregate together naked, such as in gym changing rooms. Even though, within themselves, the men may have experienced a threat to masculinity, interpersonally it was relatively easy to pass themselves off as circumcised or uncircumcised; this could be done by default, through inaction, with the penis remaining unseen. Membership of desired male groups represented by the circumcision status could have been easily questioned if others saw the penis. Breakwell (1986, pp. 116-117) uses the term 'passing' to describe how, for instance, a gay person may feign heterosexuality and 'live a lie'. Whilst she argues that the deceit is active at an interpersonal level, I suggest that circumcision status, where it is subjectively problematic, may represent a special form of 'passing', being evident on the body, but mostly remaining naturally hidden.

The lack of subterfuge generally required to keep the circumcision status hidden means that for some of the men it was an interpersonal coping strategy that they employed by default. It is as though their awareness of this only rarely surfaces, such as when Micky would not use the urinals in the synagogue or when Ron was contemplating his girlfriend finding out. However, as Breakwell (1986) has pointed out, passing is a coping strategy that is fraught with danger for the individual, as it delays acceptance and there is always the threat that they might be found out along with uncomfortable thoughts of what that might mean. This links with the findings that some of the participants were concerned with the perceptions of others reflecting a possible fear of discovery. There was a focus on those occasions when their circumcision status might be revealed. Bob took this to

an extreme, avoiding sex and long-term relationships as a way to cope with the threat to his masculinity that discovery might represent. The threat seemed to be to the continuity of his masculine identity, as he feared discovery would set him back 'donkey's years'. Passing may protect some men from inhabiting a subordinated masculinity at the interpersonal level, but it does not help them to come to terms fully with what that means to them. Indeed it may enable difficulties over circumcision status to persist.

4.4.2 **Implications for the therapeutic practice of Counselling Psychology.** The research findings shed light on the psychological significance of MC for some men. Even if small in percentage terms, the number of men affected could be large in number. My inspiration in conducting this research was borne out of my curiosity and surprise, when trying to support a client who felt traumatised by his circumcision, that there was so little research on this subject.

Counselling Psychologists can use this research as a resource if they have male clients who seek therapy for issues relating to their circumcision. It is significant that this area of male experience has been little researched. The lack of research and literature in psychology suggests that MC is a little discussed subject that may also be easily be overlooked or missed by Counselling Psychologists in therapeutic practice; it may not be easily spoken about by clients and may be little thought about by therapists.

Most of the participants mentioned during the debrief process that they had found it useful to talk about their experiences of MC. It was something that they usually kept private to themselves and in some cases had never talked about, as though it was a taboo subject. Soona exemplified this attitude, keeping his continuing research of circumcision hidden, even from his wife. It appears that the direct approach of the research, appealing for men to come forward to discuss their experiences of MC was welcome and seen as an opening opportunity. For this reason, Counselling Psychologists should reflect upon their practice and

consider whether in certain circumstances, discussed below, an approach that opens the topic of circumcision status is warranted.

The circumcised penis is in essence socially constructed and the findings suggest how this may have influenced the participants' experiences. In the therapy room, one man's traumatic experiences or difficulties related to being circumcised may be contrasted with another man's unfulfilled wish to be circumcised. Therefore, it is important for Counselling Psychologists to avoid making assumptions about MC that are not in the client's best interest.

The findings suggest that circumcision status can be problematic and that cultural norms may be implicated. However, I do not wish to imply that whether MC is the cultural norm or not determines the client's experience. What is important is that the interplay between this and any difficulties is explored and acknowledged, as there is the potential for it to be a complicating factor.

Whilst acknowledging the tentative, preliminary and exploratory nature of this research, I would nevertheless suggest that issues surrounding belonging, group identity as a man, and sense of self are areas that should be explored with clients who have difficulties regarding their circumcision status. Following Breakwell (1986), a useful way of conceptualising such identity issues would be to consider the process at the intergroup, interpersonal and intra-psychic levels and the links between these.

Due to the difficulty that men may have talking about their circumcision, when identity issues are raised, Counselling Psychologists can consider asking clients about their circumcision status and explore how they feel about that, if appropriate. A few of the participants referred to psychosexual problems and, although it is not possible to generalise from this small study, it nevertheless shows that circumcision status may play an important role in such problems for some men. In these situations, therapists should also consider assessing how men feel about their circumcision status and about the broad body image view that they hold of their penis; how it looks, feels and performs sexually.

Some participants talked of longstanding problems relating to their circumcision that had persisted over the lifespan. Counselling Psychologists should consider the evolution over time of such issues for the client, and that such issues may require longer-term therapy. Some of the participants reported that they found the research interview useful in making sense of their circumcision, actively making links during the process. I would suggest that a broadly narrative approach, enabling clients to make sense of their circumcision over their lifespan, may be a useful starting point.

For most of the participants, there was a period around adolescence or the time they were circumcised when they became aware of their circumcision status and of being different from other men. For several participants, this was something they negotiated without difficulty, while for others, who may present in therapy, there was considerable psychological turmoil. For some men, these longstanding concerns originated during adolescence; for others they originated during adulthood from needing a medical circumcision. Therapists and researchers should be mindful that there may be critical points at which psychological difficulties, relating to identity and thoughts about the penis, arise. Once again, the significance of these issues may be related to cultural context and social norms surrounding MC. Without psychological input, these concerns may persist into later life.

Issues may be exacerbated by experiences that the penis has been disfigured by MC or that for medical reasons the penis may *be* disfigured without circumcision, and this needs to be dealt with sensitively by the therapist. A further critical consideration for the therapist is the matter of the client's freedom of choice in making the decision to be circumcised, and whether this choice was made by others, forced upon them by circumstance or freely made. This is likely to colour the client's sense of agency and whether the correct decision was made or not. It is clear that every client's experience of MC will be complex and unique and that many other issues not elucidated here may be raised.

4.5 Areas for Future Research

This has been a small-scale study that illustrates the need for more research. Whilst this study has raised the issue of circumcision status having the potential to affect men's psychological lives, it has done little to suggest how many men may be affected and to what extent. However, the numbers could be considerable. A quantitative study could be undertaken to research this, with an emphasis on careful selection of a cross-section of men, so that some inferences could be made, subject to the bounds of the sample, of the numbers of men who may be impacted. This may help others to decide whether the field should be researched more diligently.

Findings from this research are unlikely to generalise to all circumcised men, but may resonate with subsets of them; those who feel most impacted. Further research using other methods such as Grounded Theory and Discourse Analysis (DA), could be usefully undertaken to see if these exploratory findings can be triangulated in other groups of circumcised men, but not with that as a primary purpose. Such an approach would enrich the field. A Foucauldian DA may illuminate issues of discourse touched on in this research, particularly those of masculinity, culture and medical health, or may add others. Further studies using IPA could use more homogenous samples; for example men with no memory of their circumcision, men circumcised as adults, or men from particular cultural or religious groups. I believe in an 'omnivorous' approach to research methods, while respecting the epistemological differences, as encouraged by Breakwell (2014, p. 23). I am entirely in accord with Rafalin's (2010, pp. 47-48) view that Counselling Psychologists are 'well-placed' to utilise methodological pluralism and that 'a real understanding of phenomena requires an understanding on both the quantitative and qualitative dimensions'.

I have stressed throughout the research that sociocultural and biographical context is important to understanding the diverse experiences of the participants. My findings suggest that future circumcision research would be well advised to

pay full attention to context and the implications of that for variations within the findings of individual studies and between findings of contrasting studies. Circumcision researchers finding contrasting experiences within data should not overlook it but embrace it instead. As was seen it the literature review on sexual functioning by D. S. Kim and Pang (2007), and the research of Krieger et al. (2008), in a study from South Africa, both their data sets had subgroups reporting contrasting experiences to the majority which the authors neglected. The findings of the two studies, which were the inverse of each other, suggest that diversity within research data should not be neglected. This is particularly important when findings are being used to promote MC for HIV prevention as in the case of Krieger et al. (2008), without consideration of minority subgroups. The current research shows that men who report poorer experiences of sexual function following MC may have long-lasting dissatisfaction that has the potential for emotional and relational difficulties. This potential should be carefully addressed by future HIV research, rather than remain hidden within the data.

Subgroups within research data, which have been highlighted in my findings, reflect the need for more research that considers adverse effects. Many authors argue that neglect of AE is particularly prevalent in psychological research (see Duggan, Parry, McMurran, Davidson, & Dennis, 2014; Jonsson, Alaie, Parling, & Arnberg, 2014; Vaughan, Goldstein, Alikakos, Cohen, & Serby, 2014). However, it is just as true that research findings concluding that there are negative consequences following MC, should also carefully report any subsets of their data that show beneficial consequences. The diverse findings of this study point to the need for Growth Mixture Modelling (GMM) techniques in quantitative research (Muthén et al., 2002). As described by Ram and Grimm (2009) GMM is a fast growing statistical technique that can help to identify *post hoc* groups within studies and a research study using such techniques thoughtfully could lead to more carefully considered findings in quantitative MC research.

This research supports the need for broader measures of genital image, as called for by S. N. Davis et al. (2012), to include how men feel about the sensations and health of their penis and the relationship between these measures and self-esteem. Measures such as the Male Genital Image Scale (Winter, 1989) should be expanded to include features of circumcision status satisfaction, circumcision scars and appearance, as well as for the features of penis curvature and shape called for by S. N. Davis et al. (2012).

4.6 Conclusion

This research has revealed that the participants' experiences of their circumcision status feature in their sense of who they are, which impacts on their self-esteem and body image.

> It set up a feeling that there was something wrong with me, with your penis sort of thing. (Bob, 74-75)

> From my personal view, you're more of a man and that's it, you know. (Rudy, 1537-1538)

The MC debate seems to split men into two opposing camps that often use rhetoric, polemic and denigration of the other to argue their viewpoint. What my research shows is that while themes around identity can be activated for the men, it is not the circumcision status itself that seems to be implicated, but the experiences of that for the individual as embodied and embedded in a sociocultural and historical context. Thus, as discussed above, being circumcised *or* uncircumcised can be experienced as compromising or enhancing male identity to varying degrees.

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Appendix 1 *MC and psychoanalysis*

Sigmund Freud, writing in 1905, described the phallic stage between the ages of around three and six when attention focuses on the genitalia and boys develop a sexual interest in their mothers with a concomitant desire to eliminate their fathers. He saw this as giving rise to castration anxiety (S. Freud, 1905/2003). Freud saw circumcision as a substitute for primal castration which he theorised must have been commonly practised at an earlier time in history. He posited that circumcision would be seen by the child as an attack on the self in the same way as castration, that could lead to a lowering of self-esteem, as he linked castration anxiety to neuroses (S. Freud, 1933). Anna Freud (1952) argued that MC could be seen as activating castration anxiety whatever age it was carried out and in some cases could be traumatic. She did not see it as a minor procedure as she emphasised that the significance lay in the child's fantasies. Kittay (1995) has argued that Sigmund Freud's view of circumcision and his corollary focus on female 'penis envy' left out any desire by men for women's attributes thereby distorting and side-lining women's sexual qualities. She sees Bettelheim's conception of circumcision as being more accurate.

