Making the Cut:

A Phenomenological Study of the Parental Decision-Making Process for Neonatal Circumcision

by

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Abstract

Male circumcision is one of the most common surgeries performed on children. Most research on male circumcision has concentrated on assessing the medical risks versus the medical benefits, despite the fact that the majority of infant circumcisions in North America are performed not for medical reasons, but for social reasons. A few quantitative studies have surveyed parents' reasons for circumcising or not circumcising their sons. However, they have not revealed the decision-making process or how social, cultural, and individual factors influence it. Drawing upon theories of embodiment, this study explored expectant parents' decision-making about neonatal circumcision. In-depth semi-structured interviews were conducted with six individuals expecting their first son. Interpretative Phenomenological Analysis was utilized to identify themes revealing the meanings of circumcision for participants and their experience of making this complex decision. Findings revealed eight major themes that characterized participants' struggles with the issue. These included 'gender jurisdiction', which referred to the question of whether fathers should inherently have more decision-making power than mothers regarding this issue. Another theme centred on deciding whose body was the focus of the decision – the baby's or the father's. All participants perceived bias, both pro- and anti-circumcision, in the information they had received from health professionals. They expressed a strong need for objective information from professionals, and support for their decisions. The findings of this study may be helpful to obstetricians, paediatricians, and midwives – as well as individuals and families facing the circumcision decision.

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Finally, I must thank my family for their overwhelming support. To my husband and partner Daniel – a tremendous thank you from the whole of my heart. You have been my rock, my constant source of encouragement and love, and my biggest cheerleader and champion. I promise to split the domestic tasks more evenly from now on, and to bake you cookies at 4:00 AM should you require them for any reason.

Dedication

This thesis is dedicated to my husband Daniel, to our daughter Kaleesi, and to our baby boy due in August 2014. To Kaleesi, my Leesi-bean, you inspire me daily if not hourly. This thesis/labour of love (and frustration, and anger, and love again) has been inspired by you and is *for* you. Never doubt your abilities and what you can do.

One last note to the future me: congratulations! You did it! But remember that you're still cookie dough. You're not done baking. Keep baking and always keep learning, because there are miles to go…

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CHAPTER 1

Introduction & Literature Review

Introduction to the Study

Male circumcision is one of the oldest surgical procedures in the world, and is still the most common surgery performed on children in North America (Fox & Thomson, 2009a; HealthLink Alberta, 2008). Almost one-third (31.9%) of Canadian women reported having their infant sons circumcised in 2006 (Public Health Agency of Canada [PHAC], 2009); the proportion is almost identical in the United States (Pediatrics for Parents, 2010).

The rate, however, has been declining in North America. In the United States, the decline has been quite dramatic: from 53% in 2006 to 33% in 2009 (Pediatrics for Parents, 2010). One likely explanation for this downward trend is the elimination of health coverage for routine infant circumcision in all provinces in Canada and several states across North America (Richters, 2006). This removal was triggered by the updated positions of several national associations of health professionals, including the American Academy of Pediatrics (AAP) and the Canadian Paediatric Society (CPS), after thorough reviews of scientific literature were conducted (Carpenter, 2010). These associations have concluded that routine infant male circumcision is a non-therapeutic surgery in which the potential benefits do not outweigh the potential risks, leading them to take the neutral position that the procedure is not recommended on a routine basis (Leibowitz, Desmond, & Belin, 2009).

This position is reflective of the current literature, as most research on male circumcision has been dominated by a cost-benefit analysis through which associated health risks and potential health benefits of the procedure are compared and debated (Fox & Thomson, 2009a). Despite this health focus in academic research, the majority of infant circumcisions performed in

North America are not medically necessitated, and a significant number are conducted for non-medical reasons (PHAC, 2009). A recent Canadian public health survey revealed that a slight majority of infant males were circumcised not because of perceived health benefits but because of social, cultural, or religious motives (PHAC, 2009). After health or hygiene, "to be like the father, siblings or peers" was the most frequently cited reason mothers in Canada gave for circumcising their sons (PHAC, 2009, p. 223). Studies conducted in other countries have yielded similar results. Social concerns were the most common reasons given by both mothers and fathers in the United States for infant circumcision (at 44% and 49%, respectively), and included responses such as "wanting him not to look different" or circumcision "will make him look better" (Brown & Brown, 1987, p. 216). A recent Australian study found that after hygiene, 'family tradition' was the most common response given by parents for having their newborns circumcised (Xu & Goldman, 2008).

The widely reported social reasons that appear to underlie a significant proportion of parental motivation for infant circumcisions may be reflective of the procedure's historical roots and current understanding as a practice of gendered embodiment. While academic scholarship of female circumcision (commonly referred to as female genital mutilation/cutting) has investigated the connection of the practice to ideals of femininity and sexuality, the gender and sexual aspects of male circumcision have not received nearly the same amount of attention (Harrison, 2002). A number of studies commissioned by both independent academic researchers and public health agencies in countries such as Canada, the United States, and Australia have surveyed parents' reasons for choosing to circumcise or not circumcise their infant sons. However, because these studies have been solely quantitative, they have not revealed the parental experience of the decision-making process and specifically how this may be connected to historical/current

understandings of the procedure and of social understandings of the circumcised and uncircumcised penis as embodying gender.

Drawing upon sociological theories of embodiment, the present study explored the experience of prospective parents as they embark upon the decision-making process of whether to circumcise their expected infant sons. The purpose of this study was to achieve a greater detailed understanding of the social, cultural, and individual factors that may influence the decision-making process. The following section will provide a review of the research literature pertaining to male circumcision, followed by a description of this study's theoretical perspective and objectives.

Review of the Literature

History of male circumcision. Although methods of performing the surgery have changed over the centuries, male circumcision continues to be understood as a procedure involving the "removal of some or all of the prepuce, or foreskin, of the penis for religious, cultural, or medical reasons" (Provencio-Vasquez & Rodriguez, 2009, p. 295). Ancient Egypt is commonly thought to be where the practice originated, as images found on the wall of a royal Egyptian tomb (circa 2400 BCE) depict the earliest known documentation of the procedure (Gollaher, 2000). This bas-relief, showing two priests using circular flints to excise the foreskin of two adolescent boys, is also the earliest depiction of a surgical procedure. Mummified remains of human males in and around Egypt have revealed evidence of circumcision as early as 4000 BCE. Circumcision was not a requirement of all males in Egyptian society and was most likely a practice reserved for male members of the upper classes (Morse, 2002). Scholars believe that for ancient Egyptians, circumcision was a puberty rite symbolizing superiority, distinction, and purification (Gollaher, 2000). Gollaher notes that purity was an obsession in Egyptian

society, as "wisdom held that the body's openings were portals through which not just impurities but malignant spirits might penetrate" (p. 5). In this hot climate where washing was not a regular occurrence, the build-up of smegma[1] beneath the foreskin could be a cause for infection. Thus, circumcision may have been a method to cleanse the body of these impurities (Gollaher, 2000). The procedure continued as a symbolic distinction of status in Egypt and eventually became adopted as ritual in Judaism. Circumcision is rooted in other ancient societies, including the Ammonites, Edomites, and Moabites, according to a biblical passage in the book of Jeremiah (Morse, 2002).

Modern medicalization. Prior to the 1870s in Britain and the United States, circumcision was viewed as unnecessary for Christian men as faith in Jesus circumvented the need for the procedure (Carpenter, 2010). Circumcision was also relegated to the domain of 'other'; a disfiguring 'alien' practice performed in cultures such as in Judaism or Islam (Carpenter, 2010). This attitude began to shift with the rise of the medical profession, the emergence of paediatric practice, and late-Victorian beliefs about - and intense fear of - sexuality (Gollaher, 2000). Non-religious circumcision rose with the career of the top orthopaedic United States surgeon, Dr. Lewis A. Sayre. After examining a 5-year-old boy who could not stand up straight without doubling over in pain, Sayre discovered the patient was also suffering from the condition of phimosis[2]. Sayre speculated that the inflammation of his foreskin was the cause of the otherwise inexplicable paralysis of the child's legs and recommended circumcision as a potential cure for both ailments. Indeed, after the surgery took place, the paralysis disappeared.

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[1] the combination of shed skin cells and moisture from normal bodily oils, collected under the foreskin in males and in labial folds in women. In males, smegma serves to moisten the glans and acts as a natural lubricant facilitating the ease of sexual activity (Van Howe & Hodges, 2006).

[2] occurs when the foreskin is unable to fully retract from the head of the penis (Darby, 2005).

Sayre was convinced that circumcision could be the cure for other types of paralysis, joint issues, and a host of other ailments, and it was not long before this news traveled across the United States (Kaicher & Swan, 2010). Soon after, American doctors began recommending the procedure as a prophylactic against hernias, epilepsy, insanity, and masturbation (Darby, 2005).

The development of germ theory as a cause of disease in the late 19th century led to intense phobia about germs and infused the medical profession with ideas about what is 'clean' and 'dirty' (Gollaher, 2000). The male and female genitals, with their permeability and bodily secretions/excretions, were seen as dirty and thus harbouring an enormous potential for contagion. Doctors reasoned that the removal of foreskin through circumcision would eliminate the build-up of infectious smegma and thus the possibility of contamination (Gollaher, 2000).

Germ theory was not completely developed at the time, and doctors had a limited understanding of how germs could contribute to disease (Gollaher, 2000). Although it was clear that sexual activity and venereal disease were linked, it was largely unclear how. As a consequence, it was believed that any sexual activity, including masturbation, could lead to infection (Kaicher & Swan, 2010). Masturbation was not just deemed inappropriate and unfitting with neo-Puritan values about the 'natural purity' of children and adolescents (Gollaher, 2000), but it was also seen as causing sexually transmissible diseases, as well as "tuberculosis, seizures, psychiatric illness, blindness, and 'nervous exhaustion'" (Kaicher & Swan, 2010, p. 19). Through removal of the foreskin, the most sensitive part of the male body and thus the most likely part to entice "self-abuse", Victorian-age physicians and parents could be assured that children would never succumb to the habit-forming practice (Kaicher & Swan, 2010). Doctors recommended the practice be done without any chloroform or anaesthetic, with the hope that the pain of the procedure will be connected in boys' minds with punishment, further reducing the

urge to engage in pleasurable genital touching (Fox & Thomson, 2009a). The desire to curb masturbation became the most prominent reason for performing circumcision, and led directly to the routinization of male circumcision performed on infants in mostly English-speaking countries such as Canada, the United States, England, and Australia (Fox & Thomson, 2009a).

Concepts of "clean" versus "dirty" signified more than just potential for disease. As immigration from Europe into North America was also increasing during this time period, being clean denoted a mark of civility, social status, and moral stature superior to that of immigrants (Fox & Thomson, 2009a). Childbirth had moved from the domestic sphere to a medical one, and "as midwives rarely performed the procedure, to be circumcised was literally a marker of the child's birth rite/right" (Fox & Thomson, 2005b, p. 172). Even after World War 1, when the previously assumed preventative benefits of circumcision were discredited, circumcision rates continued to rise in the English-speaking world (Carpenter, 2010). Therefore, the gentile Caucasian middle- and upper-classes adopted infant circumcision and considered it a moral obligation for parents, as foreskin "came to indicate ignorance, neglect, and poverty… those left behind were… the groups imagined to have filthy, malodorous bodies: people who lacked culture, manners, intelligence, and, in a word, civilization" (Gollaher, 2000, p. 108).

Current knowledge: risks versus benefits. The popularization of routine infant circumcision continued through the rest of the 19th century and for most of the 20th century in the United States and Canada. The decision not to cover routine circumcision under the National Health Service in Britain in 1948, due to a lack of scientific literature proving medical indications for the procedure, led to a massive decrease in male circumcision in the United Kingdom (Carpenter, 2010). In Britain, rates fell from 33% to 40% in the 1930s to just 6% in 1975 (Carpenter, 2010). Rates of male circumcision similarly fell for the same reasons in

Australia, from approximately 50% in the mid-1970s to 7.9% by 1999 (Spilsbury, Semmens, Wisniewsi, & Holman, 2003).

In North America, however, rates remained relatively high throughout the same time period. In the United States, an estimated 80% of infant males were circumcised in the 1970s (Gollaher, 1994). Although rates were significantly lower in Canada, slightly more than half of the male infant population (53%) were circumcised in 1979 (Spilsbury et al., 2003). Rates decreased slowly in both of these countries. In 1994, 44% of infant boys were circumcised in Canada, and 61% were circumcised in the United States (Spilsbury et al., 2003).

However, during the 1960s – a period of social change in which authority was challenged – doctors seriously began to question the legitimacy of the routinization of the practice for infants (Gollaher, 1994). The procedure was so normalized that even medical textbooks in America depicted the circumcised penis as the standard one (Gollaher, 1994). Published literature began to address the issue from a variety of perspectives, ranging from epidemiology to personal opinion, and comprised pro-circumcision and anti-circumcision sentiments. Unable to find definitive scientific data, in 1971 the American Academy of Pediatrics (AAP) released its first policy on the issue, stating: "there are no valid medical indications for circumcision in the neonatal period" (Carpenter, 2010, p. 620). This decision was reconfirmed by the AAP four years later (Gollaher, 1994). This statement, however, made little actual difference in the prevalence rate, as it was not publicized due to opposition within the academy itself. At this time, circumcision literature began to analyze the issue from a risk-versus-benefits approach, including studies that investigated medical benefits of the procedure as well as medical risks of the surgery and biological/sexual function of the foreskin.

Medical benefits.

Sexually transmitted infections and Human Immunodeficiency Virus. Van Howe, Svoboda, and Hodges (2005) describe how physicians' arguments supporting routine circumcision changed depending on which medical issue was receiving national attention at the time. In the 1870s, epilepsy was a major concern and circumcision was advocated as a preventative measure. In the 1940s, sexually transmitted diseases (STDs) and infections (STIs) were the national focus; circumcision was claimed as both preventive and a cure. This pattern emerged again with cancer worries in the 1950s and finally, with the human immunodeficiency virus (HIV) and acquired immunodeficiency disease (AIDS) crisis in the 1980s. After neo-Puritan beliefs about circumcision were discredited, advocates focused on the possible connection between the procedure and lowered risk for contracting STIs (Dunsmuir & Gordon, 1999). The primary study cited to support this assertion was a late-nineteenth century article published in the United Kingdom showing lower rates of syphilis among Jewish men (Van Howe, 1999). Research focusing on this association continued into the twentieth century.