Based on his study of disturbed children, Bettelheim (1954), in his work on 'symbolic wounds' concluded that there were convincing parallels between the boys' desires for girls' genitalia and their re-enactment of bloodletting to emulate menstruation, with the rites of passage that accompanied ritual MC. From his reading of anthropological research, he pointed out that many initiation rites were carried out long after the 'Oedipal stage' and that Sigmund Freud's views on circumcision and castration were based on Western notions of the vengeful and feared father, which is less strong in non-Western societies. He argued that MC can be interpreted as giving men mastery over creating men out of boys, thus partially satisfying men's envy of women's ability to bring another life into the world. However, in concluding his work, he admitted to being unable to fully

explain circumcision. Dundes (1976) has suggested that while anthropologists believe that MC rites of passage are about boys becoming men, psychoanalysts such as Bettelheim believe that they are about men becoming women, with the emphasis on emulation of menstruation. He points out an anthropological critique of Bettelheim's reasoning based on his study of disturbed children rather than mentally healthy individuals. Some authors (Hosken, 1994; Silverman, 2004; Boddy, 2007) suggest that anthropologists and even some feminists are more likely to explain that the removal of the clitoris, the female 'penis', and the foreskin, the male 'vulva' is seen by the societies that practise it as enhancing the gender divide by removing genital 'ambiguity' and strengthening a later desire for sexual union and marriage between the sexes.

Perhaps partly influenced by Freud's ideas, it has been generally assumed in the last 70 years that so long as circumcision is done during the period of childhood amnesia, up to the age of around 3.5 years (Joseph, 2003), there should be little long-term psychological effect, although Goldman (1997) challenges this assumption.

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Appendix 4 *Initial interview schedule*

Hello (*use name*) and thanks for - coming today and - agreeing to take part in this interview with me. I'd just like to remind you that I will be recording our conversation, but that your identity will remain confidential and that your real name will not be used in any write up. Before we begin, I'd be grateful if together we could fill in some background information about yourself on the questionnaire here (*share questionnaire*)…..

I can see from your details that …..(*make some short introductory remark if appropriate*)

So perhaps I can start by asking you what prompted you to respond and to decide to take part?

Roughly when were you circumcised?
Can you remember where that was? (*check country*)
Do you know what the reason for your circumcision was? (*ritual, medical etc)*

As you know we are going to be talking about your circumcision and that is a very personal thing. People use lots of different words for their genitals and I want you to feel comfortable. Do you have a word that you you would like us to use? (*suggest 'penis' if none other is forthcoming)*

Can you tell about what being a circumcised man means to you?

And how did this develop over time?

Prompt level 1: different experiences of, what is it like being.. , realisation of .., meaning of, effect of .. (impact). What further x can you think of for you?

Eg. What is it like for you being a circumcised man? .... What further things is it like that you can think of?

Prompt level 2: some people find it useful to think in terms of: body/image/ physical appearance /sense of self/relationships/sexual identity/sexuality/sex /memories of the procedure/first discoveries

Prompt level 3: How do you feel about that? How do you deal with that? How do your feelings about x affect your life? Do you compare yourself with others regarding x?

Feelings, thoughts, emotions, behaviour – how does it make you feel, bodily sensations, how do you feel emotionally when you think about your circumcision, do you do anything different, being a circumcised man. Does it make you think differently in any way?

The following subsections contains interview questions that I would like to cover at some point during the interview but which are only to be asked if they do not emerge from a more free-flowing style of 'interview'.

What were your first memories of your *penis*? *(or use substitute word)*

Sex life

Has your circumcision affected your sex life or has it had no effect?
How have you managed these experiences over time?

Sexuality

Has your circumcision affected your sexuality or has it had no effect?

Religion

Has being a circumcised man affected your religious identity or has it not been important in this regard?

Identity as a man

How does your identity as a circumcised man made you feel about yourself?
Elicit +ve –ve allowing for ambivalence. How have you managed this? What strategies have you used?

Has your circumcision affected the way you think about yourself as a man or has it had no effect?

Has the fact that you are a circumcised man been important in the way you see yourself as one of a group of men or has it been of no importance?

Relationships

Has being a circumcised man has affected your relationships with others or has it had no effect?

How have you managed these experiences over time?

(*If in a relationship*) What does your partner or partners think about your circumcision?

Embodiment

Has your circumcision affected the way you experience your body or has it had no effect?

How do you feel about the way your circumcision has changed your penis or have your feelings not changed about your penis?

Medical

Do you feel your status as a circumcised man affects your health or do you feel that your health is unaffected by your circumcision?

Miscellaneous

Do you compare yourself to other people who are circumcised or not? If so who do you compare yourself to and how does that make you feel?

What other influences are there that affect the way you feel about being a circumcised man?

At end of interview..

Overall how would you describe the experience of being a circumcised man?

Is there anything else that you would like to add that you haven't mentioned so far?

How did you find doing the interview? Was there anything about the discussion that you found helpful/unhelpful or particularly distressing talking about? In what way? Why? How did that make you feel?

(*Overall guide: elicit positive and negative responses and allow for ambivalence.)*

Appendix 5 *Final interview schedule*

Interview schedule

The interview will use a semi-structured format, broadly following a developmental timeline as outlined below to help the interviewee put themselves in the timeframe to help evoke memories and feelings. It is hoped that most questions will not have to be specifically asked, but will be covered naturally. The fixed questions and particularly the prompts will be asked only if they have not been answered as part of the natural flow of the discussion.

Hello (*use name*) and thanks for - coming today and - agreeing to take part in this interview with me. I'd just like to remind you that I will be recording our conversation, but that your identity will remain confidential and that your real name will not be used in any write up. Before we begin, firstly I'd like to check that you have read the information sheet and that you can then read and sign the consent form…(*fill in consent form*)… Now, I'd be grateful if together we could fill in some background information about yourself on the questionnaire here (*share questionnaire*)…..

I can see from your details that …..(*make some short introductory remark if appropriate*)

As you know we are going to be talking about your circumcision and that is a very personal thing. People use lots of different words for their genitals and I want you to feel comfortable. Do you have a word that you you would like us to use? (*suggest 'penis' if none other is forthcoming)*

So perhaps I can start by asking you what prompted you to respond and to decide to take part?

Can you tell me what your first memories and thoughts about your *penis (or use alternative word)* were, if you can remember, from before your circumcision?

Could you tell me all that you remember about your circumcision..

> Prompts; Roughly when were you circumcised?
> Can you remember where that was? (*check country*)
> Do you know what the reason for your circumcision was? (*ritual, medical etc)*
> What thoughts and memories do you have of your circumcision (and how did they make you feel)?
> What do you think influenced the decision around you being circumcised? Did others influence this decision? Did you hold any attitudes about it? Were there any other issues social, practical or perhaps emotional that influenced the decision? How does consideration of this make you feel? Family details – brothers/father circumcised?

School age

What memories and thoughts can you remember about being a circumcised boy when you reached school age between 6 and 13 years old?

Prompt: Difference from others? How did these memories/thoughts make you feel?

Prompt: Have there ever been times when you have particularly noticed that you are circumcised or that it has been drawn to your attention? How did that make you feel? What were the circumstances?

Adolescence

As you reached adolescence an onwards in your teens what memories and thoughts can you recall about being a circumcised man?

Prompt: Memories of masturbation? Did you feel that being circumcised was important in this regard or was it of no significance.

Prompt: Do you feel your circumcision affected your sexuality or has it had no effect?

Prompt: How did you feel about the way your circumcision changed your penis or is that not important for you?
How did that change over time?

Young adulthood (19-40)

During your young adult years from late teens into your thirties (*adjust for age of interviewee)* how did your memories and thoughts about being a circumcised man develop or change?

Prompt: Has your circumcision affected your sex life or has it had no effect?
How have you managed these experiences over time?

Has being a circumcised man has affected your relationships with others or has it had no effect?

How have you managed these experiences over time?

Has your circumcision affected the way you think about yourself as a man or has it had no effect?

Elicit +ve –ve allowing for ambivalence. How have you managed this? What strategies have you used?

Middle adulthood (40-65), Maturity (65+), Parenthood – depending on the age and life experience of the interviewee, questions to evoke memories, thoughts and feelings during different life stages will be evoked

Current age

Do you feel your status as a circumcised man affects your health or do you feel that your health is unaffected by your circumcision?

Has being a circumcised man affected your religious identity or has it not been important in this regard?

If a close friend told you that they are getting circumcised and asks you what you think, what would you feel you wanted to tell them?

At end of interview..

What other memories or influences are there that affect the way you feel about being a circumcised man that we might not have discussed so far?

How did you find doing the interview? Was there anything about the discussion that you found helpful/unhelpful or particularly distressing talking about? In what way? Why? How did that make you feel?

(*Overall guide: elicit positive and negative responses and allow for ambivalence.)*

General notes:

Prompt level 1: different experiences of, what is it like being/having memories and thoughts of.. , realisation of .., meaning of, effect of .. (impact). What further x can you think of for you?

Eg. What is it like for you having these memories and thoughts of x aspect of being a circumcised man? .... What further things is it like that you can think of?

Prompt level 2: some people find it useful to think in terms of: body/image/ physical appearance /sense of self/relationships/sexual identity/sexuality/sex /memories of the procedure/first discoveries

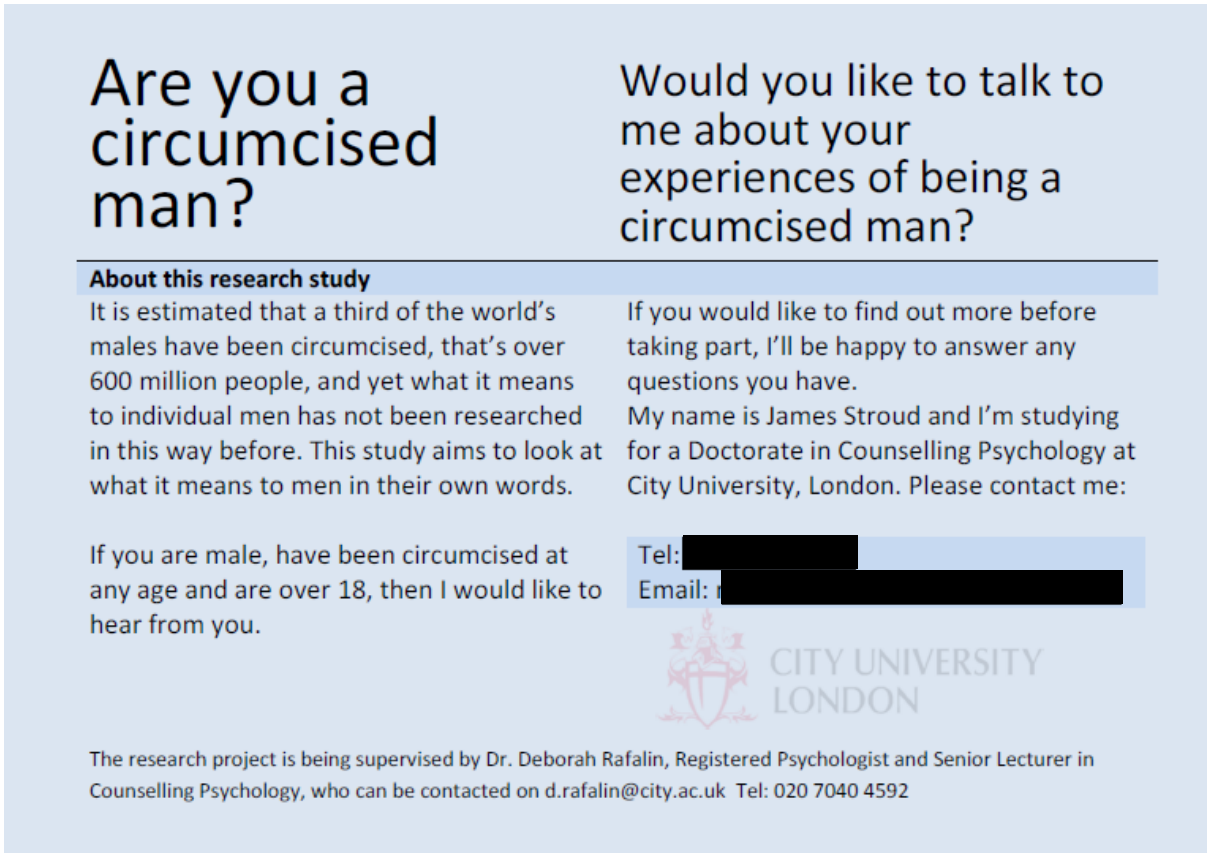
Prompt level 3: How do you feel about that? How do you deal with that? How do your feelings about x affect your life? Do you compare yourself with others regarding x?

Feelings, thoughts, emotions, behaviour – how does it make you feel, bodily sensations, how do you feel emotionally when you think about your circumcision, do you do anything different, being a circumcised man. Does it make you think differently in any way?

Have you had both positive and negative thoughts about x about your circumcision, or have you been indifferent? If you have had +ve and –ve then which view came first? When did you start to notice a change? Why do you think that is? How do you think having those views has affected you or has it left you feeling indifferent?

The design of the schedule is to be as fluid as possible, to enable the researcher to combine levels and prompts on the fly, but following the guidance of the interviewee so as to elicit what is pertinent to them as far as is possible

Appendix 6 ***Recruitment flyer***



Are you a circumcised man?

Would you like to talk to me about your experiences of being a circumcised man?

About this research study

It is estimated that a third of the world's males have been circumcised, that's over 600 million people, and yet what it means to individual men has not been researched in this way before. This study aims to look at what it means to men in their own words.

If you are male, have been circumcised at any age and are over 18, then I would like to hear from you.

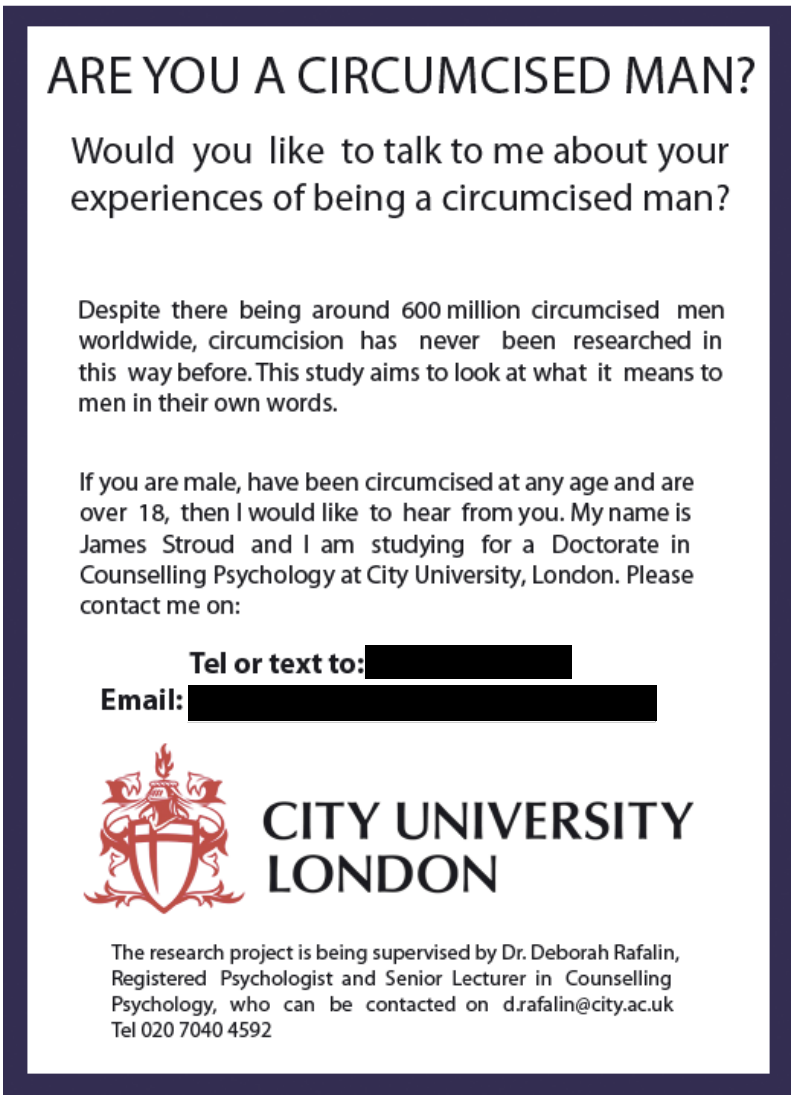
If you would like to find out more before taking part, I'll be happy to answer any questions you have.
My name is James Stroud and I'm studying for a Doctorate in Counselling Psychology at City University, London. Please contact me:

Tel: [redacted]
Email: [redacted]

CITY UNIVERSITY LONDON

The research project is being supervised by Dr. Deborah Rafalin, Registered Psychologist and Senior Lecturer in Counselling Psychology, who can be contacted on d.rafalin@city.ac.uk Tel: 020 7040 4592

Appendix 7 *Newspaper advertisement*



ARE YOU A CIRCUMCISED MAN?

Would you like to talk to me about your experiences of being a circumcised man?

Despite there being around 600 million circumcised men worldwide, circumcision has never been researched in this way before. This study aims to look at what it means to men in their own words.

If you are male, have been circumcised at any age and are over 18, then I would like to hear from you. My name is James Stroud and I am studying for a Doctorate in Counselling Psychology at City University, London. Please contact me on:

Tel or text to: [redacted]

Email: [redacted]

CITY UNIVERSITY LONDON

The research project is being supervised by Dr. Deborah Rafalin, Registered Psychologist and Senior Lecturer in Counselling Psychology, who can be contacted on d.rafalin@city.ac.uk Tel 020 7040 4592

Appendix 8 *Telephone interview schedule*

Telephone interview guide at first point of contact with interviewee	
Thanks for calling me/emailing me about this research project. Can I ask you where you saw it advertised?	
As you probably saw from the ad/article, my name is James and I'm doing a Doctorate in Counselling Psychology at City University. I guess you'd probably like to know a little bit more about what this research involves.. (pause briefly to see if they want to ask question at this point)	☐
Well, I'm keen to hear about your experiences of being a circumcised man. This would look at things such as how it makes you feel about yourself, how it's affected your life if at all and how you have dealt with this. This is something that's never really been researched before, even though billions of men have been circumcised, which is why I am keen to look at how you feel about it.	☐
What your part involves is for me to meet you for an informal interview for 1 ½ hours where you get to talk about you experiences and I'm happy to do this somewhere convenient for you to get to. I would like to audio record our interview so that I can make sure that I have all the details right of what you say. I'll then make an accurate transcription of what you say onto paper, but I will make sure that anything that might identify you will be removed from that record so that you remain anonymous and your confidentiality is protected. The same will apply to any further write up of the research.	☐
Would you like to ask any questions at this stage?...	
So I can get some idea of you before we meet, can I just ask you a few questions?	☐
What name do you like to be known by? (if not already given)	

How old are you now?	
Roughly what age were you when you were circumcised?	
Where were you born?	
Do you have a fluent level of English? (if any doubts about proficiency)	
Could we fix up a time and a place to meet? I'm really happy to come to somewhere easy for you to get to and at any time of day that suits you, even in the evening if that's best for you. Whereabouts do you live? What would suit you the best? ... (if London, I can suggest we could meet at…) etc.	
Can I note down your telephone number so I can contact you if there are any problems?	
(If a mobile… 'Would it be helpful if I text you the details that we've arranged?')	
Is there anything else you'd like to ask?	
Thanks for your help, I really appreciate it. I'll look forward to meeting you on DAY, the Xth of MONTH at XYZ location. See you then.	**NB Write Down**

Appendix 9 *Participant information sheet*

Information sheet for participants

My name is James Stroud and I am carrying out this research project as part of my doctorate in Counselling Psychology at City University London. Thank you for considering to take part in this research, 'Experiences of being a circumcised man: An interpretative phenomenological analysis', which is being supervised by Dr. Deborah Rafalin, Registered Psychologist and Senior Lecturer in Counselling Psychology.

The research is an investigation into men's experiences of being a circumcised man and what it means to them in ways that they consider to be significant or not. Hopefully, it will be a valuable opportunity for you to talk about your experience of being a circumcised man and to contribute to our understanding of what those experiences are. To protect your confidentiality, no personally identifying information, for example names or locations, will be used in any write-up of this research, nor in any later journal publication. If you would like a copy of the report once it has been completed and appraised, I will be happy to send you one.

Your participation will involve filling in a short questionnaire with some background details about yourself followed by a face to face interview with me that will last for around 1 ½ hours and will look in some detail at your experiences and how you have managed them. I will make a sound recording of the interview so that I can later transcribe it accurately. Short extracts from the transcript will be used in the final report, to illustrate your points of view or experiences. I will carry out the interview at your home or another location if you wish and at a time that is convenient for you. The important things to be aware of are that -

- Taking part is voluntary
- You can withdraw from it at any time before it is written up
- You don't have to answer questions about anything you don't want to
- Your confidentiality will be protected at all times

Your role as a participant shouldn't involve you in any greater risk of physical or mental harm than you experience in your everyday life. At the end of the interview you'll have an opportunity to ask questions and I will ask you how it was for you. I will also give you some further information on how to get support should you want it.

I would really appreciate your help in this project, as it will allow psychologists to better understand men's experiences of being circumcised men, and I hope that this understanding will lead to better services for men.

If you have any further questions that you want to ask, please contact me:

Researcher: James Stroud
Tel: [redacted]
Email: [redacted]

Supervisor: Dr Deborah Rafalin
Tel: [redacted]
Email: [redacted]

Appendix 10 *Participant consent form*

Participant consent form

'Experiences of being a circumcised man: An interpretative phenomenological analysis'

Researcher: James Stroud, Counselling Psychologist in Training, City University, London

The project is supervised by Dr. Deborah Rafalin, Registered Psychologist, The Department of Psychology, School of Social Sciences, City University London, Northampton Square, London, EC1V 0HB. Tel: 020 7040 4592

I confirm that my involvement in the project has been clearly explained in a way I can understand, that I have read and understood the Information Sheet for Participants and that I have had an opportunity to ask questions.