Early in the outbreak of the HIV epidemic, researchers began to notice lower infections rates in circumcised men in Africa (Carpenter, 2010). In 1996, Canadian AIDS researcher Stephen Moses found that male circumcision was a protective factor against the virus (Gollaher, 2000). A plethora of reviews, observational studies, and meta-analyses have been conducted to investigate the issue further. The findings have been conflicting and have ignited both criticism and controversy. Some reviews and meta-analyses have failed to report on methodological quality (Siegfried et al., 2005), while other studies have been criticized for not demonstrating a strong enough connection between circumcision and HIV status (Van Howe et al., 2005). Researchers have expressed concern that the studies, largely conducted in Africa, may not be generalizable to the North American context. Additionally, as variables such as sexual practices

are connected to particular tribal affiliations in Africa, circumcision status may be either a "risk factor or a marker for other risk factors" (Van Howe et al., 2005, p. 20). A fairly recent systematic review (Siegfried et al., 2005) confirmed earlier findings that circumcised men were approximately 60% less likely to be infected with HIV than their intact counterparts. The authors do note that the studies included were of variable quality, and the results may be limited by confounding. They conclude that "the current quality of evidence is insufficient to consider implementation of circumcision as a public-health intervention" (p. 172). However, based on these same studies, in 2007 the World Health Organization (WHO) recommended that circumcision "be included as an additional HIV strategy for the prevention of heterosexually acquired HIV infection in men in areas of high HIV prevalence" (Larke, 2010, p. 632).

Syphilis and venereal disease were matters of concern for governments during both World Wars (Dunsmuir & Gordon, 1999), and circumcision was performed on soldiers during the First World War as a preventative measure. In 1947, the Canadian Army found that of those treated for venereal disease, 77% had intact foreskins (Wilson, 1947). Critics at the time noted that the reason for this rate may have more to do with social status (as middle- and upper-classes had constituted the highest proportions of those being circumcised and thus, it was argued, were more able to maintain cleanliness and avoid infection) than to do with biology. Recent studies have further investigated the connection between circumcision status and STI rates. A 1998 review by Moses, Bailey, and Ronald found a strong association between lack of circumcision and ulcerative sexually transmitted diseases, including syphilis, genital herpes, chancroid, and gonorrhoea. One year later, a literature review of 31 relevant studies was conducted, finding "no clear evidence that circumcision prevents STDs" (Van Howe, 1999, p. 59). The first systematic review of circumcision and ulcerative STIs concluded that circumcised men are less likely to

contract syphilis and chancroid than uncircumcised (or intact) males (Weiss, Thomas, Munabi, & Hayes, 2006). Another systematic review in the same year found that circumcision does not reduce risk for human papillomavirus infection, or HPV (Van Howe, 2006). However, a recent study found a significant decrease in risk for HPV in circumcised males (Bosch, Albero, & Castellsagué, 2009). Randomized, controlled trials in Kenya reveal that male circumcision appears not to have a protective effect against Chlamydia trachomatis, Neisseria gonorrhoea, or Trichomonas vaginalis (Mehta et al., 2009). In a 1999 AAP policy statement, the Task Force on Circumcision summarized the state of available research on the issue, concluding that "evidence regarding the relationship of circumcision to STD in general is complex and conflicting" (p. 691). The AAP later reassessed this research, and in 2012 produced a new policy statement indicating that the potential benefit of lowered risk of heterosexually-acquired infection of HIV is "sufficient to justify access to this procedure for families choosing it" (p. 585).

Urinary tract infections. Beginning in the mid-1980s, increasing research attention was given to exploring the relationship between circumcision and prevention of urinary tract infection (UTI) in infant males. The first article to note this relationship was a 1982 retrospective study by Ginsberg and McCracken, which found that of the 100 infants admitted to a children's hospital for UTIs, 95% were uncircumcised. The authors speculated that the foreskin may make an infant more susceptible to developing a UTI, but with no available group for comparison, were unable to make any definitive statement about the subject.

In an effort to assess the protectiveness cost-utility of the procedure, To, Agha, Dick, and Feldman (1998) conducted a cohort study following almost 70,000 Canadian circumcised and intact baby boys for up to three years. Analysis of the results revealed that 195 infant boys would need to be circumcised in order to prevent one UTI-related hospital admission in the first year of

an infant's life. Considering available research and cost-utility analyses, in their 1999 policy statement on circumcision the American Academy of Pediatrics estimated a UTI rate of 7 to 14/1000 in intact male infants compared with 1 to 2/1000 for circumcised boys. The overall incidence of UTI in the entire age group for boys is quite low, with the absolute risk being less than one percent for intact males (Provencio-Vasquez & Rodriguez, 2009).

Penile carcinoma. A type of genital cancer that occurs on the skin or glans, carcinoma of the penis has long been both promoted and dismissed as an indication for neonatal circumcision (Gollaher, 2000). The modern debate has been tracked to a 1932 *Lancet* article in which Abraham Wolbarst noted that Jewish men never seemed to be hospitalized for penile cancer. The cause of this malignancy was attributed to smegma, a secretion beneath the foreskin often considered infectious and filthy (Updegrove, 2001). However, as early as 1935 urologists suggested the cause had more to do with hygiene of the intact penis than to the structure of the intact penis itself (Gollaher, 2000). Part of the difficulty in determining the cause and significance of lower rates of penile carcinoma among circumcised men is the low incidence rate of the cancer overall - in North America, the annual rate among adult intact men is 2 per 100,000 (Moses et al., 1998). In countries where routinized circumcision is not prevalent and most adult men are uncircumcised, the rate varies from a slightly lower rate of 0.82 per 100,000 in Denmark to a much higher rate of 2 to10.5 per 100,000 in India (AAP, 1999). Taking treatment into account, authors Cadman et al. concluded that "the 'break-even' amount for prevention is more than *100 times* the cost of disease [emphasis in original]" (p. 1355). Based on available research, a 2007 position statement on circumcision published by the American Academy of Family Physicians (AAFP) concluded that hygiene is to be considered an important factor to prevent carcinoma of the penis.

Phimosis. Phimosis, which occurs when the foreskin is unable to fully retract from the head of the penis, has also had a prominent and interesting history in the argument for routinized neonatal circumcision (Provencio-Vasquez, 2009). A word of Greek origin meaning 'muzzled', phimosis evolved into the current understanding of the condition in the eighteenth century (Darby, 2005). The syphilis epidemic, in which men presented symptoms of non-retractable foreskins due to coalescing sores and lesions from venereal disease, gave rise to the condition as a concern for sexually active men (Darby, 2005). Treatment usually involved minor fixes of bathing and hot/cold poultices, although occasionally surgical incisions were utilized in rare cases to free the foreskin from the glans (Darby, 2005).

During this time period, doctors knew phimosis to be a naturally occurring physiologic process in infants and young boys whereby the foreskin is non-retractable (Darby, 2005). At birth, approximately 96% of male babies have physiologic phimosis due to adhesions between the foreskin and glans (Steadman & Ellsworth, 2006). Over time, the prepuce becomes more retractable and gradually separates from the head of the penis. This is assisted by nocturnal erections, skin shedding, and the playful way that babies naturally pull the 'trunk' of their penises in the early years of life (Steadman & Ellsworth, 2006). However, with the rise of masturbation phobia, where any manipulation of the genitals by children or adults was seen as causing harm, physiologic phimosis in newborns and young boys quickly transformed into something pathological – a deformity that required immediate surgical correction (Darby, 2005). Thus, the term 'congential phimosis' emerged. Physicians began describing the consequences of an 'adherent prepuce' caused by phimosis in children, which included underdevelopment of the glans, urine retention, epilepsy, incontinence, and other paralytic conditions (Darby, 2005). Possibly judged to be the most serious was the purported effect of early development of sexual

arousal in children. It was thought that irritation of the area would naturally lead to touching, leading to sexual excitement, and then to the most-dreaded masturbation (Darby, 2005). It was therefore the opinion of physicians that it was "only humane and right from a moral point of view to practice early circumcision in all such cases" (Darby, 2005, p. 222).

Circumcision of newborn males continued to be prescribed as a prophylactic for, among other things, the prevention of phimosis. In Anglophone nations, physicians have been encouraged to list phimosis as the reason for neonatal circumcision and it is often the most common diagnosis code for the procedure (Rickwood, 1999; Van Howe, 1998). Understanding of what true phimosis is, and the rates of pathological phimosis, vary across countries. Researchers have found pathological phimosis to be very rare among boys, ranging from 0.9% in England to 2.6% in France (Van Howe, 2004). Complicating this rate further, most cases of pathologic phimosis in infants and young boys result from parents' forcible premature retraction of the foreskin as often advised by their care providers (Steadman & Ellsworth, 2006). A 2010 study by Garaffa, Sacca, Christopher, & Ralph found that only 1 in 113 patients with normal foreskins needed circumcision due to the more-severe condition of paraphimosis (a condition wherein the foreskin is unable to be pulled back over the head of the penis). Garaffa et al. (2010) conclude by stating "circumcision should not be considered as a routine part of penile surgery unless a significant phimosis is present or revisional surgery is contemplated" (p. 222).

Risks.

Surgical risks. As with any surgical procedure, circumcision carries inherent risks, ranging in severity, length, and time of emergence. The most commonly cited minor complications (typically immediate- and/or short-term) include risk of bleeding, infection, meatal stenosis (narrowing of the urethral opening, meatitis (inflammation of the urethral opening),

urinary fistulas, skin bridges, and pain (Steadman & Ellsworth, 2006). More serious and often longer-term issues include cosmetic complications with the procedure itself, such as injury to the glans/frenulum, scarring, removal of too much tissue, partial or full amputation of the glans or penis; necrosis; sepsis; the risks that using anaesthetics pose; haemorrhage; phimosis and concealed penis; and death (Hutcheson, 2004; Steadman & Ellsworth, 2006; Van Howe, 2004).

The overall complication rate associated with neonatal circumcision is difficult to determine for several reasons. First, this depends on where the procedure is performed geographically and by whom (Bocquet, Chappuy, Lortat-Jacob, & Chéron, 2010). Second, there are many different techniques and instruments for performing the procedure, both in ritual and clinical settings. Each device is different and carries different risks (Gollaher, 2000). Third, infant circumcision complication rates vary according to what is defined as a complication, and complications may only arise years and decades later with sexual development (Gollaher, 2000).

Due to all these factors, the commonly reported range of complication rates vary from a low of 0.2% to a much higher figure of 55% (Bocquet, Chappuy, Lortat-Jacob, & Chéron, 2010). A baseline rate for complications at the time of surgery ranges from 0.2% to 10% (Andres, 2007). For procedures performed in hospitals in North America, authors generally cite a complication rate of about 1.5% (MacDonald, 2011). Overall, the most frequently occurring complications include continuous bleeding, infection, and incomplete circumcision (Lazarus, Alexander, & Rode, 2007; Weiss, Larke, Halperin, & Schenker, 2010; Joint United Nations Programme on HIV/AIDS, World Health Organization, 2007).

One of the most frequent complications is redundant foreskin (excessive skin left over), or too much skin being excised during the procedure (Pieretti, Goldstein, & Pieretti-Vanmarcke, 2010). Redundant foreskin is corrected by a second subsequent circumcision. A penis with too

much foreskin removed is more difficult to treat. An excessive amount of remaining skin reflects the diversity of the human penis, as surgeons, "cannot adequately judge the appropriate amount of tissue to remove because the penis will change considerably as the child ages… a small difference at the time of surgery may translate into a large difference in the adult circumcised penis" (Van Howe, 1997, p. 780).

The most serious complications include injury to the glans, shaft, or urethra; penile necrosis; and partial or full amputation of the glans (Alpert, Koff, & Jayanthi, 2008; Steadman & Ellsworth, 2006). Necrosis usually results from infection following the procedure or other problems accompanying the surgery (Hutcheson, 2004). Injuries to all areas of the penis, and partial/complete amputation, most often occur in clamp devices, when instruments are not sized to the infant properly, or when an improper device is used (Johnson, 2008). Although rare, several recent reports of complete penile and glans amputation can be found in the literature (Ceylan et al., 2007; Charlesworth, Campbell, Kamaledeen, & Joshl, 2011; Faydaci, Uğur, Osman, Şermin, & Bilal, 2010; Okeke, Asinobi, & Ikuerowo, 2010; Shaeer, 2008). The occurrence of partial/full amputation is not known precisely. In his 2008 study of penile restoration, Shaeer describes plasty methods used with 32 male patients aged 2 months to 6 years. In their sample of 260 infant circumcisions, Okeke et al. (2010) found that 2 babies (3.1%) presented with amputation of the glans penis.

Although no typical method of treatment exists, authors in recent literature are clear that every attempt should be made for restoration (Charlesworth et al., 2011; Faydaci et al., 2010; Shaw, Sadove, & Rink, 2003). Historically, this has been far from standard practice. The most infamous case of penile amputation, dubbed 'John/Joan', pioneered sex reassignment surgery as recommended treatment for children with ambiguous genitalia (as a result of genetic defect or

after-birth mishap) and other intersex conditions (Fox & Thomson, 2009b). Following a negligently performed circumcision resulting in total penis loss of an infant twin, paediatrician and psychologist Dr. John Money advised sex reassignment surgery as treatment. Although Money asserted that that the child had successfully adopted female gender roles and abandoned all trace of male roles, in reality he had never fully felt comfortable as a girl. Growing up, he preferred playing with toy guns and trucks, liked standing to urinate, and reported not feeling female. The John/Joan case ended as tragically as it had begun - although the boy went on to marry and adopt his wife's children, his lifelong depression and psychological troubles did not cease and he committed suicide in 2004. (Colapinto, 2001 [revised 2006]).

Bleeding and hemorrhage are most often controlled by applying direct pressure (Palmer, 2011). In cases of severe bleeding, other treatment such as "silver nitrate application, thrombin foam, electrocautery, or suture ligation" may be needed (Alpert, Koff, & Jayanthi, 2008, p. 491). Undoubtedly, the rarest and most tragic complication is death, usually as a result of excessive bleeding (Weiss et al., 2010). It is difficult to precisely determine its occurrence, as some deaths may not be reported as being caused by circumcision (Van Howe, 2004). One of the first statistics cited was Gairdner's, who reported a range of 9 to 16 annual infant deaths occurring over the course of six years in England and Wales (1949). Currently, an estimated rate of 1 death in 500,000 hospital procedures is generally accepted (Van Howe, 2004).

Pain. Prior to the 1980s, physicians and parents commonly believed that infants could not adequately feel pain because of the assertion that their nervous systems are not yet formed or are at least underdeveloped (Gollaher, 2000). Thus, the rationale for infant circumcisions was clear - the earlier the better, so they will neither feel pain nor remember the experience. As any

crying was thought to be due to minor discomfort as a result of being restrained, pain management interventions were typically not used (Geyer et al., 2002).

In 1987, a pioneering study emerged detailing the effects of pain in fetuses and newborns. Authors Anand and Hickey highlighted a large body of evidence describing the observance of cardiorespiratory changes during and after surgical procedures such as circumcision. They also commented on behavioural changes associated with pain, including facial expressions of pain, the differentiated 'pain cry', and interrupted sleep schedules along with increased irritability and wakefulness (Anand & Hickey, 1987). The authors concluded that the neural pain pathways are well-developed in newborns, and recommended that medical professionals treat the importance of pain management for newborns and adults equally.

In 1987, the American Academy of Pediatrics released a position statement on neonatal anesthesia, stating that the use of local anesthetics/analgesics is relatively safe and recommended during surgical procedures. A joint 2006 AAP/CPS statement, reaffirmed in 2011, specified that "pain relief for circumcision should always be provided" (AAP & CPS, p. 223). Historically, the medical community was not quick to adopt these recommendations into practice. A 1993 Ontario study revealed that only 24% of family physicians and pediatricians used some form of analgesia during circumcisions (Wellington & Rieder, 1993). The most frequently used medical intervention was oral ethanol, "given as a small dose of whiskey" (p. 542). Only 3 of 74 physicians used dorsal penile nerve block, considered the most effective and easily administered pharmacological technique (Long, McCartan, Cullen, Harmon, & Floor, 2010). Of those who performed the procedure regularly, none used the dorsal penile nerve block (Wellington & Rieder, 1993). The most common reasons given included a lack of familiarity with medical interventions for the procedure and concern about adverse and/or side effects. Nearly half of

physicians felt that the "procedure does not warrant it", while 35% believed that "infants do not remember pain" and 12% thought that "infants do not seem to feel pain" (p. 542). In 1998, Stang and Snellman found that only 45% of physicians performing circumcision use anesthesia, 85% of whom use the dorsal penile nerve block. Reasons included concern over adverse effects (54%) and a belief that the "procedure does not warrant anesthesia" (p. 1).

The most recent AAP and CPS policy statement on neonatal pain summarizes the effects of persistent pain, including long-lasting altered sensitivity to pain, possible behavioural abnormalities and emotional, learning, and/or behavioural disabilities. Some findings indeed indicate altered pain sensitivity, as circumcised infants display a greater pain response during routine vaccinations 4 to 6 months post-surgery than do uncircumcised infants (Taddio, Katz, Ilersich, & Koren, 1997).

Sexual functioning. Sexual functioning is another highly debated topic in the 'risks versus benefits' literature. To understand how sexual functioning may be affected, it is important to understand the function and complexities of the foreskin. Taylor, Lockwood, and Taylor (1996) collected samples of foreskins from the autopsies of over twenty adult males and from four circumcised babies. They found that circumcision removes anywhere from 33 to 50% of penile skin, more than most parents expect based on typical explanations of the procedure (1996). Moreover, almost all fine-touch neuroreceptors contained in the internal surface of the foreskin are removed (Taylor et al., 1996). Cold and Taylor (1999) have concluded that the only area of the human body with fewer fine-touch neuroreceptors than the glans is the heel of the foot.

Studies comparing sensitivity between circumcised and intact men have been criticized for involving "few subjects, a relatively short follow-up and a reliance on subjective self-

reporting obtained from men with a history of penile and sexual dysfunction" (Sorrells et al., 2007, p. 864). One complication is that a high percentage of studied circumcised men (27.3% to 64.2%) had the procedure performed to correct a pre-existent penile problem to which any sexual functioning problems could be attributable (Sorrells et al., 2007). An interview study of men circumcised in adulthood found that erectile function worsened and penile sensitivity decreased following surgery (Fink, Carson, & DeVellis, 2002). However, increased sexual satisfaction was reported – perhaps attributable to the correction of medical problems or for perceived aesthetic improvement. In contrast, Kim and Pang (2006) found "no significant differences in sexual drive, erection, ejaculation, and ejaculation latency time between circumcised and uncircumcised men" (p. 619). The authors did find decreased masturbatory pleasure, lower sexual enjoyment, and increased masturbatory difficulty in many circumcised men, with 20% reported worse sex lives overall post-circumcision.

A few studies have explored how circumcision status may affect the sexual functioning of female partners. A survey of women who had sexual experiences with both circumcised and uncircumcised men found that sexual relations with circumcised partners yielded less likelihood of vaginal and multiple orgasms, more likelihood of male premature ejaculation, increased discomfort, reduced vaginal secretions, and reduced intimacy (O'Hara & O'Hara, 1999). The authors speculated that the reasons for these differences are anatomical, explaining that the moveable foreskin reduces friction and discourages withdrawal. This study was however prone to self-selection bias, as the survey was advertised in magazines and in an anti-circumcision newsletter. A later Australian study confirmed the increased likelihood of vaginal dryness during sexual intercourse with circumcised men (Bensley & Boyle, 2003). In an analysis of a Danish health survey, Frisch, Lindholm, and Grønbæk (2011) found that circumcised men were

"more likely to report frequent orgasm difficulties", while women with circumcised partners "more often reported incomplete sexual needs fulfillment and frequent sexual function difficulties overall, notably orgasm difficulties and dyspareunia [painful intercourse]" (p. 1).

Gender and sexual aspects of male circumcision. While physiological studies may indicate that circumcision can affect sexual sensitivity and functioning, individual perception of how the procedure relates to the issue of sexual function may vary widely according to cultural background, norms, and traditions. Men's and women's preferences for circumcised or uncircumcised partners, as well as men's own perceptions of their genitalia, are embedded within a system of social norms.

Two recent studies investigated parental viewpoints of circumcision and whether the AAP's position impacted these views. A study of pregnant patients and their partners found only a slight decrease in support for circumcision after reading the updated AAP policy summary (Wang, Macklin, Tracy, Nadel, & Catlin, 2010). Participants also read a description of recent studies exploring the positive connection between HIV rates and circumcision status. Predictors of increased support for the procedure after reading the study included "having a prior circumcised boy and being US born", whereas "being of Hispanic ethnicity and believing that the uncircumcised penis was more culturally normal" were predictors of decreased support (p. 129). In a first-of-its-kind study to compare the attitudes toward, and practices of, male circumcision among immigrants, non-immigrants, and physicians, Jia et al. (2009) examined support for the procedure among those from circumcising and non-circumcising cultural backgrounds. Circumcised non-immigrant males were surprised to learn that they were in the minority worldwide and were also the most supportive of circumcision. Although immersed in a culture of routinized circumcision, immigrant males maintained their prior attitudes.

Interestingly, the authors state that all groups believed that "in the absence of a strong medical recommendation, cultural or religious traditions for or against [circumcision] would dictate decisions about whether or not to circumcise a baby" (p. 96).

Studies from Canada, the United States, and Australia spanning several decades consistently indicate that regardless of changing information concerning the risks and benefits of circumcision and updated policy statements from organizations such as the AAP and CPS, to 'look like dad' is a primary reason for circumcising or not circumcising. Parents in other countries appear to have similar concerns. A study by Oh et al. (2002) surveyed parental attitudes about male circumcision in Korea, where American beliefs about the procedure were introduced and incorporated post 1940s. Concerns about peer pressure and 'fitting in' were prioritized in the decision-making of parents; 41.9% of parents were worried about their son being ridiculed if not circumcised, while 27.4% feared their son would be made fun of if he was circumcised. In one of the few studies to include reasons for *not* circumcising in their questionnaire, Adler, Ottaway, and Gould (2001) found that mother's choice, father's choice, health reasons, and 'looks like father' were the primary reasons given by parents for their decision. Also on this list was the desire for their son to look like his peers and/or brothers. The authors unfortunately did not break down these categories into parents who circumcised and parents who did not, which would have proved helpful for clearly determining the importance aesthetics and family tradition have for each group. A 1987 U.S. study found that the most significant factor associated with the circumcision decision was whether the boy's father was circumcised (Brown & Brown). The authors showed how social concerns, such as "wanting him not to look different" and "it will make him look better" (p. 216) accounted for a large part of the decision to circumcise. Likewise, social concerns were prominent in the decision not to

circumcise, as parents cited the desire for their sons to look like their fathers as a reason. This was followed by the feeling that the procedure was not medically important, belief that it should not be done, and concern about pain arising from the procedure. Aesthetics has been shown to be a factor in the circumcision decision as far back as 1966 - in Patel's Canadian study, some parents responded that circumcised penises just 'look better'.

In their explorations ideologies of masculinity, authors have also noted the symbolic meaning some attach to the aesthetic properties of the intact penis and the circumcised penis. Boddy (2007) describes how several cultures aim to remove ambiguity in the genitalia of infants and young children in order to affirm the child's sex in their practice of circumcision - for males, this means removing the 'feminine' foreskin and for females, the 'masculine' clitoris and labia. The foreskin as feminized has been documented in early pro-circumcision literature that invoked myths of female contagion, including the analogizing of the foreskin to the clitoris and labia as unclean, permeable, dangerous interior spaces (Fox & Thomson, 2009a). In this way, Fox and Thomson see the foreskin as feminized flesh representing what Judith Butler calls "bodily permeabilities unsanctioned by the hegemonic order" (1993, p. 168). Richters (2006) examines how infant male circumcision is performed for sociocultural reasons, but is given post-hoc medical justification:

> As a form of body modification, it serves to exaggerate the visual difference between male and female. Reducing the ambiguity and untidiness of the penis turns it into a neat phallus more specifically fitted for what is seen as its purpose in a gendered sexual culture focused on coitus. (p. 248)

As the foreskin can be seen as feminized due to its "soft, moist and receptive" properties, removing this tissue emphasizes the phallus as "firm, dry and insertive", closely resembling "an

erect penis even when flaccid" (p. 251). Similarly, Fox and Thomson (2009a) state: "in its circumcised state, the penis is also imagined as erect; ready for penetration, a clear signifier of masculinity" (p. 203). The conceptualization of an uncircumcised penis as feminized is not only connected to ideologies of masculinity, but to a hegemonic order of masculinity wherein certain forms are more highly valued and accepted than others (Connell & Messerschmidt, 2005). The uncircumcised penis as permeable is not only feminine in its "capacity to function as a receptive space (for objects such as the partner's tongue) and as a receiver of sensory stimulation", but this also connects to heteronormative understandings of the penis as important only for penetration (Richters, 2006, p. 248). Thus, the reduction of sexual sensitivity as a result of circumcision, as described above, may not often be interpreted as negatively as one would think: "the nature of the loss is in a sense 'unspeakable' and for many people unimaginable, because the reception of delicate sensation is not part of their notion of masculine sexuality" (Richters, 2006, p. 248). To recognise the uncircumcised penis as permeable would clash against what is seen as the primary function of the penis - to be inserted, and not receptive. The restrictive understanding of bodies in this way privileges only one form of male sexuality in this system of hegemonic masculinity. Deviation from this norm is seen to represent a less respected form of masculinity; one that is either feminized or homosexual, as "only the gay male body is 'leaky' and vulnerable, because it is penetrated" (p. 252).

When one considers how this form of body modification may be symbolic of gender norms and ideologies of masculinity, one can better understand why one of the main reasons parents circumcise is for aesthetic appeal. As Richters (2006) explains, "for many men (and women) whose sexuality is focused on gender and role adequacy, on the performance of coitus,

the argument against circumcision on the grounds of sexual sensitivity is tantamount to saying that you shouldn't have your son circumcised in case he wants to be a pervert" (p. 254).

Sense of masculine belonging is also related to these ideologies of masculinity through circumcision. In inscribing this hegemonic masculinity onto the body of an infant male, he 'joins the club' (Waldeck, 2003). Central to this belonging is the experiencing of certain actions and feelings that further embody cultural markers of strong masculinity - the infant shows maturity and courage (even if crying) in the face of a painful procedure (Fox & Thomson, 2009a). Being tough or acting brave is an important element here, as fathers tell sons to 'tough it out', and 'be a man'. Therefore, the importance of 'looking like daddy', resembling peers or other male siblings, may have to do with masculine belonging and camaraderie as much as valuing aesthetic similarities. Interestingly, a 1997 study by Van Howe found that there is wide variation in the appearance of genitals of circumcised men, whereas uncircumcised penises usually are more similar to one another. The so-called 'locker room defense' for circumcision (i.e. parents not wanting sons to be made fun of while changing in front of other boys) was also called into question by a 1992 study, which found that only 68% of American adolescent males were able to correctly discern their own circumcision status (Schlossberger, Turner, & Irwin).

Female genital mutilation/cutting. Several authors have begun examining the practice of male circumcision for its comparison to female genital mutilation (FGM) or female genital cutting (FGC), more frequently called female circumcision by individuals in cultures that routinely perform the procedure (Bell, 2008; Darby & Svoboda, 2007; Delaet, 2009; Fox & Thomson, 2009a; Hellsten, 2004; & Johnson, 2010). These authors generally do not assert that male circumcision is similar to FGM/C in the procedure itself or severity of consequences, but

rather draw attention to the parallels that exist in the background and reasons given for having the procedure performed.

As with male circumcision, FGM/C is usually rationalized for reasons of cultural tradition and/or interpreted as necessary by one's religion; family tradition and belonging; and aesthetic and hygiene reasons. Additionally, recent literature has pointed out how both procedures have historical roots as a deliberate method of controlling the child's sexuality (Bell; 2008; Fox & Thomson, 2009a; & Hellsten, 2004). Certain differences that exist, pertaining to how the two practices are perceived and given attention, are also highlighted (Delaet, 2009).

In discussions with university students, Bell (2008) articulated that while some identified both of the most severe forms of the procedure as mutilating, "students did not think that carving up male genitalia had any damaging effects on male sexuality as long as the penis remained largely intact… [they] reason that as long as the man retained the ability to ejaculate, his sexuality was unimpaired" (p. 127). Bell further revealed that the students' insistence on this point "seemed to have less to do with these practices themselves and more to do with underlying assumptions about the nature of female and male sexuality, assumptions echoed in the dominant discourses on genital cutting" (p. 127).