I understand that taking part is voluntary, that I can withdraw my consent at any time up to the completion of the research, and that I do not need to give a reason. If I withdraw my consent, all the records will be destroyed straightaway.

If any interviews are not finished, I understand that the records taken up to that point will be destroyed immediately.

I understand that this consent form will be kept separately from any other records of the research.

I understand that a sound recording will be made when I am interviewed and that this will be transcribed afterwards. All the identifying information about me in the transcript will be altered and a pseudonym will be used in place of my name in any written material. I understand that these records will be destroyed once they are no longer required for the academic appraisal of the research.

The written report of this research project will be submitted as part of the researcher's Doctoral course in Counselling Psychology at City University London, and may also be submitted for journal publication.

If I need to withdraw my consent, I can contact the researcher as follows:
James Stroud
Tel: [redacted]
Email: mailto[redacted]

The research will be conducted following the Code of Human Research Ethics of the British Psychological Society (BPS), the Code of Ethics and Conduct of the BPS and the Guidance on Conduct and Ethics for Students of the Health and Care Professions Council.

I agree to take part in the above study.

Signed (Participant)	_____
Name (Printed)	_____
Date:	_____

On behalf of all those involved in this research project, I undertake to comply with all the above statements regarding confidentiality and the protection of the anonymity of the interviewee in any and all materials presented for the purposes of the research.

Signed (Researcher)	_____
Date:	_____

Would you like to receive a report on the results of the project?	
If YES: Please enter your address	_____
	_____
	_____
	_____
	_____

Please sign both copies of this consent form. When the forms are signed by both of us, I will give you a copy for your records.

Contact information:

Researcher: James Stroud
[redacted]

Supervisor: Dr Deborah Rafalin
[redacted]

Appendix 11 *Background information questionnaire*

Experiences of being a circumcised man
Background information

First of all, I would like to ask you a few questions to get some basic background information about you. This will be useful to be able to show readers of this research something about the cross-section of men that it studies. None of the information will ever be used to identify you, as this research is completely confidential and anonymous, but if you don't feel like answering any of the questions then please feel free to leave any of them blank. Many thanks for taking the time to do this.

How old are you?	
What is your current *legal* marital status?	(*Please tick as appropriate*)
Single	☐
Living together - Cohabitation	☐
Married	☐
Civil Partnership	☐
Divorced/Separated	☐
Separated	☐
Widowed	☐
Other: *Please specify*	☐
What is your current relationship status?	(*Please tick as appropriate*)
No regular partner	☐
One regular partner	☐
One regular partner with casual partners as well	☐
More than one regular partner	☐
More than one regular partner with casual partners as well	☐
Other: *Please specify*	☐

How do you describe your sexual orientation?	(*Please tick as appropriate*)
Heterosexual	☐
Bisexual	☐
Gay	☐
Other: *Please specify*	
Do you have children?	(*Please tick as appropriate*)
Yes	☐
No	☐
If yes, how many children do you have?	
What's your highest level of education? Examples of qualifications	(*Please tick as appropriate*)
None	☐
GCSE's, Key Skills Level 1 and 2, BTEC Diplomas level 1 and 2, NVQ level 1 and 2	☐
A levels, IB, Key Skills level 3, BTEC Diplomas Level 3, NVQ level 3	☐
Certificates of Higher Education, HNC, BTEC Professional Diplomas, NVQ level 4	☐
HND Higher National Diploma, Other higher diplomas	☐
University BA/BSc, BTEC Advanced Professional Diplomas	☐
Postgraduate Masters, NVQ level 5	☐
Postgraduate PhD, Doctorate	☐
Other: Please describe	
Are you currently employed?	(*Please tick as appropriate*)
Yes	☐
No	☐
If yes, what is your current occupation?	
If no, have you been employed in the past?	(*Please tick as appropriate*)
Yes	☐
No	☐
If yes, what was your previous occupation?	

What is your nationality (*if any*)? *Please state all if more than one*		
How would you describe your ethnic origin?		(*Please tick as appropri*ate)
Asian or Asian British -	Indian	☐
	Pakistani	☐
	Bangladeshi	☐
	Other	☐
Black or Black British -	Caribbean	☐
	African	☐
	Other	☐
Chinese -	Chinese	☐
	Other	☐
Gypsy and Traveller -	Irish Traveller	☐
	Gypsy	☐
	Roma	☐
	Other	☐
Mixed -	White & Black Caribbean	☐
	White & Black African	☐
	White & Asian	☐
	Other	☐
White -	White British	☐
	White Irish	☐
	Other White	☐
Other: Please describe		☐

Do you have a religion?	(*Please tick as appropriate*)
Yes	☐
No	☐
If yes, what is your religion?	
If yes, how important is your sense of being religious to you?	(*Please tick as appropriate*)
Unimportant	☐
Not that important	☐
Averagely important	☐
Quite important	☐
Very important	☐
What are the first two letters of your postcode? **If you live in London please give the first letters and number (eg. SW5, N16)**	
How did you hear about this research? **(*please specify*)**	

If you need to get in touch over any aspect of this please email James on research.james.stroud@gmail.com

Thank you

Appendix 15 ***Summary of master themes and subthemes***

1. Who am I? Circumcision and my Self
    - 1.1. In or out?
    - 1.2. Feeling different?
    - 1.3. Perception of others.

2. The physical experience. Circumcision and my body.
    - 2.1. Reflections on appearance.
    - 2.2. Experiences of sensation.
    - 2.3. Representations of health and hygiene.
    - 2.4. Memories of the operation.

3. Reflecting on the decision.
    - 3.1. Did I have a choice?
    - 3.2. Reviewing the decision – Is it right?

Appendix 16 *Ethics release form*

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc M.Phil M.Sc **D.Psych** n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

Experiences of being a circumcised man: An interpretative phenomenological analysis

2. Name of student researcher (please include contact address and telephone number)

James Stroud, [redacted]
Tel [redacted]

3. Name of research supervisor

Deborah Rafalin

4. Is a research proposal appended to this ethics release form? **Yes** No

5. Does the research involve the use of human subjects/participants? **Yes** No

If yes,

a. Approximately how many are planned to be involved? 6-9

b. How will you recruit them?

They will be recruited from advertisements placed in various public places such as post offices and newsagents, mens clubs, toilets, and others places frequented by men. The flyers will also be handed out in the street to men, in London and other UK locations.

c. What are your recruitment criteria?
(Please append your recruitment material/advertisement/flyer)

Men, over 18 years of age, who have been circumcised.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? **Yes** No

d1. If yes, will signed parental/carer consent be obtained? Yes **No**

d2. If yes, has a CRB check been obtained? Yes **No**
(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

Each participant will be asked to attend an interview, approximately 90 minutes in length, during which they will be asked about their experiences around their male circumcision, and how they have managed those experiences. A semi-structured interview format will be used

7. Is there any risk of physical or psychological harm to the subjects/participants? **Yes** No

If yes,

a. Please detail the possible harm?

There is a small risk of possible psychological harm. For instance, a participant may get in touch with emotions that they had not been fully aware of which may leave them feeling some discomfort and the need for further support. Physically, the journey to meet the researcher may involve a small risk, but no more than that which is normal in day to day life

b. How can this be justified?

The risk of harm outlined above is small and in no way would be *caused* by the research itself,(which in itself involves no deception and has a transparent process), but is rather something that may be triggered by the evocation of memories. It is anticipated that the potential benefits of talking to someone about the experiences of being a circumcised man will in general outweigh the risk of harm, even before the potential benefit of the research to throw some light on men's experiences of circumcision is considered.

c. What precautions are you taking to address the risks posed?

The participants will be debriefed after the interview in order to identify if they have been disturbed in any way or have any misconceptions that can be clarified. I will use my counselling psychology skills and training throughout the process to keep in mind the possibility of harm and also to look for non-verbal cues to adjust my responses as necessary to make the whole process as open, welcoming and as risk free as possible I will give a list of psychological resources to each participant should they wish to follow these up to get further support.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

(Yes) **No**

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

Yes (No)

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

(Yes) **No**

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Digital audio recordings, transferred to computer as digital audio files; verbatim (anonymised) transcripts; computer records; research notes; consent forms

12. What provision will there be for the safe-keeping of these records?

All tape recordings will be erased from the recording device once transferred on to a password and fingerprint protected computer and internal folder. The transcript ID keys and consent forms and will be kept separately secured in a locked cabinet at the researchers home. Other research notes will be kept separate from the identifying consent forms and transcript key, to ensure confidentiality and anonymity.

13. What will happen to the records at the end of the project?

Audio material, anonymised transcripts and other records will be destroyed when the research project and appraisal procedures have been fully completed.

14. How will you protect the anonymity of the subjects/participants?

Consent forms and any key identifying the transcripts will be kept locked and separate from other research material. The participants' name will be anonymised in the transcripts, all written work and in any published material by using a pseudonym. Any other details which may be used to help identify participants will be omitted or changed in research project to further preserve anonymity.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

A provision will be made for a verbal debriefing at the post-interview stage in order to identify any unforeseen harm, discomfort or misconceptions. Upon completion of this, the participants will be given a written debrief that also contains information listing appropriate psychological resources for support, along with the means for contacting them, should the need arise.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

It is intended to use adult men who have experienced circumcision at some point in their life (not necessarily adulthood). It is anticipated that English will be the first language or spoken fluently, so as not to require the need of a translator. It is not anticipated that the research will entail any mental or physical risk to the participants, beyond that which experienced in day to day life, notwithstanding the small risk of psychological harm mentioned in 7. above. However, a list of support resources will be given at debrief, so that in the event of a participant experiencing emotional difficulties, they will have access to a number of routes through which they will be able to gain help.

Signature of student researcher [redacted] Date:16/10 2012

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal
Recruitment Material
Information Sheet
Consent Form
De-brief Information

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? (Yes) No
If yes,

a. Please detail possible harm?

The researcher will possibly be entering the homes of people who are effectively strangers: there is a small potential risk involved in this, should a participant have intentions to harm.

b. How can this be justified?

This is seen as being a low risk, and outweighed by the potential benefit of the research once the precautions have been taken into account (see below)

c. What precautions are to be taken to address the risks posed?

The researcher will use a'buddy system' whereby someone will know where he has gone to undertake the interview and when he will contact them to assure them of his safety, and the procedure to follow if he does not.

Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted [redacted]

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature [redacted] ---- Date [redacted]

Section D: To be completed by the 2nd Departmental staff member

*(Please read this ethics release form fully and pay particular attention to any answers on the form where **underlined bold** items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature [redacted] ---------- Date [redacted]

Post–interview participant information

Thank you for taking part in this interview. I very much appreciate having the opportunity of listening to your experiences and of receiving your help with this project. The intention of the interview has been to allow you to discuss your experiences of being a circumcised man. You will have been asked about things which were important for you about being a circumcised man, both positive and negative. The purpose of the research is to gain a more in depth understanding of men's experiences of being a circumcised man and will help psychologists understand some of the common themes that men consider important about being circumcised and also show the diversity of experiences that men have that may be individual to them. Your contribution and your views and feelings on this subject have therefore been valuable, especially considering how little research has been done regarding the psychological impact of male circumcision. You have been a valuable part of helping to increase understanding of these experiences.