These assumptions connect with privileged understandings of only one acceptable form of masculinity, viewing the penis as sufficient if it can achieve penetration. Genital cutting of both females and males is seen as a gendering practice, one that inscribes standards of femininity/masculinity onto the child or fixes sexuality according to cultural norms (Fox & Thomson, 2009a). In her book exploring the genital cutting of females in a global context, Boddy (2007) notes that circumcisions are performed to:

> Complete the social or spiritual definition of a child's sex by removing anatomical traces of ambiguity, thus differentiating socially what is deemed 'naturally' similar. Thus Sudanese remove the 'masculine' clitoris and labia in the case of girls and the 'feminine' foreskin in the case of boys. (p. 60)

It is therefore not surprising that aesthetic preference and hygiene concerns rank as prominent parental reasons for having both FGM/C and male circumcision performed. While hygiene might be construed vaguely as medical, aesthetics and hygiene are intertwined in both cases. A World Health Organization (WHO) report on FGM/C (year) lists the most common justifications for the procedure and includes 'hygiene and aesthetic reasons' in one main category: "the external female genitalia are considered dirty and unsightly and should be removed to promote hygiene and provide aesthetic appeal" (p. 4). In North America, the male foreskin is associated with a similar stigma - that it is ugly or aesthetically unpleasant, and even 'sexually repellent' (Johnson, 2010). Authors have revealed that this belief is so prevalent in western culture that the uncircumcised penis as ugly is presented for comedic effect in many American sitcoms (Johnson, 2010; & Young, 2009). Parents have reported a belief that their child will be rejected by future potential sexual partners if they are not circumcised (Johnson, 2010; & WHO, 2008). Individuals in cultures that practice either routine FGM/C and/or male circumcision state that circumcision makes genitals 'look sexier' (Catania et al., 2007; Williamson & Williamson, 1988). An older Canadian study found that a prominent reason parents gave for having the procedure performed was that they "thought it was cleaner and sexier" (Reynolds & Szul, 1980, p. 272). A 2008 comprehensive interagency joint statement on FGM/C stated that the procedure is "considered to make girls 'clean' and beautiful. Removal of genital parts is thought of as eliminating 'masculine' parts such as the clitoris, or in the case of

infibulation, to achieve smoothness considered to be beautiful" (p. 6). Bell (2008) notes how striking it is that in western culture, the issue of reduced penile sensation from circumcision (and likely reduced sensation for their female partners) is deemed irrelevant; that the male can simply compensate with better sexual performance. This contrasts with western discourses of FGM/C, where "the idea of a woman undergoing genital surgery to enhance her partner's sexual pleasure (while concomitantly reducing her own level of sensation) strikes most observers as 'barbaric' and misogynistic" (p. 138).

Just as the procedures for males and females have been compared in terms of their inscriptions of cultural understandings of masculinity/femininity upon the infant/child; they have also been compared in terms of the underlying motive to control the child's sexuality. Male circumcision was historically advocated as a way to prevent masturbation through penile desensitization (Fox & Thomson, 2009a). In that purity-obsessed time period in North America and the UK, genital surgeries on females – mainly involving removal of the clitoris – were also being performed (Green, 2005). While prevalence is impossible to determine, literature published post 1860s details the operation as acceptable practice (Sheehan, 1981). It continued as a routine practice in England and the United States as late as the 1950s, in order to combat sexually 'deviant' behaviour including promiscuity, same sex desire, and to "delineate gender roles by removing the clitoris and labia (those male parts of a woman) to ensure gender dimorphism" (Green, 2005, p. 164). Fox and Thomson (2005a) explain: "significantly, both male and female circumcision were justified in terms of managing sexuality; yet, while cliterodectomies soon declined, with other forms of [FGM] eventually becoming a focus for domestic and international outrage, male circumcision became routinised in medical practice" (p. 464). The role FGM/C plays in managing female sexuality is overt in the procedure itself, which

is designed to reduce or remove altogether females' sexual desire (WHO, 1997). Fox and Thomson (2009a) show how the affirmation of desirable gender norms (i.e. what is acceptably masculine and feminine) and the managing of sexuality in male circumcision closely align with the justifications for FGM/C.

Parallels also exist between the two procedures in regards to a sense of belonging and tradition. Whilst enforcing male gender norms of bravery and toughness, male circumcision also acts as identity-affirming through a covenant of pain that men share (Fox & Thomson, 2005a). Beneke (1997) terms compulsive masculinity as "the need to relate to, and at times create, stress or distress as a means of both proving manhood and conferring on boys and men superiority over women and other men" (p. 36). Fox and Thomson (2005a) identify this concept as present in the way fathers express pro-male circumcision statements such as, "It'll make a man of you". These authors even propose that the medical profession's lag in implementing appropriate pain medications is directly related to this (p. 466). Likewise, in many societies where FGM/C is practiced, the procedure is deeply engrained as a traditional coming-of-age or identity/community membership affirmation for girls and women (WHO, 2008).

Authors also note the specific differences that exist, and their relationship to ethnocentrism and enforcing gender norms (Bell, 2008; Darby & Svoboda, 2007; Delaet, 2009; & Hellsten, 2004). Since becoming known on an international level, the practice of FGM/C has consistently been classified as a human rights issue by countries and nongovernmental organizations including the United Nations. While male circumcision has been actively discussed as a human rights issue for decades in non-governmental organizations opposing non-therapeutic circumcision for children, the procedure has not received the same amount of attention as FGM/C in this regard (Gollaher, 2000). As with FGM/C, many vocal opponents of

infant male circumcision also regard the practice as a violation of human rights - taking issue with the fact that the procedure's primary patients are children, that it is contrary to protecting bodily integrity, that it represents its own form of gender oppression, that the procedure can be cruel (especially without anesthesia), and it can violate the child's right to health (due to complications) as well as, although rarely, right to life in the case of accidental death (Bouclin, 2005; Delaet, 2009; Gollaher, 2000; Hellsten, 2004; Johnson, 2010).

For FGM/C, a prominent issue is that of informed consent and related ethical issues. Its opponents argue that regardless of the severity of consequences or the degree of cutting performed, a non-therapeutic practice that impacts the healthy and natural bodily integrity of minors without their informed consent is a human rights issue (Bell, 2008). As young children do not have the capacity to make medical decisions, parents generally have the right to give informed consent on behalf of their children (Bouclin, 2005). However, this is generally restricted to therapeutic treatment performed in the child's best interest. As infant male circumcision is most often classified as a non-therapeutic elective procedure, an argument may be made that it violates the child's section 7 rights to security of person under the Canadian Charter of Rights and Freedoms.

Some evidence suggests that parental consent to the procedure is often not informed, as doctors may be not providing accurate and unbiased information to parents. One recent US study comparing video versus traditional informed consent for 300 new mothers showed that 18% felt that physicians and/or nurses they saw were biased about circumcision (Chantry, Byrd, Sage, & Calvert, 2010). When bias was perceived, "it tended to be in the direction of advising the parent to have the child circumcised" (p. 1421). Similarly, Adler et al. (2001) found that that 22% of parents of uncircumcised sons felt their decision was not respected by their medical

provider, whereas 4% percent of those with circumcised sons reported this perception. A public health survey of Canadian mothers with male babies revealed that over 30% reported not receiving enough information about circumcision (PHAC, 2009).

Summary. The literature concerning male circumcision is dominated by a risk-benefit approach focusing on physical health outcomes. The results of these studies often conflict, which makes it difficult for parents to make a decision about whether to have their infant sons circumcised. Without clear answers to the question of whether circumcision affects boys' long-term physical and psychological health, it is likely that many parents consider other factors to help them make this decision.

Some research does exist on parents' decision-making about this issue; however, it has tended to be quantitative in nature using questionnaires with simple close-ended options to choose from (Adler et al., 2001; Brown & Brown, 1987; Oh et al., 2002; Patel, 1966; PHAC, 2009; Xu & Goldman, 2008). While the findings have been helpful to our understanding of what parents consider when making this decision, they have tended to be superficial. The decision about whether to have surgery performed on a newborn infant is likely a very difficult one for parents to make. But we know very little about the process they go through or what the meaning of the decision is for them. For some, it might be solely a decision based on medical and health concerns. For others, it might involve deep symbolic, familial, gendered, or spiritual meanings. And for others, it might involve human rights considerations. We do not have research exploring the psychological weight of this decision for parents, or on how they navigate its many dimensions to reach a decision that has life-long implications for the child. This phenomenological study constituted a first attempt to address and bridge this gap in the literature through exploring the decision-making process of prospective parents expecting sons.

Purpose of the Present Study

The overall purpose of this study was to explore the decision-making process of expectant parents who were deciding whether to have their sons circumcised soon after birth. The study addressed two research questions: 1) What are parents' beliefs and attitudes concerning, and previous experiences with, male circumcision as well as of the penis as circumcised and/or intact?; and 2) Do parents' beliefs and attitudes shape the process of deciding whether to circumcise an infant son, and if so, how?

Theoretical Framework

This study and its methodological approach were guided by sociological theories of Embodiment. Merleau-Ponty's phenomenological work on bodies is the most cited among body theorists and those "wishing to explore the 'lived experience' of the embodied subject" (Shilling, 2001, p. 329). In contrast to essentialist theories of the body as biologically determined, embodiment theories understand the body as a social agent: "We are in the world through our body, and… we perceive that world within our body" (Merleau-Ponty, 1962, p. 206). Crossley (1995b) points out that Merleau-Ponty's work should not be understood as an accounting of the experience of embodiment, but that it is "the very basis of experience. We experience by way of our (sentient) embodiment. Our body is our way of being-in-the-world, of experiencing and belonging to the world. It is our point of view on the world" (p. 48).

In his book examining the body in relation to social theory, Shilling (2003) identifies four theoretical approaches that have influenced views of the body as socially constructed. First, Mary Douglas' (1966, 1970) anthropological work developed "the idea of the body as a receptor of social meaning and a symbol of society" (Shilling, 2003, p. 64). She argues that the body is a metaphor for society and that the body will reflect prevalent ideas about that society and will

symbolize social location. In a social crisis situation, for example, "when national borders and identities are threatened, there is likely to be a concern with the maintenance of existing bodily boundaries and the purity of bodies" (Shilling, 2003, p. 64). Second, work on the history of the human body, in particular how the meaning of bodies has not been stable but has rather consistently shifted over time, has also influenced social constructionist perspectives of the body. Third, Michel Foucault's radical approach to viewing the body as socially constructed moves beyond seeing meaning imposed upon the body to viewing it as entirely constructed and controlled by discourse (Shilling, 2003). Lastly, Erving Goffman's (1963, 1968) work focuses on the importance of the body in social interaction as a social agent, and how "the body assumes a status of a resource which can be managed in a variety of ways in order to construct a particular version of the self" (Shilling, 2003, p. 66). In Goffman's view, one's body has a significant role in the relationship between one's self-identity and one's social identity. As Shilling describes, "the social meanings which are attached to particular body forms and performances tend to become internalized and exert a powerful influence on an individual's sense of self and feelings of inner worth" (2003, p. 73). As one interacts in the social world, rules of engagement and bodily representation must be followed in order to be thought of as normal (Crossley, 1995b). Shilling further explains Goffman's suggestion that: "bodily norms not only enable individuals to recognize and label others… but to grade them hierarchically, and stigmatise them in a manner which facilitates discrimination" (p. 337).

Critiques have noted that extreme social-constructionist views of the body in effect minimalize the importance of the corporeality of bodies (Shilling, 2003). A third view of bodies as neither simply biologically-determined nor purely socially constructed is presented by Connell (2000), who argues for a more meaningful framework from which to understand the relationship

between men's bodies and masculinity in particular. Her theory of body-reflexive practice emphasises bodies as "both objects and agents of practice, and the practice itself forming the structures within which bodies are appropriated and defined" (p. 61). This alternate social constructionist approach includes the physical body and its practices as important in the social construction of gender. Connell states: "bodies, in their own right as bodies, do matter. They age, get sick, enjoy, engender, give birth. There is an irreducible bodily dimension in experience and practice: the sweat cannot be excluded" (p. 51). This prioritizing of the corporeality of the body in social practice differentiates Connell's theorizing of the body from other social constructionist approaches. For Connell, the body is the "central means through which gendered identity is constructed" (Wellard, Pickard, & Bailey, 2007, p. 84). Understanding conceptualizations of masculinity and femininity as socially constructed, Connell emphasizes the role of the lived experience of the body, explaining:

> The physical sense of maleness and femaleness is central to the cultural interpretation of gender. Masculine gender is (among other things) a certain feel to the skin, certain muscular shapes and tensions, certain postures and ways of moving, certain possibilities in sex. Bodily experience is often central in memories of our own lives, and thus in our understanding of who and what we are. (p. 52-53)

The body is therefore "inescapable in the construction of masculinity, but what is inescapable is not fixed" (p. 56). The body is engaged in a complex relationship with social systems, relations, symbolism, and social institutions, all of which are subject to change over time. Connell discusses how social process impacts our view of sexed bodies, through elaborating on bodily differences between the sexes (for example, with the use of a codpiece), or can "distort, contradict, complicate, deny, minimize, or modify bodily difference" (p. 52), as can be seen in

the intentions of male and female genital surgeries to reduce ambiguity and fulfill the cultural definition of the child's sex. Thus implicated in inequality and domination, "particular versions of masculinity are constituted in their circuits as meaningful bodies and embodied meanings. Through body-reflexive practices, more than individual lives are formed: a social world is formed" (p. 64).

Following Connell's conceptualization of body-reflexive practice where social practices are understood as gendered, Monaghan (2002) argues for the importance of recognizing the "plurality of masculinities *and* intra-gender relations that effectively include and exclude different kinds of masculinity… hierarchies exist between men embodying superordinate and subordinate masculinities and the body is the primary vehicle in negotiating this perilous landscape" (p. 340).

Infant male circumcision is implicated as a practice designed to embody socially determined gender roles and to engender the child by further exaggerating the visible physical differences between males and females. Therefore, Connell's adapted social constructionist theory of embodiment and body-reflexive practice guided the methods used to address this study's research questions.

Significance of the Present Study

The aim of this study was to provide insight into the specific social, cultural, and individual factors that influence expectant parents' decision-making about whether to circumcise their newborn sons through the use of qualitative methods of inquiry. Its findings may contribute to further theoretical development exploring the sociology of the body, which may in turn drive future research. The findings from this study may be useful to a wide range of health care providers and professionals – including obstetricians, surgeons, family physicians,

paediatricians, midwives, nurses, and doulas – as they support families facing the circumcision decision. Finally, this research may help parents articulate and perhaps better understand their choices regarding whether to circumcise their infant sons.