I'll send you a copy of the final report once it has been written up if you asked for one, or you can always get in contact with me and request one later.

If you have any further questions to ask about the research, you can contact me on: James Stroud, [redacted] or [redacted]

The contact details of my research supervisor are as follows: Dr. Deborah Rafalin, Registered Psychologist, The Department of Psychology, School of Social Sciences, City University London, Northampton Square, London, EC1V 0HB. Tel: 020 7040 4592. If there is anything you would rather not talk to me about regarding the research or the way it has been conducted then you can feel free to contact her.

I asked you at the end of the interview how it had been for you and if it had raised any difficult issues. If you are experiencing any feelings of discomfort, either now or in the future, as a consequence of the interview, for example, emotional distress, uneasiness, or negative feelings about yourself or your body, please have a look at the list below. This gives details of organisations that you can contact in order to get some further help. Many people find that it is useful to contact organisations such as these so they can talk over personal issues on a confidential basis.

Thanks again for your time and help with this study!

You could ask your GP or NHS Direct for help or could contact the British Psychological Society (BPS) or the Health & Care Professions Council (HCPC) or the British Association for Counselling and Psychotherapy (BACP) for help choosing an accredited therapist and checking their specialised areas of therapy.

NHS Direct

Tel: 0845 4647
Web: *www.nhsdirect.nhs.uk*

British Psychological Society

Help with finding a psychologist with experience of particular areas of mental health

Tel: 0116 254 9568
Web: www.bps.org.uk/psychology-public/find-psychologist/find-psychologist
Email (general enquiries): enquiries@bps.org.uk

Health & Care Professions Council (HCPC)

Help with checking the professional registration of a psychologist and other healthcare professionals

Web: www.hpc-uk.org

British Association for Counselling and Psychotherapy (BACP) client information helpdesk

This is a service which will enable potential clients to find a suitable counsellor with whom they feel comfortable, in their particular area

Tel: 01455 883316

Web: www.bacp.co.uk
The British Association for Counselling and Psychotherapy:
BACP House
15 St John's Business Park
Lutterworth
LE17 4HB

Spectrum
Men For Men On-Going Groups

These group address issues such as how you experience yourself, imagine others experience you, concerns about past and present experiences and how these are connected, how you have been shaped by life how you can shape life in the future and many more

Tel: 0208 341 2277
Web:
www.spectrumtherapy.co.uk/index.php/personal/ongoing_groups/men_for_men_on_going_groups

Male Body Image Group

Terapia Consultancy, Therapy and Counselling in Central London

They will let you know when the next available male body image group is beginning

Tel: 020 7278 4304
Web: www.terapiaconsultancy.co.uk

The Recover Clinic

Support for eating disorders, with men's groups available.
Free information on support groups in your area.

Tel: 0845 603 6530
Email: help@therecoverclinic.co.uk
Web: www.therecoverclinic.co.uk/mens-therapy-group/

The Marylebone Center, Psychological Therapies

The UK's first sex addiction treatment programme for men and women. This programme has helped treat people with compulsive patterns of sexual behaviour for over 10 years. Individual, couple and group therapy.

Tel: 020 7224 3532
Email: info@marylebonecentre.co.uk
Web: www.sexual-addiction.co.uk

PACE

PACE is London's leading charity promoting the mental health and emotional wellbeing of the lesbian, gay, bisexual and transgender community.

Professional and experienced staff and volunteers have been offering a range of services that includes:

- Counselling – general, sexual health, alcohol & drugs
- Family support – including national helpline
- Mental health advocacy
- Training
- Workshops and groups

All PACE services are either free or low-cost.

Tel: 020 7700 1323
Email: info@pacehealth.org.uk
Web: www.pacehealth.org.uk

Supportline

They offer confidential emotional support to children, young adults and adults by telephone, email and post. They work with callers to develop healthy, positive coping strategies, an inner feeling of strength and increased self esteem.They also keep details of counsellors, agencies and support groups throughout the UK.

Tel: 020 8554 9004
Web: www.supportline.org.uk

Terence Higgins Trust

Advice and support around HIV and sexual health issues, free counselling

Tel:
Web: www.tht.org.uk

AMSOSA UK (Adult Male Survivors of Sexual Abuse)

Helpline and support group for male survivors 17 and over of rape and childhood abuse.

Tel: 0845 430 9371
Web: www.amsosa.com

Gingerbread – Single Parents, Equal Families

They provide expert advice, practical support local groups and campaign for single parents

The Gingerbread Single Parent Helpline is open as follows:

- Mondays: 10am to 6pm
- Tuesdays/Thursdays/Fridays: 10am to 4pm
- Wednesdays: 10am-1pm and 5pm-7pm.

Tel: 0808 802 0925

Web: www.gingerbread.org.uk

Samaritans

You can talk to Samaritans at any time of the day or night.

If you use a language other than English, please visit **www.befrienders.org** to find your nearest helpline.

Tel: 0845 790 90 90
Web: www.samaritans.org.uk

Mind infoline

Mind helps people to take control over their mental health. They provide information and advice, and can help direct people towards appropriate resources for further help.

Tel: 0300 123 3393
Web: www.mind.org.uk

Mind infoline
PO Box 277, Manchester, M60 3XN

Central and NorthWest London NHS Trust

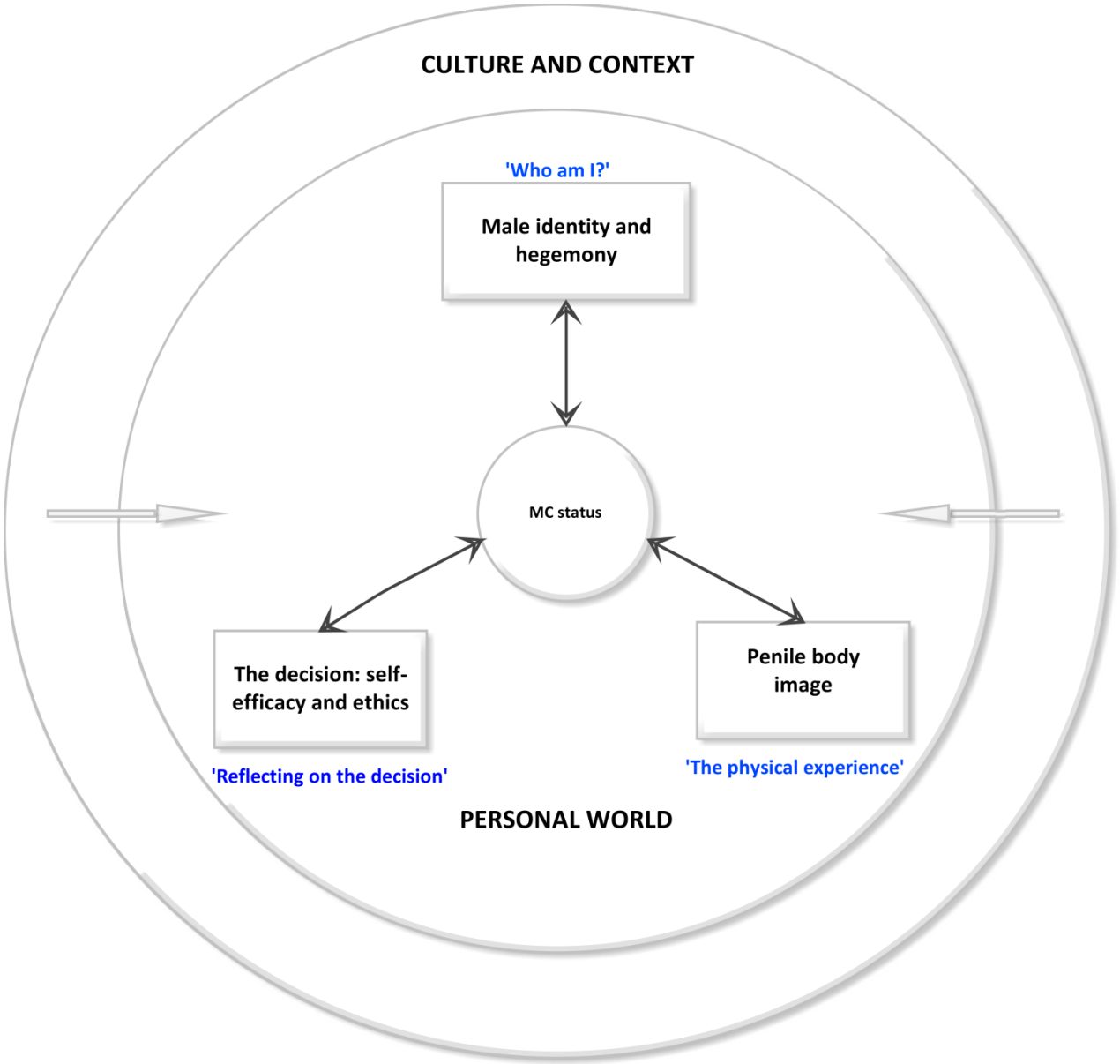
Maintain a useful web page detailing many more organisations that can provide support for specific issues
Web: www.cnwl.nhs.uk/nationalsupportgroups.html

Men's Health Network

Men's Health Network (MHN) is a national non-profit organisation whose mission is to reach men, boys, and their families where they live with health prevention messages and tools, screening programs, educational materials, advocacy opportunities, and patient navigation.

Web: www.menshealthnetwork.org

Appendix 18 ***Diagram of MC model***



Part C: Client study (removed from electronic copy)

A Client with Post-Traumatic Stress Disorder:
A Cognitive Behavioural Therapy Approach

Part D: Critical Literature Review

Cultural Differences in Social Anxiety Disorder: A Counselling Psychology Perspective

1 Cultural Differences in Social Anxiety Disorder

The implications of studies of cultural differences in Social Anxiety Disorder (SAD) are reviewed in this paper. SAD (American Psychiatric Association, 2013) is a common mental disorder in many countries, as will be reviewed in section 2.1 below, and cultural differences in SAD are therefore of relevance to therapeutic practice and research in Counselling Psychology.

1.1 Definition and Clarification of the Problem

DSM-5 (American Psychiatric Association, 2013) definitions of SAD are ipso facto 'culturally situated' diagnoses and yet an analysis of the impact of this is often overlooked. Much of the research reviewed takes a western medical perspective of SAD, privileging the view that it is a cross-cultural mental disorder. Some research reviewed questions how culture shapes SAD, its symptomology, and how it might best be treated. An area of interest is to elucidate extent to which there are cultural differences and cultural similarities in experiences of SAD amongst different population groups. This is relevant to the development of effective treatments.

1.1.1 **What this review sets out to do.** The current state of research into SAD will be reviewed. Studies that emphasise cultural differences within SAD and that are representative of the current state of research will be critiqued. Epidemiological studies are reviewed first; problems arise in measurement. The DSM-5 lists Taijin Kyofu Sho (TKS) as a culture bound syndrome chiefly found in East Asia and closely related to SAD. Debate in the literature about TKS as a culturally bound syndrome is reviewed next.