CHAPTER 2

Methodology

Phenomenology

As the aim of this study was to explore the decision-making process of parents questioning whether to have their son circumcised by describing and analyzing their thoughts, beliefs, and experiences, a qualitative research design was employed. Specifically, a phenomenological approach was used, which is concerned with "gaining a deeper understanding of the nature or meaning of our everyday experiences" (van Manen, 1990, p. 9) through exploring a phenomenon of interest amongst many individuals. In other words, phenomenological studies aim to identify specifically how people have experienced a particular phenomenon and what meanings they ascribe to their experiences (van Manen, 1990).

Aside from its longstanding tradition in qualitative methodology, phenomenology is strongly connected to important philosophical assumptions (Koch, 1995). Two approaches to doing phenomenology have been developed out of philosophical traditions: 1) transcendental or descriptive phenomenology, and 2) hermeneutical or interpretive phenomenology (Lopez & Willis, 2004). Considered the founder of the method, German philosopher Edmund Husserl believed in no presuppositions, calling on the researcher to suspend belief of the 'outer world': "The 'reality' of this outer world is neither confirmed nor denied, rather, it is 'bracketed' in an act of phenomenological reduction" (Koch, 1995, p.829). This concept of bracketing, which Husserl termed 'epoché', is an important focus of the transcendental approach to phenomenology, which aims to *describe* the subjective experience of individuals rather than interpret it. Through the practice of epoché, the preconceptions of the researcher are set aside in

the aim of abstaining from judgement of the participants' experience and to have as fresh a perspective as possible of the studied phenomenon (Koch, 1995).

Hermeneutical phenomenology, on the other hand, prioritizes *interpreting* participants' subjective experience of the phenomenon of interest (van Manen, 1990). This approach originated with philosopher Heidegger, a student of Husserl, who challenged some of his tenets about phenomenology (Lopez & Willis, 2004). Heidegger's hermeneutic variation "goes beyond mere description of core concepts and essences to look for meanings embedded in common life practices. These meanings are not always apparent to the participants but can be gleaned from the narratives produced by them" (Lopez & Willis, 2004, p. 728). The term 'lifeworld' is coined by Heidegger to connote that "individuals' realities are invariably influenced by the world in which they live" (p. 729). From this perspective, one cannot separate the self from the world in which that person lives – individuals are permanently engaged with 'being-in-the-world' (Lopez & Willis, 2004). Hermeneutical phenomenology is then concerned with what participants' subjective experience implies, rather than a concentration on the content of the subjectivity itself (Lopez & Willis, 2004). While followers of both approaches accept the inevitability of researcher subjectivity, hermeneutical phenomenology is not concerned with bracketing. In the interpretive tradition, it is not thought to be possible, nor even desirable, to try to suspend one's beliefs and preconceptions in favour of viewing the research objectively (Finlay, 2009). Instead, the researcher's subjectivity is brought to the foreground in self-reflection. During the research and analysis process, the researcher goes back and forth from his/her own preconceptions to what the data reveal, examining how this might affect interpretation and questioning these pre-existing beliefs (Finlay, 2009). This approach aligns with the hermeneutic circle of continual questioning and re-questioning of knowledge.

Interpretive phenomenology views research as a "dynamic process with an active role for the researcher", whereby access to the 'insider's perspective' is dependent upon the researcher, yet also complicated by his/her personal perspective (Smith & Osborn, 2003, p. 53). Smith and Osborn see these as requirements in order to "make sense of that other personal world through a process of interpretative activity" (p. 53). They describe a double hermeneutic interpretation process: "the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (p. 53). As the hermeneutical approach draws upon the symbolic interactional position of understanding meanings as constructed within a social context (Smith, 1995), and this study was aimed at exploring the meanings behind the parental decision-making process, this approach to phenomenology has been adopted.

Study Design

A qualitative study design was constructed for this study, following Jonathan Smith's (1995) Interpretative Phenomenological Analysis (IPA), which served to guide the sampling procedures and data collection, analysis, and interpretation. Smith's IPA approach was selected due to its emphasis on arriving at a greater understanding of participants' subjective experience, and for its ability to ask critical questions of the data such as, "Do I have a sense of something going on here that maybe the participants themselves are less aware of?" (Smith & Osborn, 2008, p. 53-54). IPA was also chosen for its suitability to exploring the complexity of a process or a highly personal issue (Smith, 1995).

Data Collection

Sampling. Smith and Osborn (2008) have described detailed stages for conducting IPA. They offer a structured way to navigate through a hermeneutic phenomenological study, while

acknowledging that there is no single way to conduct IPA. Given the intensive and time-consuming analysis process outlined below, IPA studies are conducted on quite small sample sizes. Consistent with phenomenology's aim to elucidate the essence of the lived experience of a particular phenomenon, researchers attempt to find a homogenous sample that has that experience in common. For these reasons, purposive sampling is utilized with IPA, and was used in the present study.

The participants in this study all fit specified inclusion criteria. At the time of the interviews, they were all prospective parents expecting their first male child and planning to raise their child themselves. To produce the detailed interpretive accounts needed for IPA, a small sample size is warranted. In the past, a sample of five or six has been recommended for student researchers. Recently, IPA studies have sacrificed breadth for depth and Smith even argues the case of analyses of single case studies (2008). Currently, a sample size of three is advocated for student researchers completing IPA for the first time. This is thought adequate to allow for "sufficient in-depth engagement" with each case but can also provide a "detailed examination of similarity and difference, convergence and divergence" (p. 57). Given the goals, timeline, and scope of this study, a sample size of six to eight participants was planned.

Recruitment. The sample was recruited from a variety of prenatal education sites in the city of Winnipeg. As outlined in the section above, purposive sampling was used to obtain a homogenous sample. Prenatal education sites were selected as this was thought best to yield a sample of parents who were representative of the majority of the Canadian population making the decision – for routine rather than traditional circumcision. Recruitment posters (Appendix A) were displayed at the sites where prenatal education courses are held, such as community centres, health clinics, and other applicable businesses. The recruitment poster provided key

information about the study and was designed to target individuals fitting the inclusion criteria discussed above. Contact information was provided on the poster as well as removable tags containing this information that interested individuals could take with them. I also sought permission to attend prenatal classes to give a short (5-minute) presentation about the study and invite expectant parents' participation. I gave four of these presentations at two prenatal education sites in Winnipeg.

When interested individuals contacted me, I described the project in greater depth, answered questions, and determined whether they met the inclusion criteria. If they wished to participate in the study, and if they met the inclusion criteria, an in-person interview was arranged at each individual's convenience. Participants selected the interview locations, all of which took place in their homes. Participants were told that they would receive a gift card from the Babies R Us department store at the end of the interview in recognition of their time.

Interview procedure & instrument. In accordance with the aim of IPA to "analyse in detail how participants perceive and make sense of things that are happening to them", a flexible method for collecting data is encouraged (Smith & Osborn, 2008, p. 57). While other instruments have been used for studies using IPA, the semi-structured interview with probes is considered the exemplary method. Smith and Osborn describe how this technique provides a guide for exploring the phenomenon with the ability to modify questions as new areas arise from participant responses (2008). As the ordering of questions in this guide is not considered important (and questions may even be skipped), the interviewer is more able to probe into interesting responses and follow the respondent's lead. This type of interview is suited to the phenomenological approach, which aims to "try to enter, as far as possible, the psychological and social world of the respondent. Therefore, the respondent shares more closely in the

direction the interview takes" (p. 59). Smith and Osborn (2008) describe the respondent as the 'experiential expert', who should be afforded the best opportunity possible to tell their story of the phenomenon studied. Interesting areas may emerge and the interview may stray from the guide, yet the interviewer needs to decide just how much movement is permissible in each instance.

The interview guide created for the study (Appendix B) contained general questions designed to encourage dialogue about the topic with as little prompting as possible, in order to avoid leading the participant (Smith & Osborn, 2008). If the participant did not understand or provided a vague or brief reply, previously-constructed specific prompts were given to provide a 'gentle nudge'. The questions were open-ended in order to optimize the depth of participants' descriptions of their thoughts, feelings, and experiences (Smith & Osborn, 2008).

Section one: demographic information. The first section of the interview involved the collection of demographic information - namely age, ethnicity, number of children (including their ages and genders), marital status, and education level. All interviews were electronically recorded and later transcribed to ensure accuracy. Brief hand-written notes were taken to record ideas that emerged during the interview process (Patton, 2002). The interviews were begun in this fashion to ease the participant into the interview and establish rapport, which Patton (2002) has identified as appropriate when exploring areas that may be sensitive to the participants.

Section two: beliefs, attitudes, and experiences with male circumcision. This section addressed the first research question, exploring expectant parents' beliefs and attitudes concerning, and previous experiences with, male circumcision as well as of the penis as circumcised and/or intact. Considering the importance of bodily lived experience in Connell's body-reflexive practice, as well as in the phenomenological method, questions were phrased to

focus on respondents' feelings about the procedure itself as well as of the penis as either circumcised or intact.

Section three: decision-making process. This section corresponds to the second research question examining whether expectant parents' beliefs and attitudes shape the process of deciding whether to circumcise an infant son. Questions were phrased to explore the lived phenomenological experience of respondents as they have been going through this process.

Ethical considerations. Prior to the commencement of recruitment and interviewing, this study was granted ethics approval from the Joint-Faculty Research Ethics Board at the University of Manitoba. Each participant read and signed a consent form (Appendix C). Participation was voluntary and individuals were advised that they could refuse to answer any question asked as well as withdraw from the study at any point in time with no consequence.

Multiple efforts were made to protect the privacy and confidentiality of study participants. Information collected during the interviews was not disclosed to anyone other than the primary researcher and research advisor. All material collected from participants - consent forms, interview notes, audio recordings, and transcripts - were stored in a private locked office accessible only to the primary researcher. Electronic recordings and typed interview documents including transcripts are password-protected and stored only on the researcher's computer. To protect the confidentiality of study participants, all names and other potentially identifying information were changed on all written materials. Any data that contains identifying information will be destroyed one year following the formal defense of this thesis.

Given the extent to which expectant parents are likely to be struggling with the question of whether to circumcise their infant boys, a resource sheet was provided to participants wishing to seek out more information about circumcision (Appendix D). This list was approved prior to

the interviews by the research ethics board and contains a variety of appropriate resources.

While the interview process had the potential to elicit stress for the participants involved, it also provided a valuable opportunity for individuals to share their experiences, thoughts, and feelings about the topic. The researcher emphasized that with their personal stories and perspectives, they were contributing to a largely unexplored area of a sensitive decision that impacts the lives of parents, children, and their families. The participants were told they would be given the option to pause or stop the interview and debrief with me in private should they become distressed at any point in the interview. This did not occur with any of the participants. All participants had the option of obtaining a summary of the finished study through mailing or electronic distribution by the researcher at no cost to the participant.

Participants. Six individuals were recruited from four separate prenatal education classes, taking place at two separate education sites in Winnipeg. These individuals contacted me following a brief presentation I made at the beginning of their class. In each case, when an individual contacted me, interviews were arranged with that participant as well as their spouse/partner, who also wished to participate in the study. Interviews took place in the participants' homes and took place in private. The interviews were conducted with one participant at a time – i.e., the female partner was interviewed first, followed by their respective male partners immediately following. This was not specifically designed to take place in this order; rather, participants decided the order themselves in each case.

Three women and three men completed interviews. Five participants self-identified as Caucasian, while one male stated his ethnicity as "English Canadian". All participants had no children other than the boy they were then expecting. Four participants were married and two were engaged. Two female participants had Masters degrees. Two male participants had

completed college degrees. One female had completed one year of college, and one male had completed high school. Participants' ages ranged from 22 to 36 years. Although this was not explicitly asked, it was revealed in the interviews with the three males that two were circumcised. The participants' characteristics are summarized in Table 1.

Data Analysis

This research followed Smith and Osborn's (2008) step-by-step approach for conducting IPA. While the authors provide this system to help guide a hermeneutic phenomenological study, they note that the "analysis itself is the interpretative work which the investigator does at each of the stages" (p. 67). For a project involving more than a single case, it is advised to begin in-depth analysis with a single interview transcript and then move on to others. This approach begins with specific examples and themes and gradually builds to the development of general claims.

To identify themes within the very first case, the researcher begins by becoming familiarized with the transcript through reading and rereading it several times. Smith and Osborn relate this to a free textual analysis, in which there are no explicit rules about dividing the text, and more insights will emerge through rereading. The researcher will typically use the left-hand margin of the transcript to jot down interesting responses, and this was done in this analysis. This might include paraphrasing respondents' words, as well as initial interpretations, noting the respondents' use of language and the similarities and contraindications in their accounts. Once this step is completed, the researcher returns to the start of the transcript and begins noting theme titles in the opposite margin: "Initial notes are transformed into concise phrases which aim to capture the essential quality of what was found" (p. 68). This process was

continued throughout the transcript. There is no requirement to produce themes for each section; newly emerging themes will depend on the richness of each passage.

Table 1

Study Participants

Pseudonym	Gender	Age	Un/circumcised	Decision
Quinn	Female	33	N/A	Has decided not to circumcise
Noah	Male	36	Uncircumcised	Has decided not to circumcise
Rebecca	Female	28	N/A	Unsure – leaning to not circumcising
Miles	Male	30	Circumcised	Unsure – leaning to circumcising
Kelli	Female	22	N/A	Has decided to circumcise
Aaron	Male	32	Circumcised	Has decided to circumcise

The second stage of analysis involved connecting the themes found in the first transcript. After a list of themes was made in the order that they appeared, the researcher enters a higher analytical stage of attempting to make sense of the connections. Some themes connected and clustered, while others superordinated over others. A table of themes was then constructed. Clusters became a superordinate theme with a title, with the individual themes below it, and identifiers were used to easily identify the location in the passage from which the theme originated. Themes that were found not to fit in the emerging structure were dropped.

Once this process was completed for the first case, it was repeated with subsequent transcripts. If there are numerous interviews, the researcher can use the first table of themes to "orient the analysis of the subsequent ones", while a sample size of three would warrant starting the "analysis of each case, as though it was the first" (p. 74). In the latter case, it is better to begin fresh and later compare across the cases, and this approach was adopted in the analysis. After completion of this process with all cases, a master table of superordinate themes was created. This required prioritizing and reducing the data – not simply based on prevalence within the transcript, but also for factors such as richness and how the themes contributed overall to the analysis.