Theoretical papers have made suggestions about the origins of cultural differences and how these lead to social anxiety. These papers are scarce and those studies which cover contrasting and complementary theories are reviewed, reflecting the current state of research. The focus will be on what these differences imply for research and practice both for SAD and for Counselling Psychology.

The implications of a more integrated view of culture and psychology will be put forward. Culture impinges on the mind as ideas, as patterns of behaviour and practice, and as institutions and artefacts (Kluckhohn, 1951). However culture is not monolithic. Individuals have a choice of cultural scripts (Ryder, Ban, & Chentsova-Dutton, 2011), even though choice may be constrained. Cultural scripts exist for both positive and negative mental states and such ideas have relevance for understanding the presentation of SAD. I will argue, furthermore, that this review has wider implications for the ways in which Counselling Psychologists may be able to influence cultural research and to broaden the extent to which psychology can take on board cultural issues, becoming culturally diverse at its core.

1.2 Definition of Culture

All groups of people who identify themselves to each other based on some shared aims, needs, or the similarity of background, belong to the same culture and they may have a common language, set of values and life experiences (Johnson et al., 1997). Culture depends on symbols, with the most important being the details of the language used within that culture (Hofstede, 1984). Broader definitions of culture include institutions, organisations, and sub-cultures (Brislin, 1990). However, the term culture is often used by psychologists as shorthand for ethnicity and national groupings and this tends to be the stance taken by many of the studies reviewed hereunder.

1.3 Cultural Differences

Three areas of focus for psychology regarding cultural differences can be distinguished.

a. Cross-cultural studies of differences compare differences between cultures.

b. Trans-cultural issues in psychology revolve around the central question of ensuring that psychological theories and findings can be applied across different cultures.

c. A fully formed and informed cultural psychology would be culturally diverse at its heart. This is expanded upon in section 4.2 below.

Most of the literature reviewed below reflects the dominant position of cross-cultural studies in the literature on SAD.

1.4 Cultural Psychology

Jerome Bruner (1990) has argued for the importance of cultural psychology; 'cultural psychology must venture beyond the conventional areas of positivist science with its ideals of reductionism, causal explanation and production' (p. xiii). This is a two-way process with mind being affected by culture and culture by mind (Hiles, 1996). Wilhelm Wundt (1920) recognised a lower order psychology that could be studied experimentally and a higher order psychology that could be studied indirectly through its cultural products. Psychology's emphasis on the experimental scientific approach has for too long neglected the study of mental processes indirectly, by investigation of cultural products. Psychology's concern with its scientific status, wanting to be seen on a par with the natural sciences, has doomed cultural products to decades of neglect in an attempt qualify itself as a hard science.

Even at the level of the experimental research within psychology, cultural differences are important because of their effect on the replicability of results. For example, Bond and Smith (1996) carried out a meta-analysis of studies based on the Line Judgement Task of conformity (Asch, 1956) and found considerable variation in results due to cultural differences linked to individualist and collectivist societies, as reviewed in section 2.5 below regarding SAD.

1.5 Social Anxiety Disorder (SAD)

Social phobia was first included as a psychiatric diagnosis in DSM-III (American Psychiatric Association, 1980). Subsequently, following the publication of the DSM-IV (American Psychiatric Association, 1994), the term was changed to SAD. Diagnosis is based on certain symptoms outlined in the DSM-5, notably 'marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others' and in which ' the individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated', and that 'the fear, anxiety, or avoidance causes clinically significant distress' (American Psychiatric Association, 2013, pp. 202-203). Cultural assumptions are implicit within the DSM-5. Examples of the assumptions made are that the threshold at which the fear is perceived as being excessive will be the same across cultural groupings and that there are no other ways for the fear to be recognised that might preclude this.

1.6 Expediting the Review

Studies were identified by searches on PsycINFO, Embase, and Google Scholar using primary search terms such as social anxiety, social phobia, culture, cultural, differences and secondary search terms such as prevalence, epidemiology and Taijin Kyofu Sho (TKS). The search aimed to concentrate on work published within the last six years, although papers were selected from earlier years if the contribution had not been updated since. The numbers of papers that could be reviewed were small, because epidemiological studies of SAD separately are scarce and cultural aspects are not often considered. Where similar papers did not add to the current state of research, only the most recent or most informative have been included.

2 Literature Review

2.1 Prevalence and Epidemiology

Worldwide prevalence rates for SAD vary significantly; lifetime estimates refer to whether SAD is experienced at any point during the lifetime and 12-month estimates refer to the previous year only.

In South Africa (Stein et al., 2008) a lifetime rate of 2.8% was estimated while from Nigeria (Gureje, Lasebikan, Kola, & Makanjuola, 2006) a lifetime rate of 0.3% and a 12-month rate of 0.3% was reported. In the USA, lifetime prevalence was 13.3% and 12-month at 7.9% (Kessler et al., 1994) with further estimates by Ruscio et al. (2008) at a lifetime and 12-month prevalence of 12.1% and 7.1%. Further south in Mexico the 12-month estimate was 1.7% (Medina-Mora et al., 2005), while in a localised sample from Brazil, the lifetime estimates varied from 6.7% to 11.7% and the 12-month rates from 5.2% to 9% according to whether ICD-10 criteria or DSM-III-R criteria were used (F. L. Rocha, C. M. Vorcaro, E. Uchoa, & M. F. Lima-Costa, 2005). From Chile, Vicente et al. (2006) reported lifetime and 12-month rates of 10.2% and 6.4%

In Asia, estimated 12-month rates in China at 0.2%, whilst in Japan (Kawakami et al., 2005) the 12-month rate was 0.8%. In Australia the 12-month estimate varied from 1.3% to 2.7% (Andrews, Henderson, & Hall, 2001) depending upon whether DSM-IV or ICD-10 (World Health Organization, 1992) criteria were used. Wittchen, Stein, and Kessler (1999) estimated the 12-month prevalence in Germany to be 5.2%. Pakriev, Vasar, Aluoja, and Shlik (2000) found from a localised sample in Udmurtia, Russia that the 12-month rate was 44.2% and the lifetime rate 45.6%. From these estimates we can see that the 12-month prevalence estimates vary from 0.2% (China) to 44.2% (Udmurtia, Russia) or by a factor of 220. Even if the extreme values from Udmurtia are excluded as an outlier, the estimates still range from 0.2% to 7.9% (USA) or by a factor of 40.

2.2 Measurement Difficulties

Before assuming that these variations are due to inherent cultural differences, it is necessary to look at other factors. Few measures of social anxiety have been developed for non-English speaking cultures meaning that the content validity of measures used in these cultures has not been validated (Caballo et al., 2012).

2.2.1 **Use of the CIDI.** Compared to earlier studies, the widespread use of the World Health Organization (2001) Composite International Diagnostic Interview (CIDI), which includes a specific section for SAD based on DSM-III-R (American Psychiatric Association, 1987) and ICD-10 (World Health Organization, 2004) has improved consistency (Lecrubier et al., 2000). The CIDI is suitable for use with epidemiological studies in different cultures and using alternative diagnostic systems (Robins et al., 1988). Studies reviewed are limited to those papers which used the CIDI in order to exclude gross variations due to the data collection format. However, this does not discount the fact that variations in how the interviews were carried out or the meanings of those interview questions to participants might significantly affect the results as seen later (see section 2.2.3 below).

2.2.2 **ICD-10 vs DSM.** The criteria of SAD used in these studies are taken from the DSM-III-R, DSM-IV, DSM-IV-TR and ICD-10. Some of the range in estimates can be accounted for by the differences in these criteria although the relationship is not always clear. For example, F. L. Rocha, C. M. R. Vorcaro, E. Uchoa, and M. F. Lima-Costa (2005) reported 12-month ICD-10 rates of 5.2%, while the DSM-III-R estimate was 9% in their Brazilian study. Conversely, in Australia, the DSM-IV 12-month rate was half that of the ICD-10 estimate, although the estimates were lower at 1.3% and 2.7%. This would suggest a possible large disparity in DSM-III-R to DSM-IV estimates which is not, however, found between the DSM-III-R USA data from 1994 and the DSM-IV 2008 data where 12-month rates vary from 7.9%

to 7.1%, suggesting that other factors affect the estimates. Since SAD frequently becomes an issue in adolescence, samples that include a greater percentage of younger people will generally show a higher 12-month prevalence rate than those with older adults. Rates are inversely related to socioeconomic status and are somewhat higher amongst women (Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996).

2.2.3 **Role of the researcher and clinical evaluation.** The requirement for clinical significance of impairment in the DSM-III-R onwards, introduces a subjective evaluation (Magee et al., 1996). Thus, Crozier and Alden (2001) argue that researcher attitudes to these criteria or whether the participant just has poor social skills and is shy can make a large difference to prevalence estimates.

2.2.4 **Sampling issues.** Kessler, Stein, and Berglund (1998) point out that people with psychiatric disorders are less likely to participate in interview studies and that this might vary for cultural reasons. Furthermore, in countries such as Japan, where stigma can fall on the whole family and not just the afflicted person, there may be greater resistance to admitting the severity of symptoms (Hsu & Alden, 2008).

2.3 Review of Selected Studies of SAD and the Difficulties of Cross-cultural Comparisons

The problems outlined in section 2.2 above make cultural comparisons difficult. With this in mind, three of the above studies will now be critiqued to look at further difficulties that can arise.

The National Comorbidity Survey Replication (Ruscio et al., 2008) estimated lifetime SAD at 12.1% and 12-month at 7.1% in a probability sample of 9282 respondents (Kessler et al., 2004). The degree of functional impairment was assessed more extensively than in the prior NCS study by using the Sheehan Disability Scales. There was a considerably increased risk of cross-domain impairment even with just a few social fears (Ruscio et al., 2008). This was a new

finding. The lay-administered CIDI interviews generated more conservative estimates than clinician-administered SCID DSM-IV interviews which were carried out for validation purposes on a representative sub-sample to check for diagnostic consistency.

The greater emphasis on impairment means that estimates in the NCS-R are likely to be conservative (Ruscio et al., 2008). Small variations in base questions can lead to estimating differences, making cross-cultural comparisons difficult.

The study used factor and latent class analysis and concluded that there were no specific sub-types of SAD. An assumption the authors make is that the DSM-IV covers all aspects of social anxiety which, as seen later, is unlikely to be true.

It was found that the 62.9% co-morbidity found in lifetime SAD meant that most respondents had been in treatment with mental health services, but not for SAD. This was more likely the higher the number of social fears the respondents reported and suggests that Counselling Psychologists should be wary of pre-existing diagnosis, and reassess for SAD as necessary.

Data from the national South African Stress and Health study (N = 4433) found a lifetime rate of 2.8% for SAD (Stein et al., 2008). The CIDI interviews were carried out in seven different languages yet the authors neglect to discuss that the effectiveness of translation of the CIDI is a potentially confounding variable. Clinical validation of a sub-sample of findings from the CIDI could have largely controlled for this and helped to validate the estimates, as was done in the NCS-R study (Demyttenaere et al., 2004).

Interestingly, the authors found that there were no statistically significant variations according to ethnicity, despite clear differences in access to healthcare. They hypothesise that, because the heterogeneity of ethnicity in South Africa,

many local factors cause variations between individuals within these groups, but it is not mentioned why this would have a levelling effect.

A study of social phobia in Udmurtia (Pakriev et al., 2000) has been widely referenced but with little comment beyond the very high rates of SAD reported at a 12-month rate of 44.2% for ICD-10 criteria and 49.4% for DSM-III-R. The study used a sample of 995 adults from rural Udmurtia in the Russian Federation. Systematic random sampling between the ages of 18 to 65 ensured representativeness. This study is included here, as despite raising a number of methodological questions, it poses intriguing findings regarding cultural differences.

The one year rate of SAD amongst Udmurt men is significantly higher at 50.3% than amongst Russian men at 32.6%. Amongst Udmurts there is a high comorbidity between SAD, depression and alcohol dependence. These findings are strongly suggestive of cultural influences, especially given the traditional acceptance of shy behaviour amongst Udmurts. As the authors point out, this tradition casts some doubt on the high estimates found, as it is likely that some of those with SAD were simply showing typical Udmurt behaviour. Furthermore, given the theoretical possibility that acceptance of socially anxious behaviour in Udmurts means that SAD may act as a catch-all for anxiety disorders, it is clear that further detailed research is necessary to clarify these findings. DSM definitions of SAD are grounded in a western culture that promotes the individual self and the benefits of positive feelings (Heine, Lehman, Markus, & Kitayama, 1999) and emphasises deviations from these in diagnosis. Udmurt culture does not appear to value the same 'norms' and ideals of behaviour that the DSM does.

The interviews were not carried out by trained practitioners but by the main author himself, Pakriev. Thus there is the potential for researcher bias that is not addressed. Quality control issues were not mentioned regarding the

interviews and some independent cross checking on a representative sub-sample, which were then assessed blind, should have been carried out.

2.3.1 **Summary.** Epidemiological studies of SAD are complicated by the issues raised above. National studies are used as a proxy for looking at cultural differences and the quality varies substantially. It is not possible to state with confidence that the difference in estimates that we see between areas reflect real differences. This is largely due to lack of clinical verification (Kessler & Merikangas, 2004), subjectivity in diagnosis of SAD and cultural and linguistic variations in responses to the CIDI. Thus culture itself complicates the search for cultural differences between epidemiological studies. Where more localised studies are used, the lower funding available means that less sophisticated methods have been used for data collection and handling. Difficulties such as these mean that direct comparisons are difficult to make; there are many gaps in knowledge.

TKS is listed in the DSM-5 as a culturally bound syndrome related to SAD and studies of this will now be reviewed.

2.4 TKS

2.4.1 **Introduction.** Taijin-Kyofu means fear as regards others. Sufferers exhibit excessive fears of social situations and it has been subdivided into two types, the tension subtype and the conviction subtype (Kinoshita et al., 2008). In the conviction subtype, which is principally confined to East Asia, there is a *conviction* by sufferers that they will offend, embarrass or harm others through their blushing, eye contact, body smell or deformed body (Kirmayer, 2001). There is, therefore, an *allocentric* basis to the harm which contrasts to the *egocentric* embarrassment that would be felt typically in SAD (Markus & Kitayama, 1991).

Since there are no major epidemiological studies of TKS in Japan or other countries it is difficult to come to a view on the cultural boundedness of TKS (Suzuki, Takei, Kawai, Minabe, & Mori, 2003). Due to the paucity of well-

constructed studies, I am limited here to reviewing three that contribute further to the understanding of TKS from a cultural stance.

Choy, Schneier, Heimberg, Oh, and Liebowitz (2008) studied symptoms of offensive TKS in patients diagnosed with SAD in both Korea (n = 64) and the US (n = 181). Symptoms were evaluated for the level of fear evoked on a scale of 0 to 3, in each of 3 domains, self-embarrassment, discomfort to the other and offence to the other person. However, the authors assess for fear of offence rather than conviction of offence, maintaining the confusion over this in the literature (Kinoshita et al., 2008).

The study utilised structured interviews in the US but not in Korea; there is likely to be some discrepancy in diagnosis because of this. Since there were more than twice the proportion of married or student participants in the Korean sample, it is surprising that the authors do not discuss the potential impact of this.

In both samples the fear of embarrassment was more significant and offensive fears were only larger for specific offensive symptoms. Korean patients with SAD were no more likely to exhibit fears of offence to others than US patients. However, because of lack of knowledge about TKS in the US, these symptoms were not noted in the clinical diagnoses. The authors point out the need for fear of offence being screened for in cultures other than those familiar with TKS. The findings indicate that TKS may not be as culture bound as noted in the DSM-5.

Kinoshita et al. (2008) used vignettes of patients with social anxiety symptoms from six countries (Japan, China, Korea, Australia, the Netherlands, and the USA). The real case standardised vignettes were provided by eight researchers from different countries, who provided 'typical SAD', 'conviction subtype SAD', and 'questionable diagnosis SAD' vignettes. These were used to test inter-rater reliability of 13 researchers who used the vignettes with the DSM-IV criteria, and also with a modified DSM-IV criteria (known as Nagoya-Osaka)

that included 'The person believes that the fear is commensurate with his/her inadequacies.' to include the conviction subtype.

They found that in each vignette there was on average 87.6% agreement when using the expanded criteria but only 61.5% when using the original DSM-IV criteria. However, the use of the DSM-IV led to a much greater variability in diagnosis in cases with TKS as illustrated by the vignettes. The authors reported lower than 50% reliability, with alternate diagnoses such as body dysmorphic disorder or other psychotic disorders being made. The argument is that these disparate diagnoses could all be contained more effectively under a conviction subtype SAD diagnosis, increasing reliability. Unfortunately, the authors do not effectively deal with the counter approach; that possibly some of the alternate diagnoses were more accurate and that a catch-all subtype diagnosis would only be preferable if it is more meaningful and leads to more effective treatment.

Tarumi, Ichimiya, Yamada, Umesue, and Kuroki (2004) carried out a factor analysis of a student sample ($N = 111$) at Kyoshu University in Japan who showed symptoms of social anxiety.

They used a TKS scale (Kleinknecht, Dinnel, Kleinknecht, Hiruma, & Harada, 1997) to collect data from the students. TKS scores were analysed factorially. Their primary finding was that two groups showed features of the offensive (conviction) type TKS. Only those who replied positively to a broad stem question relating to social anxiety went on for further questioning. Sensitivity to the stem question is critical to the number of respondents that get included in the main sample, as has been seen from the NCS and NCS-R epidemiological studies. In this study the authors state that their sample was not a clinical one and that the students were showing symptoms consistent with offensive TKS. The authors assume that the symptom patterns, even though at a sub-clinical level, may reflect similar patterns found in clinical populations, which is not proven. Furthermore, the limitation of a student sample are discussed

regarding intelligence and social status, but no further analysis of the sample on age, sex or other criteria was made by the authors. However, the study is useful in that it does show empirically that offensive TKS symptoms group together.

The authors make the assumption that TKS is culturally bound to Korea and Japan, taking a position that was frequently found in the 1990's by authors such as Kirmayer (1991). However, as we have seen from the previous two studies, this position is more frequently being challenged today.

Counselling Psychologists should be aware that the conviction subtype of TKS is not necessarily culture bound (Choy et al., 2008) but may be found globally and may be overlooked in the West, underlying the importance of keeping an open mind to diagnosis. Kinoshita et al. (2008) have pointed out that the subtlety of conviction type TKS may be missed through the use of the DSM, as the conviction of offence is not stressed. They suggest that varying the diagnostic criteria so that TKS comes under SAD may be helpful to avoid cultural bias in diagnosis and so that suitable treatment protocols can be tested in future. Furthermore, Coles et al. (2006) point out the overlap between body dysmorphic disorder (BDD) and SAD in TKS with the fear of a deformed body, further complicating the nosology and casting doubts on diagnostic emphasis.

2.5 Studies Emphasising Cultural Explanations of Differences in SAD

2.5.1 **Variation in expression of social anxiety across cultures.** Many different reasons have been given for expressions of social anxiety: Kirmayer (1991) emphasises differences in child rearing in Japan and a culture that emphasises the need for sensitivity in dealing with others, while refraining from showing negative emotion. Chang (1997), in a theoretical review, relates anxiety disorders to the 'honorific-humble system' of the language, more authoritarian child-rearing, the ideal of social harmony, non-assertive norms of behaviour, and a generally allocentric orientation in Japan and Korea. Kleinknecht et al. (1997)

looked at the ways individuals used *self-construal* to define themselves as *independent* or *interdependent*, finding that those who self-identified as interdependent were more likely to show social anxiety. Intuitively, one might suspect that an allocentric focus on social conformity in collectivist cultures could increase social anxiety; Heinrichs et al. (2006) found in data from six countries, including Korea and Japan, that countries more tolerant of socially avoidant behaviour were collectivist in nature, and that social anxiety (rather than the disorder) was higher, but with a modest effect size (d =.34) for collectivism. However, 12-month SAD in Japan is estimated at 0.8% (Kawakami et al., 2005), as seen in the epidemiological reviews, which is a relatively low worldwide rate. The possibility here is that the high social anxiety in collectivist countries affects the threshold (Rapee & Spence, 2004) at which 'the person recognizes that this fear is unreasonable or excessive' (American Psychiatric Association, 1994, 300.29).

2.5.2 **Gender differences.** Moscovitch, Hofmann, and Litz (2005) speculate that social anxiety occurs when individuals have taken in the cultural norms for social interaction but see themselves as being unable to meet those norms, such that there is a discrepancy. In a correlational study of 97 US Caucasians, using self-report questionnaires, they found that *independence* in males predicted lower rates of social anxiety, while for females *interdependence* (Markus & Kitayama, 1991) was the protective factor. Thus, gender specific differences in cultural norms may have a powerful influence on social anxiety; this is an area that would benefit from cross-cultural research, given the wide influence of cultural differences on gender role. (Matsumoto, Grissom, & Dinnel, 2001) have pointed out the importance of reporting effect sizes in cross-cultural studies to avoid stereotyping based on small, but significant results. Although Moscovitch et al. (2005) report some effects sizes in their study, other results are just reported for statistical significance.

2.5.3 **Collectivist vs individualist cultures.** Caldwell-Harris and Aycicegi (2006) tested a 'culture clash' hypothesis in an analysis of students from Istanbul (*collectivist*) and Boston (*individualist*), finding that *allocentrics* in an individualistic culture were positively correlated with increased social anxiety, although with modest effect sizes, whereas *idiocentrics* had low social anxiety. However, the authors state that the *idiocentric*s were not the most mentally healthy; the most healthy were those also showing relational skills within groups (Oyserman, Coon, & Kemmelmeier, 2002). However, *idiocentrics* in the *collectivist* culture did not show higher social anxiety. They were looking at a range of psychiatric symptoms in non-clinical samples. Discrepancies of this nature when researched with samples from general populations may help explain individual differences better. The authors assume Istanbul as *collectivist* and Boston *individualist* based on anecdotal evidence only. What may also be important is the individual's *perception* of the nature of the society they live in and future research could use measures of this.