The final stage of IPA consisted of "moving from the final themes to a write-up and final statement outlining the meanings inherent in the participants' experience" (p. 76). Analysis continues into this step as themes are elaborated upon and explained:

> The table of themes is the basis for the account of the participants' responses, which takes the form of the narrative argument interspersed with verbatim extracts from the transcripts to support the case… when one sees the extracts again within the unfolding narrative, often one is prompted to extend the analytic commentary on them. (p. 76)

CHAPTER THREE

Findings

Analytic Strategy

Data analysis took place in accordance with Smith and Osborn's (2008) steps for studies utilizing IPA. Initial codes emerged from each transcript, which later evolved to become a categorical table of themes, individualized for each interview transcript. Once this process was completed for all interviews, a master table of superordinate themes was created through the comparison, prioritization, and reduction of data across the six transcripts. A total of eight superordinate themes emerged, each containing a number of sub-themes. The eight superordinate themes were: 1. The complexity of the decision-making process; 2. Partners and social networks: helpful or hindering?; 3. Health promotion intervention or unnatural intervention?; 4. Whose body is it?; 5. Who has gender jurisdiction?; 6. Form or function?; 7. Social norm or outmoded practice?; and 8. What do expectant parents need?

The Complexity of the Decision-Making Process

The degree to which the participants struggled with the decision about whether to circumcise their sons varied widely. Some found it to be a simple decision, while others were struggling and even panicking about making the decision. The factors that eased or exacerbated the difficulty of participants' decision-making included whether the issue had been contemplated prior to the pregnancy and the degree of agreement between the spouses.

"It's very simple."

In general the decision was less taxing for participants who had considered the issue prior to becoming pregnant, and/or when their spouse agreed with the decision being made. Quinn, who had opted not to circumcise, found the process very easy: "We both had decided before we

had even discussed it. Before we got pregnant I think we knew what we would choose if we ever got pregnant and had a boy". Her husband Noah expressed a similar sentiment: "Not that I don't listen to what (Quinn) has to say, but I think that we had already both made our own conclusions, uh, before we talked about it". When asked when he first began to think about the decision, Noah responded, "I don't think that I ever did. I was just making the assumption that I wouldn't (circumcise)".

It appeared that even when the decision had not been finalized, having previously considered the question of whether to circumcise prior to becoming pregnant helped to minimize the stress of the situation. Aaron had made the decision to circumcise his son long before finding out he was having a boy. He described the process as "very simple." For him it was not truly a "thinking process"; he automatically knew his son would be having the procedure performed. Although Miles still felt undecided about the issue, the fact that he had been thinking about it "for years and years and years" seemed to help make the process less stressful. While he acknowledged that he and his wife were "so much on the fence, anything could kind of sway", he did not feel that the experience itself was very difficult for him: "It's not been complicated, it's not been, like there's not been any fights about it. We - we're just kind of, we're wondering ourselves... Like it's, it's not, it's not something that, I don't know, we're not stressing over it".

Participants who found the decision easy seemed to have confidence in their own logical thinking ability. Quinn remembered her prenatal education instructor discussing circumcision: "she sort of stuck to facts and stuck to sort of logic and that sort of fit with what my decision process was too". She and her husband Noah opted not to circumcise. They explained that because there was a noticeable absence of any reason to have the procedure performed, they decided against it. Noah stated, "Usually I will do things if I can come up with reasons to do

them, um… so I don't necessarily have any reasons not to circumcise, I just don't have any reasons to do it". Noah expressed strong trust in his own sense of reasoning. Upon consideration of his spouse's opinion, Noah's thought process exemplified what he described as a reliance on his "practical side": "If I wasn't able to explain (Quinn's reasons) away, or… um, offer any evidence to the contrary, then um, I probably would have come to a different decision." Rebecca also conveyed a desire to seek out facts and felt confident that this would provide her with clarity. She described wanting to "get some legitimate facts" and would "weigh the pros and cons" accordingly.

Some participants also relied on their own experiences to help them make the decision. As Noah explained, "to sum it up, having not experienced any difficulties that I can imagine would have been corrected with the removal of my foreskin, um, I… it's not, uh, it was never an issue". Aaron felt that his own positive experiences with circumcision made it easy to choose it for his son. These past experiences, all of which revolved around sexual experiences with the opposite sex, were described as the most important factor in his decision: "I've had girls that tell me I have a nice-looking penis, so, other than that…" However, unlike the other couples, Aaron and Kelli did not fully agree on this decision.

"I never thought I'd be so conflicted."

Kelli began thinking about the issue when she was about 20 weeks along in her pregnancy, at the time that she had found out she would be having a boy. Although she considered the issue to be decided due to her partner Aaron's strong feelings about wanting to circumcise their son, she expressed that she was still feeling a great deal of inner conflict about it. Kelli had not realized that she would find it to be such a complicated issue, and she had not

felt it was even something ‘to be thought about’, due to her mistaken belief that she was carrying a girl:

> “I don’t know why I was set that I was having a girl (laughs). When I saw the little image on the screen I was just in total shock. I wasn’t expecting it so, it’s not something I ever, ever thought about, so when I had to think about it, I was just like, ‘whoa, this is a big decision, what am I - which way am I going to go?’”

Through the course of the interview, Kelli repeatedly brought up issues with which she was grappling and expressed that some of these issues were “coming up for the first time”, in the interview itself. For Kelli, the lack of agreement with her partner and the fact that she had not considered the issue prior to her pregnancy made the decision a difficult one. She also was having difficulty discussing her struggles with Aaron due to his certainty in his decision.

The decision-making process also was daunting for other participants who had not given the issue much thought prior to becoming pregnant. Rebecca felt stress and a sense of panic as she was still largely undecided and nearing her due date. She described the combination of not thinking about the issue beforehand, and learning during her pregnancy about how complex the decision is, as a cause of stress:

> “I think it’s something I wasn’t really expecting to have to think about, um, until - once we decide to have a boy and realize that this is something that we have to deal with ‘cause it’s the first of many parenting things that you have to learn to deal with but um… and I never thought I’d be so conflicted on it, too. Um, I thought that it would be pretty transparent on which one I’d want to do but I didn’t realize, yeah there’s a little bit of things pulling me each way and so, um, I never thought I’d still be sitting here trying to make a decision on it, and I never thought (Miles) would be so on the fence still too, but

he's considering pros and cons for so long as well so that I've found very interesting and realizing that the days are coming down and we have to actually make a decision so (laughs)… I'd say that's the main kind of surprising thing or experiences that we've had."

Partners and Social Networks: Helpful or Hindering?

Some participants chose to involve others in their decision-making process, such as partners, family members, close friends, and even co-workers – while others found it either difficult or irrelevant to discuss it with others.

"It's not something that comes up in conversation."

Noah and Aaron felt that circumcision was too awkward a subject to discuss with other people. Noah described feeling slightly uncomfortable during the interview, and interestingly even stated: "I guess maybe that's part of the study as well, the awkwardness of discussing it… there is still some awkwardness". He explained that, for him, the issue of circumcision "would never come up in conversation unless it was forced, and uh… the conversation I'm assuming would have to be forced". However, Noah did consider his partner's views: "If there was some reason for (Quinn) to have chosen otherwise, then uh… as I said before, I'm only fifty percent of the decision-making, so I would have taken her concerns very seriously".

Aaron said that an adult male friend of his had recently been circumcised, and that while he had spoken to him "when he first got it done, kind of, briefly… it's not something that comes up in conversation (laughs), 'How's your circumcised penis doing nowadays?'". He did not consider either his fiancé's views or his family's/friends' experiences as having an impact on his decision-making. When Kelli learned she and Aaron would be having a boy, she assumed that they would be opting to circumcise; however, she did not bring Aaron in to the conversation

until a later point in time. Aaron primarily considered his own feelings in the decision-making process: "It was actually very simple. I just decided this is what I want." Aaron recalls that when Kelli eventually brought up the issue with him for the first time, he matter-of-factly stated, "No, he's being circumcised". Aaron described Kelli's role in the decision-making process:

> "She just asked me what I wanted to do and I said I'm dead-set on getting it circumcised, you know, obviously it's the two of us making the decision but she was - she was, I don't think she cared either way so she was just okay with the decision. It was a pretty short conversation."

"I like to take everybody's experiences and thoughts into consideration."

Rebecca and Miles were very comfortable in discussing the issue with each other and with friends and family. Rebecca stated that she was "heavily weighing (Miles') opinion on it, how he feels". Although Miles was strongly leaning towards circumcising, he stated that he would ultimately defer to his wife for the decision, and "probably would just let her do whatever she wants". Rebecca also remembered a casual conversation with a fellow running partner, also pregnant. Miles discussed the issue with Rebecca's parents one day while listening to a program on the topic on the radio. Miles also found it very interesting to discuss the decision-making process with his female co-workers.

The topic also came up in discussion for Quinn with one of her female co-workers who was expecting a girl at the time. The two joked about their children getting married one day. The co-worker, who was a practicing Muslim, joked that she would want Quinn's son to be circumcised before she would allow him to marry her daughter. Quinn indicated that this was just a casual way they would discuss the issue and that it did not have any impact on her decision-making process. Kelli described venting to her female friends about the issue, some of

whom had complained about the stress of taking their own daughters to the doctor to have their routine vaccinations, to which Kelli responded, "How do you think I feel about taking him to get circumcised, and him being - having to recover from that?"

The participants who felt comfortable involving others in the discussion seemed to value their personal experiences. At a dinner party that Rebecca and Miles had attended the night before their interviews took place, the issue of circumcision came up as a topic of conversation. Their friend detailed her own experience circumcising their son. Rebecca recounted:

> "They have a little boy and they did get him circumcised, um… she actually, I don't know where he was, but she took him to the hospital and met her sister-in-law there and actually had the sister-in-law go in with the baby because she said as a new mom, I wasn't ready to do it, she said - and when her sister-in-law came out, she said, uh, you know, I support that this was your decision… but… that was horrible."

Rebecca explained that hearing of this experience - and the fact that her friends likely would not circumcise if they had another male child – weighed on her decision and caused her to lean more heavily toward not circumcising. Miles also brought up the conversation that took place at the dinner party: "One of the couples last night, their son got circumcised and apparently it was pretty brutal when it was being done". He described taking this experience into account in his decision-making process, expressing that it has added to his confusion.

While Rebecca had not yet discussed the issue with her family, she planned to do so. Her sister, who she described as very 'holistic' in lifestyle, had opted to circumcise their son:

> "I want to talk to my sister about it, um… whether or not it will influence me more so than say talking to my friends I guess not so much, as I do believe it's our decision, and um, I do like to take everybody's experiences and thoughts on it into consideration, um…

but it's not just going to be that she did so I'm going to do it. Other than that, we haven't had a lot of family experience."

Health Promotion Intervention or Unnatural Intervention?

All participants articulated a variety of reasons for the decision they had made – or were leaning towards – at the time of the interview. Some participants believed or at least considered the possibility that circumcising their sons as newborns might be a preventative health promotion measure; whereas others asserted that this type of intervention was unnecessary from a health- or pain-based standpoint.

"It's more hygienic."

Miles referenced cleanliness as a dominant reason that he was leaning towards circumcising his son, saying he'd heard that "it tends just to be a little bit more clean". His partner, Rebecca, stated that easier hygiene was the only factor left to consider as a reason to circumcise, but also believed that it was not "a big enough reason" to warrant changing her opinion. While Kelli felt very conflicted about the decision to circumcise her son, she did see hygiene as one big advantage and cited past experience as an example: "I just think it's more hygienic in general. Like I think it's more pleasant in general. I've been with people that haven't been and they're a little bit, uh, dirty (laughs)". Her partner Aaron briefly mentioned the concept of hygiene, but did not consider it as influential in making his decision; rather, it served to affirm his decision already made: "I guess the whole cleanliness factor apparently, it's you know, you gotta – it's a little harder to clean if it's uncircumcised".

While Rebecca was largely leaning away from circumcising, her major concern was about risk of infections. She remembered that "people have said that you can get infections from not having circumcision". Her husband Miles echoed this apprehension, recounting that he's

"heard of a couple people who had to get circumcised later on in life because of some sort of infection". While none of the participants articulated the specific type of infection they were worried about, Kelli also cited concern about infection as a result of not circumcising: "From what I've read, apparently there can be infections in the foreskin and uh, removing the foreskin can help with that".

"I believe the body can clean itself."

Most of the participants stated their belief that circumcision is an unnecessary surgery for several reasons, including that it is not medically-needed. Rebecca questioned, "If it's a non-medically-necessary procedure… um, then, really, why are we doing it?". Quinn and Noah saw circumcision as a mutilating procedure and cited it as a major reason for their decision not to circumcise. Quinn described it as an "unnecessary change to a perfectly good body" and that it is "really about mutilating a baby". Noah expressed the same view, and considered the foreskin a result of human evolution:

> "It's essentially if you boil it down to the simplest form it's mutilation or modification of the body. I uh… I have fairly good um, um, respect for, um, evolution or whatever force caused us to become the shape and the form that we are today."

He discussed wanting to be "true to the species" because "as organisms we're pretty awesome". When asked whether personal religious beliefs impacted his decision, he described his faith this way: "When you say faith, then perhaps my faith in humanity's ability to survive, um, with their - what it is that they're born with, that may have been a factor". Even Kelli, who is opting to circumcise due to her partner's strong opinion on the subject, briefly mentioned her belief in the human body's natural design: "I believe the body can clean itself... it's (not circumcising) the more natural thing to do".

Some participants took issue with the procedure itself as a substantial reason not to have the procedure done. Kelli described being uncomfortable with the thought of having to take her new son to somewhere unknown: "Having to take him out to a doctor that I don't really know very well and… 'cause I think there's only a limited amount in the city that can actually do the procedure". Likewise, Quinn related that it is easier to not have to take the extra steps required to circumcise: "The fact that it's… the decision that we made is the one that requires us to do nothing (laughs) is additionally good". Rebecca was concerned with surgical risks in general:

> "I think if you're going to do something, you have to have a good reason why to do it, and if we don't have any really solid reason why we're circumcising him, then I don't see taking even that small of a risk of him getting an infection and putting him through that procedure if we can't solidly say these are the reasons why he needs to be circumcised."

All participants, except for Aaron, discussed pain arising from the procedure as a reason not to circumcise their sons. For most participants, this was a serious consideration and one that weighed heavily on their decision-making. Solid in their decision not to circumcise, Quinn described how the procedure causes "pointless and unnecessary pain", while partner Noah called the surgery "a little gruesome". Rebecca expressed similar concerns, stating, "It sounds awful, like strapping the baby down… it sounds painful." She wondered, "Why would you put a baby through that?" Miles was also worried about pain, and specifically how it might impact the immediate postpartum period: "I also want to enjoy the [baby], you know, the first couple days. I don't want to think that he's hurting". Miles identified this as the primary reason not to circumcise, and said that he "wouldn't want to put him through that". Kelli focused on the issue of pain repeatedly throughout the interview, also with particular worry about healing and pain lasting multiple days, and how this will cause her grief: "I would feel horrible, him being very,

you know, upset about it for the first week or however long it take him to recover". Kelli was nervous about her own emotions in relation to getting the procedure done, and was unsure about how she would handle being present for the procedure itself:

> "If he cries I'm just going to bawl my eyes out too, so I'll probably just make his dad do it (laughs)… I'll probably come but I'll probably - no, I'll probably be there, but I'll just have to suck it up, but… I - yeah, I'm not going to, I'm not going to be too happy about that if he cries."

Kelli hoped that it "doesn't hurt too much", and repeatedly stated her belief that "the baby's not going to remember it" as affirmation to herself in having the procedure done. Miles likewise articulated that although he doesn't want his son to be in pain, he does "understand completely that it will… I know that from my experience, it's not going to, I'm not going to, he's not going to remember it". While Rebecca also acknowledged the likelihood that her baby wouldn't remember having the procedure done, she didn't feel that this resolved the issue, as the baby would still need to experience pain in the first place:

> "I know uh, they're not going to remember, and actually that's another thing my friend said yesterday with uh, 'cause they did circumcise their boy, was that why it's no different today than, I mean, it hasn't affected him, so, um, but I mean at the same time the baby is going through pain at that time, and, um, so yeah the procedure kind of… I don't know, scared me a little."

Whose Body Is It?

The concept of bodily integrity presented itself during the interviews multiple times, with some participants discussing how routine the procedure has become and if it is part of your

family tradition, you take part in it, while others affirmed that it is not the parents' decision to make, but the child's.

"You should be circumcised if your father was circumcised."

Most participants thoroughly discussed the issue of matching and the apparently common desire for the baby's circumcision status to be the same as that of the baby's father. Interestingly, while some agreed with the importance of matching the father, all participants questioned whether this desire was a valid reason to have the procedure performed. Even though Quinn and Noah were steadfast in their decision not to circumcise, Quinn speculated that had Noah's personal status been different, his decision might have been different too. She stated, "I suspect he, honestly, if he were circumcised, maybe he would want to circumcise our son". She further explained how 'matching' is important to people: "You should be circumcised if your father was circumcised. Why would you have a different penis? You're the same family, so… I mean, you match genetically, right". But to her, this concept of penis-matching is an invalid reason to circumcise. She recalled the following moment from her prenatal class:

> "The doula who was teaching the class made a funny joke, and she's like, 'You know what, you won't… your newborn son does not look like your adult husband's penis, like, they are not the same thing, they don't look the same.' You know, that's… she just didn't have a lot… didn't subscribe a lot of value to that which I would agree with."

Rebecca also addressed the motivation to have a baby's penis match his father's: "There's always the, well if the hus- if the dad is circumcised, you circumcise the baby. So (Miles) is circumcised, so… that's come into play, um, in our minds as well, so that the baby's not wondering why his dad is different." Rebecca had initially agreed with her partner Miles' first instinct, which "was to say, 'Well, I'm circumcised so of course we're going to get him

circumcised,'" but she later re-considered this position. Likewise, Rebecca countered this concern with alternative ways of coping if the baby's and father's circumcision status do not match:

> "I know he'll (Miles) be the type of dad to - he always wants to have lots of conversations with our kids. He always says, you know, teaching your kids something, that's the best way so he's always, he kind of realizes now that yeah, why don't we just have that conversation with him and say, "Well you're different because…" and you know, that should be enough for a kid, I don't think it's an earth-shattering thing for them to be different from their father, so… I think that fact is kind of weighing less on us now, when at first I think it was actually one of the most important things we thought of immediately, whereas now we're learning a little bit more about it and other factors are coming into play, we're kind of thinking, that is one conversation, I don't think it's going to be earth-shattering for the kid, so we probably aren't going to think that way as much anymore."

Miles echoed similar thoughts about the issue. He described initially wanting to opt to circumcise his son due to "the fact that I am", but also questioned the validity of such a concern:

> "I think I'm actually almost embarrassed to, to think like that. Like I don't feel that's a good legitimate reason… I don't think that should be a reason. But I feel like it is. And I feel like for most people it is. But I feel like it shouldn't be."

Similar to Rebecca, Miles had also reflected on strategies to overcome the issue:

> "I guess depending on what - what age the child is, I would just describe, I would just tell him, why it looks different. We got him - he's uncircumcised, I'm circumcised, that's… I guess I would have to figure out a way… I mean depending on his age figure out a way

to explain why and I'm sure if it's at a young age… or maybe he won't notice at all, or maybe we won't ever shower together, I have no idea. But I don't think it's that big of a deal. I think a lot of people put a lot of weight into that."

Additionally, Miles found it quite interesting to discuss this particular issue with others, including his spouse's parents, friends, and female coworkers. His father-in-law advised him to "do whatever I am", and noted his anecdotal findings from discussions with co-workers that the "female partner tends to be very biased towards what her husband is". He described the experience as "fun to talk about just to see how people get swayed by, by their own sort of personal like, what - whatever they are, I guess", but expressed wanting to "talk to somebody who just says something different once".

Although Aaron didn't specifically identify wanting to circumcise his son for the purpose of "matching," Kelli suspected that it was probably Aaron's main motivation: "He told me that it's very important to him that the baby be circumcised. Not 'cause he's religious or anything, but uh, just because he… I guess, is circumcised and wants the baby to be circumcised too, so that's where I guess I kind of said, 'Yeah, okay, let's do that'".

"It's really up to the baby."

Partners Noah and Quinn each expressed a belief in the importance of informed consent and choice in the issue of neonatal circumcision. Regarding his respect for the body in its 'as-is' condition, Noah explained:

"I do get that there are some things that have evolved that are not necessarily useful… um, but um, I think that getting a tattoo, or getting piercings, or removing one's pinky finger for, for laughs, or for what you think your body should look like is okay, but I don't think that that's a decision that anyone should make for another person."

When discussing what could be helpful to other parents as they go through this process, Noah began stating that presenting facts on the procedure is helpful. However, he subsequently questioned this sentiment, given his belief that it is not the parents' decision to make in the first place: "But then, it's really up to the baby. And how do you present the baby with the facts so that they can make the decision?" Quinn similarly stated, "If my child grew up and wanted to circumcise himself that would be up to him I guess, but I don't think that happens very often".

Who Has Gender Jurisdiction?

Female participants described a sense of feeling the need to defer to their male partners in the decision-making process, while one male participant believed his wife had more say in the issue due to the fact that she is the one carrying the baby and would be going through childbirth.

"There's a sort of bond there… that I would feel obligated to respect."

All female participants identified the issue of what Quinn termed 'gender jurisdiction' – the idea that the male partner has more say in the circumcision decision-making process because he is the one with the penis. Quinn stated that she would have an emotional response if her husband disagreed with her decision and wanted to circumcise their son, and specifically discussed how she would feel obliged to comply with his wishes:

> "I guess I would probably feel like, because I'm a woman, and he's… my husband's a man, our son… like he would somehow have some sort of gender jurisdiction over him, because of that, and he'd be like, 'I want my son circumcised'… You know, somehow there's sort of a bond there, like, that I would feel obligated to respect, while still feeling really strongly that that was the wrong thing to do."

Although Quinn was the one to name this phenomenon, she also questioned whether it was a valid way to consider the issue: "I guess somehow, there is some sort of a um… realm in which

he has some degree more of decision-making about that. I - I don't know, whether I actually believe that or not (laughs), I don't know".

Similarly, Rebecca explained her first instinct was to defer to her husband on this issue: "I didn't really know anything about it, so for me, I've kind of… in my head, I always just thought I would just leave it to (Miles) to decide". As mentioned earlier, Rebecca felt that "matching" was not a valid reason to circumcise her son, and that "it's one simple conversation with your child to explain why" he is not circumcised but Miles is. However, Rebecca delegated this task to Miles due to her perception of her own lack of knowledge and her belief that it is Miles' realm:

> "I think that I would just leave it up to (Miles) (laughs). So I guess it'd be (Miles') conversation (laughs). Maybe that's bad, but I guess I just feel, they would, you know, know more about it, and just do better as a father-son type conversation. Of course if (Miles) wasn't around I would step up. Well then, I guess he (her son) wouldn't be comparing it to (Miles) so (laughs)… yeah, it would be a conversation that (Miles) would be having."

Kelli also expressed conceding to Aaron's wishes due to her own perceived lack of knowledge:

> "I felt it's his kind of place, as you know, a guy to make that decision, because he's the one who's kind of grown up with that, so, if it was a girl, I would be more comfortable making that decision like that for her, but… Well like, I just - I guess I just don't know enough about what it's like to grow up, you know, circumcised or not circumcised, or all that stuff too. I - don't know what that's like."
>
> **"I would just let her do whatever she wants because she's having the baby."**

Interestingly, one male participant felt that the mother has "gender jurisdiction." Although Miles was leaning towards circumcising his son, he acknowledged that given the fact that his wife will be the one giving birth, he will ultimately defer to her judgement:

> "But, I pro -, I probably would just let her do whatever she wants (laughs) because she's going to be going through all that… like she's having the baby… I don't want her to worry about him you know, getting an infection or, or after the surgery, or um, or hurting, you know, she does - if she doesn't want him to go through that, then fair enough."

Form or Function?

Two participants (couple Aaron and Kelli) thoroughly discussed the importance of a perceived higher aesthetical value of the circumcised penis, while other participants expressed concern with the sexual function of circumcised penises.

"This world is based on looks."

Aaron and Kelli were the only participants to discuss the aesthetics of un/circumcised penises. This issue was particularly salient for Aaron, who revealed that he himself is circumcised. Aesthetics were so significant to him that he identified this as the sole reason for opting to circumcise his son. He explained having decided long before he knew he was having a boy that he would be circumcising any sons he had:

> "Um, to be blunt and candid like I said, I've got a, a - I've been with girls that have told me I have a nice looking penis and it just seems, seems normal. I want my kid to be older and not have girls be turned off by the way he looks."

Aaron further elaborated on what he meant by 'nice looking penis': "Just the way it looks, the appearance of the penis, circumcised compared to uncircumcised. Looks better circumcised than (uncircumcised)… this world is based on looks". His personal sexual experience provided his

evidence: “I’ve had girls tell me that I have a nice-looking penis”. When Aaron divulged that his friend opted to be circumcised as an adult, he presumed that it was based on being more appealing to the opposite sex: “Well I think he just - probably his woman wanted him to do it more. Um, to me it just, it seems like what women want”. Aaron thought ahead to his son’s future and the potential (presumed heterosexual) sexual experiences of his son, and summarized his thoughts on the issue: “This is what it looks like. I want my son to grow up and be with a girl and her to be like, ‘Oh, you’ve got a nice-looking penis’”. Aaron believed that his high valuation of the aesthetics of the circumcised penis is not common: “I’m pretty sure 99% of other parents, well I don’t know, I can’t judge them, but probably are not basing their decision based on that”. However, he expected that others would also rely on personal sexual experiences when making this decision: “It’s got to be personal too. I mean if you grow up having an uncircumcised penis and you have twenty girls saying, ‘Oh, I prefer a circumcised penis’ or vice versa, you know, that’s going to affect your decision-making”.

Kelli, largely deferring to Aaron in this decision, reiterated that Aaron valued the aesthetics of the circumcised penis: “Um, he just says that he prefers it better, and he thinks his son will prefer it better when he’s his age, so he thinks he’ll be doing his son a favour I guess”. Kelli described her own personal preference: “I don’t know if it’s appropriate to say, but personally I prefer, uh, a non- er, a circumcised penis”, and that she thinks circumcised penises are “more pleasant in general… more pleasant uh, sensations”.

“Circumcised penises do become less sensitive.”

Some participants briefly discussed the subject of sexual function in regards to circumcision status. Miles stated, “To my understanding, from what I’ve heard, that it, I guess it, um, provides less stimulation during sex… if you – if you are (circumcised)”. He further

provided supplementary clarification that he didn't want to be thinking about his son's future sexual endeavours: "Not that I'm really thinking about that for him (laughs), or any time, right". Kelli identified a sexual preference for circumcised partners, stating that she has experienced "more pleasant sensations". Her fiancé Aaron also brought up the matter of sexual function, saying that he's "read that basically the... (circumcised) penis, they become less sensitive over time, because they don't have that protecting, um but it really does not… circumcised penises do become less sensitive, yes". But he went on to counter this concern, stating: "Um, I haven't experienced it, so you know I don't know whether I believe it or not and it's not going to affect my decision I don't think".

Social Norm or Outmoded Practice?

The study participants frequently commented on how cultural norms about circumcision are changing, and most participants expressed interest in this, speculating about the reasons why this might be. Participants also revealed how circumcision has become so standardized that for many people, it is an unquestioned norm. Male participants recalled initially believing that their own personal circumcision status (regardless of knowing or not that an actual procedure had or had not been performed on them) was universal.

"If that's the way you see your first penis, that's the way penises are."

Some participants, including females, assumed that the penis(es) they grew up with (whether their own or their sexual partners') were reflective of how all penises were. When discussing her own experiences with circumcision, Quinn recalled her first sexual experiences with circumcised male partners and how she assumed that was the way that all penises are:

> "My first sexual encounters were with circumcised boys and then subsequently had others with non, so, you know, at first, you're probably… like it's mostly like, you know,

the anatomy of the opposite sex is foreign to you in general and uh, so, if that's the way you see your first penis, that's the way penises are, and uh… but then if you see one that's not circumcised you're like, 'There's a totally different side to this situation.'"

Quinn described how this may have affected her overall thoughts about circumcision when she was younger, stating that "Maybe when I was younger I was like, 'Oh, circumcision for sure', but then because I hadn't seen the other kind…" she later reconsidered this position.

Likewise, Miles detailed his mistaken belief that circumcision was more common, based on his personal circumcised status:

"I used to think that a lot more people were. But I soon realized that a lot of people aren't. I remember my friend, my best friend growing up, he wasn't… and I don't know when I figured that out but I thought it was really weird as a child… I thought that was weird, and then of course you realize as you, as you get older what's going on."