A cross-cultural study of depressed psychiatric outpatients (N = 279) from Canada and China (Zhu et al., 2014) found that anxiety about causing discomfort to others was greater amongst Han Chinese than Euro-Canadians and was distinct from fears regarding social interaction. The study carefully considered measurement equivalence. The findings add to suggestions that SAD cannot be understood apart from the cultural context.

2.5.4 **Stigma and shame.** Zhong et al. (2008), in an empirical study (N = 422) of shame and the effect on social anxiety in China and the USA using structural equation modelling, found that only in the Chinese sample was shame a mediating factor, suggesting that clinicians should be aware of such cultural nuances. Birchwood et al. (2007) have proposed a stigma model in the development of SAD from their study of schizophrenic patients that have comorbid SAD in the UK, with comorbidity rates of around one third. Cultures

where schizophrenia is highly stigmatised are seen as more likely to produce higher overall rates of SAD.

3 Gaps and Inconsistencies in the Literature

3.1 Future Research and Therapeutic Practice

SAD needs careful research to tease out the different processes at work. This is importance for meaningful comparisons of SAD rates worldwide, such is the size of the gap in the literature. Schreier et al. (2010) replicated the Heinrichs et al. (2006) study but included Latin American countries, finding that individualism and collectivism did not correlate with the low social anxiety in Latin America. Hofstede and McCrae (2004) studied cultural dimensions, identifying masculine (assertive) /feminine (caring), power distance (acceptance of status quo), uncertainty avoidance and individualism/collectivism. More research needs to be done using these cultural dimensions as a basis for analysis, with the final goal being better 'culturally appropriate treatment' (Hofmann, Anu Asnaani, & Hinton, 2010). Explorations afforded by qualitative research such as thematic analysis and Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009) could help to underline the complexity of cultural dimensions, moving away from a naïve reductionist approach.

Papers such as this review, while illustrating the need further cross-cultural research, point to the complexity of potential associations between SAD and cultural differences. Layers of complexity and gaps in knowledge exist that would benefit from the kind of qualitative research that Counselling Psychologists or ethnographers might carry out. Furthermore, as pointed out above, the implications for Counselling Psychologists lie in the client's individual perception of these complex layers and the therapist's need to keep an open mind while being aware of the depth of cultural influences.

3.2 Cultural Scripts

In negative mental states cultural scripts can help individuals make sense of the experience of negative emotion (Ban, Kashima, & Haslam, 2010) helping to make the overwhelming pressure of phenomenologically experienced symptoms easier for the individual to bear. However, symptoms not included within the cultural script may not be expressed so easily. European and North American views of deviant cultural scripts tends towards a conviction of the individual's need for self-awareness and understanding of internal psychological states, whereas those from Asia tend to emphasise collective attributes (Chentsova-Dutton, Ryder, & Tsai, 2014). Terms such as SAD are culturally loaded; it is preferable to use less culturally specific terms (Ryder & Chentsova-Dutton, 2012).

North American and European templates for psychological well-being privilege the need to maximise positive emotions and excitement (Sims et al., 2015). This sits at some distance from Asian context where greater emphasis is placed on peace and calm.

4 Next Steps in Solving the Problem: Summary and Conclusion

The review of the epidemiological literature shows the large variety in prevalence of SAD globally. However, difficulties remain around measurement, language, the use of stem or base questions in surveys, comorbidity, clinical validation, diagnosis and variations in statistical sophistication. Epidemiological studies strongly hint at cultural differences in SAD, but the estimates themselves are not directly comparable. Counselling Psychologists need to be aware of this variety in clinical practice and for the need of further research.

4.1 Diagnosis

The literature on TKS throws considerable doubt on diagnosis in SAD. The labels themselves are socially constructed and entail assumptions about symptomology that can lead clinicians to miss symptoms that are not culturally recognised by formal diagnosis. There are suggestions that TKS may be misdiagnosed as BDD or forms of psychosis and research is needed to validate the

best methods of psychological treatment. Thus a syndrome once seen as culturally bound may have implications for how SAD may be diagnosed and treated worldwide. There are many other culturally bound syndromes that could benefit from being researched in this way (Guarnaccia & Rogler, 1999). The DSM-5 lists 'ataque de nervios' (Latino), Dhat syndrome (South Asia) Kufungisisa (Zimbabwe) and Khyâl cap (Cambodia) amongst others (American Psychiatric Association, 2013, pp. 833-837).

Studies looking at the cultural dimensions underlying SAD are at an early stage of development and effect sizes are generally modest. There is an assumption made by many researchers that because of the social nature of the disorder, research from a broadly social constructionist standpoint should be privileged. However, heritability estimates from twin studies for SAD have been reported at around 0.50 (Kendler, Karkowski, & Prescott, 1999) so it is not surprising that some of the cultural effect sizes are modest, although the full picture may be complex.

4.2 Implications for Psychology

This review has illustrated the limitations of the DSM medical and diagnostic approach to SAD, originating in psychiatry. However, it is not possible for any one approach to explain the phenomenon we understand as SAD. Culture, mind, brain, and body are best understood as interlinked within a multi-level system. The emphasis on culture in this review should not be seen as suggesting that biology is unimportant. Further research needs to take place on the links between genetic sensitivities to environmental stressors and cultural context. Researchers need to be sensitive to their place and their skills within the culture, mind, brain and body dimensions, and pay attention to linking their findings to other studies so that a better understanding of the processes evolve (Ryder et al., 2011). The evolutionary layers of the brain, from the brainstem to the outer cortex, shape our experience and yet culture also shapes our brain (Kirmayer, 2001).

Studies of the role of culture in SAD have concentrated on the dimension of individualism/collectivism. There have been contradictory findings from studies as to whether these dimensions effectively capture the differences in SAD. Given the nuances of cultural differences and the variety of dimensions that have been proposed far more research is required. Rather than labelling cultures as individualistic/collectivist and studying SAD in relation to this, a more fruitful approach would be to look at how individuals *perceive* their culture and their place within it and how this contributes to SAD (Moscovitch et al., 2005). Furthermore, simplistic categorisations of individuals as *dependent* or *interdependent* need to developed further, reflecting that individuals may be dependent in some spheres and interdependent in others as well as looking at other dimensions. Other factors of importance identified are gender role, language, child rearing, shame and stigma of mental health.

The complexity of cross-cultural research needs to increase and will be dependent on further development of theoretical ideas, formulation of hypotheses and testing, along with a greater emphasis on qualitative research. Only when this cycle is advanced several revolutions will we be able to make firmer conclusions about cultural differences in SAD and the relative importance of factors that contribute to them. Of course, culture is now moving and changing at an ever increasing pace; studies even six years old may be outdated, so that the cultural differences and the factors contributing to them are likely to change between age cohorts. Counselling Psychologists in practice are likely to be aware of the speed of such change, but future research identifying this is likely to underline its importance.

Empirical research and especially epidemiological studies tend to blur the differences between individuals with the aim of making generalisations and proving hypotheses. While quantitative research of this kind is dominant in the field of cultural differences in SAD, it has been noted at various points in the

review that there is a need for more qualitative research of an exploratory nature or designs incorporating mixed methods. Counselling Psychologists would be ideally suited to making such contributions. The research reviewed has been selected to illuminate some of this complexity while hinting at more. For example, Counselling Psychologists would be advised to consider client's desires to meet perceived cultural norms and their abilities to do so (Moscovitch et al., 2005) as well as to evaluate the client's patterns of cognition, behaviour and emotions within the relevant cultural and social context (Heimberg et al., 2014).

This review is a reminder for Counselling Psychologists to be sceptical of diagnosis, to be wary of our own assumptions and to be open to new ideas. Unless we can read the literature in this way, the temptation may be to assume that one expression of SAD is similar to another when in fact there are subtle and important differences. Many cultural differences on a large scale may be reflected at smaller scales (Choy et al., 2008).

An emphasis on process rather than description is the key value that would underline this approach. Culture belongs at the heart of psychology; Betanzos has shown how Wilhelm Dilthey went further and suggested that psychology should have been a foundational science to anthropology and the humanities as a whole (Dilthey & Betanzos, 1988), but the focus on experimental psychology has isolated and reduced its impact. In a world of ever-increasing cultural change, it is time for psychology to rebuild its rightful position. Counselling and clinical psychologists could lead this transition, yet cultural psychology remains a neglected research backwater, perhaps because we are so immersed in culture that we don't see clearly that culture and mind are co-constituted (Shweder, 1990). Psychology needs a shift in emphasis onto the processes underlying mental distress returning its foundations as an empirical, human and cultural science, as outlined by Wilhelm Dilthey (Dilthey & Betanzos, 1988) and Wilhelm Wundt (1920).

Cultural scripts offer a way of linking together the different approaches to represent ways in which culture influences behaviour and propagates meaning in the real world (Ryder et al., 2011). Counselling Psychologists have a central focus on dealing with 'disorder', but this cannot be understood outside of the cultural and social context, particularly when psychology and psychiatry as a cultural product in their own right are what define that very disorder (Gone & Kirmayer, 2010). Philippot and Rimé (1997) have stressed that difficult individual circumstances call for cultural scripts as a means of self-explanation. These cultural scripts are finite and consist of a limited number of symptoms. This can lead to exaggeration of certain symptoms in cultures; somatisation within Chinese populations has been extensively studied (Kolstad & Gjesvik, 2014). DSM disorders are themselves cultural scripts. Since the introduction of social phobia in the DSM-3 diagnosis has increased several fold (Essex, Klein, Slattery, Goldsmith, & Kalin, 2010). Furthermore, depression as a 'chemical imbalance in the brain' is one that is now often recruited by sufferers to explain their affliction. Reviews of 'extinct' or 'endangered' disorders are another facet to this approach. Glass delusion as a symptom of psychiatric distress was reported in Europe between the 15th and 17th centuries (Speak, 1990). Individuals reported that they were made of glass and feared that they would shatter if touched. Some confined themselves to bed, others wore protective clothing. This syndrome disappeared sometime during the 17th century although isolated cases are still reported. Symptomology is indivisible from its historical and cultural context. Recent acceleration of sociocultural change in Japan has been implicated in the identification of a new syndrome known as 'hikikomori', which entails a complete withdrawal from society for six months or longer (Kato et al., 2012). Nagata et al. (2013) have demonstrated comorbidity of hikikomori and SAD in 19% of SAD cases but conclude that important features of hikikomori are not covered by the DSM-5.

In some ways Counselling Psychology can be seen as inward facing with its focus on internal mental processes. A culturally centred approach could help Counselling Psychology to become more outward focused, not only in the way we approach therapeutic practice, but also in our role as change agents in society. As Kirmayer and Crafa (2014) have stated, a 'multilevel, ecosocial approach to biobehavioral systems' (p. 435) is needed to ensure that social processes are not sidelined in an era of increased research in neuroscience. Culture and context cannot and should not be excluded from psychopathology research.

> 'Culture is not just an ornament of human existence but … an essential condition of it." (Geertz, 1973, p. 46)

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