Aaron revealed a similar experience growing up, not realizing that not everyone is circumcised: "Well, growing up I just assumed everybody was. I don't know, I just - just, it was normal to me. I guess probably in my teen years is when I probably found out it's not everybody". Throughout the interview, Aaron repeatedly communicated that being circumcised "just seems natural": "to me it's just what I know, it's just, I think… obviously, everybody's different, they all have their own choice. To me, it's the way it should be, it's just - it just seems normal to me". In fact, Aaron's belief in 'circumcised-as-normal' was so strong that he analogized foreskin to deformity. He disagreed with what he viewed as a societal trend toward a more natural lifestyle that included viewing the intact penis as the "way it's supposed to be":

"I don't necessarily agree with it, you know, if you have a big - born with a big bump on your hand that you get removed too why would you remove it, it's natural. Certain things are natural, and doesn't - not necessarily mean it's for the best."

Many participants referred to stigma as it relates to circumcision status. Quinn suggested that stigma accompanied uncircumcised penises/men when circumcision rates were higher:

"I think that at one time it was pretty common for everyone to be circumcised and it might have been… you might have been an outlier if you weren't, and that that might have caused some sort of stigma associated with it and made the child uncomfortable or feel different."

Miles speculated that since circumcision rates have declined so dramatically, his son might be more at risk of being the 'odd one out' if he were to be circumcised: "I guess that would also mean that less kids are going to be getting circumcised because it's - it's not free… which means that he might be singled out in a hockey shower or something (laughs)". However, when asked if the possibility of stigma due to circumcision status would be something he would consider in the decision-making process, Miles was confident that it would not, stating, "I tend to think that he's going to have a strong - a strong confidence, a strong personality. I hope that I instill that in him. That (being circumcised) won't make a difference".

"It just seems a little crazy, the more you start to think about it."

Some participants addressed the way that circumcision had evolved into standard cultural practice, and is (or rather, mostly, was) unquestioned and routinized. As Quinn stated:

"But everyone was circumcised, right, like, I was born in 1979, and I'm sure it was done as a matter of course in the hospital, with like one consent form and then it was done. Now you have to ask for it and pay for it and book it yourself and… totally a different

experience. As is birth, right? Like intervention was the norm back then, and I guess that this was just another piece of that."

Quinn described how circumcision as "matter of course" became an engrained, almost automatic procedure:

"I think that, um… when a procedure like that is popular, it's not just because… like I think that something that might start out as a religious rite of passage or something that's done out of some perceived medical advantage becomes common, and it's like you do it because everyone does it, and it's part of your… it's part of your… the cultural process of having your son, and having your baby, and you get your child circumcised, everyone does, and that's… what you do, and it's engrained, and people don't question it."

Further, Quinn suggested that the fact that it is no longer such an engrained cultural practice (including that there are more steps to be taken to have the procedure performed) has further reduced circumcision rates: "Maybe a generation ago it was a passive decision, or it was a non-decision because you were probably pressured by the medical industry at the hospital to do it, right"?

Correspondingly, Quinn's husband Noah described circumcision as engrained standard practice, and proposed that some people choose to circumcise because of this:

"I don't necessarily have any reasons not to circumcise; I just don't have any reasons to do it. And there are a lot of things that we kind of take for granted in uh, our culture and I'm sure it's the same in all cultures… things are just traditional and… I'm usually one to question those kind of things."

Rebecca also discussed how circumcision "Somehow got adopted more across the board" and became culturally embedded as a non-decision: "I guess now it is becoming more of a

decision thing whereas before they used to do it more, so, I'm learning that too, that it is more of a decision to make." She clarified this further with examples of how this has changed:

> "From what I hear (laughs), is back in the day it was just all done in the hospital right after the baby was born and it was something that they just did, and now it's something, um, that you have to go back to the hospital for, you have to pay for."

Rebecca went on to reveal that the more she thinks about circumcision, the odder she finds it as a standardized practice: "It is an interesting thing too, circumcision. I mean (laughs) you're cutting off part of a boy's penis, like it just seems a little crazy too, the more that you start to think about it." Her husband Miles also discussed how circumcision was formerly an almost automatic choice, saying that "doctors just used to do it when the child was born".

Quinn noted that there is "no social advantage" now to being circumcised, and explained further her belief that this was due to changing norms, and circumcision rates dropping. She recalled learning more about this in her prenatal class:

> "The instructor actually mentioned like, and I wasn't aware of this, she said, like, there's been a reversal of circumcision levels, so… you know, that's pretty extraordinary that now, whereas one time maybe even a generation ago I guess was… the majority of the boys were circumcised. Now it's just completely changed."

Later she referred again to this shift in norms and how her prenatal instructor pointed it out during class:

> "Basically she said, like, there's no medical benefit in terms of a social benefit, you know, just so you know… I don't remember the actual statistics, I think it was like 80% of boys are not being circumcised right now. I might be remembering that wrong. So, in

our country, in Canada, it was either a Canadian or North American statistic, so um, she was using facts to sort of say… this would influence your decision maybe."

Quinn expressed surprise and interest at how much circumcision rates have changed over the years, and she ventured some guesses about the root of the change:

"I think it's interesting that it's changed in one generation. Um… like, I wonder why that is. I really don't know why that is. Like, is it, the demedicalization of birth in general that's also sort of led to that? Is it the fact that there are more… like I don't think that it's part of Christian religion, and like in general I guess that we are like more secular than we've ever been and, um… I wonder how much of a role, the fact that you can't get it done for free anymore has to play, when people are suddenly like, the decision becomes an active one, right? …And I don't know - and I don't know whether it's the same in the U.S., you have to pay for everything there so… (laughs) I wonder if it's different. But yeah, that's definitely an interesting topic, how it's changed."

Rebecca also voiced surprise in learning that circumcision practice has changed and that a minority of boys are now being circumcised:

"Um, someone was telling me, I don't have any (laughs) facts to back this number up, that only twenty percent of babies are being circumcised now, so, um… that's a huge difference because, I mean, I think back in the day most men were getting - it was more unusual to not be circumcised than to be circumcised, so it's now becoming a decision… and I guess an ethical decision in some ways, people would say."

Her husband Miles suggested financial cost as one reason that circumcision rates are decreasing:

> "It used to be free I think, and now it's - it's expensive… I mean, and it's so, like expense is one thing, right, like who cares, but, but to me it's um… I guess that would also mean that less kids are going to be getting circumcised because it's - it's not free. It's like four hundred bucks or something like that."

Aaron also commented on shifting norms about circumcision, stating that "everybody – not everybody has it but everybody… most people as far as I know are circumcised but I think it's changing nowadays too". He saw this change as reflective of a larger societal movement toward people embracing a more "organic, natural" lifestyle: "This is another one of those natural things that, 'Why would you get it removed if that's the way, way it's supposed to be?'" He related this shift to the movement toward natural childbirth:

> "Yeah, same with natural childbirths. There's a hell of a lot more natural childbirth nowadays than there was. Well, back in the old days that's all they had, but since I was born, and in the eighties, and the nineties, it's becoming more natural, and everything's natural."

What do Expectant Parents Need?

All participants identified a variety of suggestions regarding what may be helpful for other expectant parents as they engage in this decision-making process, including the kinds of information that they should seek out and/or receive from applicable health care professionals, and offered advice for family, friends, and care professionals. Participants also considered the biased information they had received during their own decision-making process.

"Give them the information they need to make their own decisions."

Many participants believed that expectant parents should receive factual and detailed information about circumcision. Quinn suggested that those considering circumcision should

have a good "understanding of the procedure (and) recovery". Her husband Noah believed that 'knowledge is power':

> "Ultimately just, uh, giving people the ability and power to decide for themselves, whether that's by, um, forcing them to exercise their - the muscle of opinion, to a point where they're able to flex it at will, but also to give them the information they need to come to their own decisions."

He proposed that "written material in the form of some kind of clinical study if people were at all curious to read those types of publications would be beneficial".

Rebecca also advocated for learning as much as possible about circumcision, advising that parents should know:

> "Exactly what is entailed in the procedure, um, what are the risks versus the benefits of the procedure, um… I guess, like, 'cause that was the main thing, I mean for me I guess it is, it's a risk versus benefits thing, so I think that would be the main thing."

She also saw written material being a way to transmit this information, but specified being cautious of its source, recommending "government-type sites and stuff that actually have facts that have been researched", as well as "something like a pamphlet just because you know they're only going to give out factual information that you can go ahead and use".

Miles expressed that, personally, he desired information that was "black and white" that contained "no bullshit", but "just facts". He saw this as the antithesis of opinion pieces, stating: "I don't think I'm passionate enough about the subject to - to want to read anything that's passionate". In particular, he felt that the following information would be helpful for him and for others making the decision:

> "I just want to read what's the history behind it… behind why people do it, why people don't, what - what religions did it, what religions didn't, uh… is it cleaner, is it not cleaner, is there risk of infection either way, one way or the other… (and) does it provide less sexual stimulation."

He suggested making this information available as "a little pamphlet that was at the hospital", originating from a source "like a university or government". He wondered "if the government would even care to do that, or… I think they should put something out like that. I mean I'm sure there is, right? I'm sure there is. I've just not seen it".

Kelli also recommended that expectant parents obtain as much information as possible about the issue and recommended that care professionals, such as doctors and midwives, play a large role in dissemination:

> "Just sharing all the information they can. I find that helpful. Like if my first - if the first (midwife) I had talked to had shared more information about it, I probably would have been more decided on it at that point but uh, I just - yeah, as much information - I'm someone who likes to gather as much information as I can, just store it somewhere."

Kelli also found it useful to conduct her own research online, "about the information and what the procedure's like, and how to take care of it afterwards", and enjoyed blogs and question/answer websites such as 'Yahoo! Answers', where "there's people that ask questions on there, and lots of people who give their opinion on it too, which is helpful." Additionally, she mentioned finding written material such as "brochures or little pamphlets" helpful and recommended that the offices of care providers have these resources available.

Aaron, who was choosing to circumcise his son solely for aesthetic reasons, thought that "a nice video maybe showing them (prospective parents) some pictures of uncircumcised versus

circumcised (penises)" posted on-line would be helpful. He believed that care professionals should inform individuals of the applicable risks, "even though I don't know of any risks there are either way". He felt that care providers should say, "This is what it is, you know, this is - if you get him circumcised, this is what happens. If you don't, this is what happens, you know. Your choice."

"My lack of faith in humanity might be showing."

Interestingly, all participants described encountering bias from one or more sources, both in written information and from care providers. Quinn recalled that the topic of circumcision came up one day during her prenatal class, and that although the doula teaching the class "wasn't judgemental" and "didn't say you shouldn't do it or you should do it," and the doula had said, "I have a very strong opinion of this, and I'm going to try to keep my opinion out of it", it actually was quite "evident that her opinion was to not circumcise your child". While Quinn didn't personally take issue with this, as she stated agreeing with the doula's opinion, she acknowledged that this might be problematic for others:

> "I was on-side with her on most of what she taught, so that was fine for me, but if there was somebody who was Jewish or Muslim in the class, who wanted to circumcise their child… or, it was just not an option, it might have… she might have perceived it differently."

Quinn also perceived bias in the popular book, What to Expect When You're Expecting, which she noted "tells you you should circumcise your child (laughs), just like they tell you to have an epidural (laughs)."

Noah noted that health care providers can be biased by generational norms in place at the time they were trained:

"Everybody has their own backgrounds and their own, um, their own education even. Trying to teach an older doctor who was raised and taught that circumcision is very important for health reasons, um… they're an expert in their field, and, they have much, much more experience than the new doctors or the new, um, opinion-makers who are coming forth now with - with these new ideas of say, circumcision being, um, optional. Uh, but it's um… trying to cause the old schools of thought in any subject to align with the new schools of thought is probably next to impossible. 'Cause those young kids don't know what they're talking about, and those old guys don't know what they're talking about."

Noah also questioned the objectivity of research studies, suggesting that their results might be more reflective of the researcher's opinion than of objective facts:

"I'm sure there's been many, many studies, and uh, whether or not the studies were done um, legitimately, or whether they were just basically fabricated to push someone else's opinion, um, it's hard to say. And maybe the new facts that we're now basically taking for granted, um, maybe those have been just brought into being, so that somebody could further their career by coming up with an original idea. . . . My lack of faith in humanity might be showing (laughs)".

Rebecca described encountering bias in the advice of friends and family members, such as the anti-circumcision posts of her cousin on Facebook. While the opinions of friends and relatives has "kind of been influencing… here and there on - on what decision to make," she questioned whether they were objective: "You can read things on Facebook or talk to friends all you want, but I mean, are they looking up research, or are they really basing it on facts?"

Miles described feeling "like everybody's so biased":

> "One thing I've really noticed is that people, when they talk, they tend to be biased on - to whatever they are (un/circumcised)… I feel like everybody I talk to, it's - it's always been just whatever they are, that's how - how they go, that they're biased against it that way."

He also expressed mistrust of the information given by care providers, and perceived pro-circumcision bias from doctors:

> "I feel like if the doctor's male… I feel like maybe they'd be biased, if they even said anything, or if they didn't say anything at all, uh… I think doctors tend to be a little bit more old-fashioned in a way… I think they might lean towards it - you know, yeah, yeah, maybe, maybe towards getting it done."

Likewise, he suspected that any information received from midwives or doulas may reflect anti-circumcision bias:

> "I feel like a midwife or a doula, as much as we totally want to go that route, I feel like they would be a little bit more biased against it. I feel like that, and that's just because they tend to be a little bit more natural, in, in everything that they do. I don't know if that's correct or not."

Kelli described perceiving bias from her midwife when she asked questions about circumcision during a regular appointment:

> "We told her, we shared that with her (choosing to circumcise), and she's um… I don't know if it was just me being a little insecure about it, but she didn't seem fully for it… I had asked her, because I wanted information on where we do it and where, who, which doctor. I didn't know anything about that, so she - she gave me some brief information

and uh, she didn't give me much, and she didn't - she wasn't very… I don't know, she wasn't very specific."

Kelli hypothesized that the reason for the midwife's bias against circumcision bias is "maybe 'cause it's not totally necessary." At an appointment with a different midwife on her care team, she had a more positive experience; she "gave me all the information I needed and more".

Aaron reported not trusting information he's discovered on the Internet about circumcision, reading that "apparently there's procedures now to uncircumcise you, but again, Internet's not always right".

"I didn't realize that so few people were getting circumcised."

Most participants were interested in the recent change in cultural norms regarding circumcision and the decline in its incidence, and thought that it would be helpful for expectant parents to have this information. Quinn believed that providing this information will contribute to a further decline in incidence rates:

"Probably the demographics of how many people are actually getting it done these days (would be helpful). I think that maybe, looking like other people plays a large role in the decision when it's not a religious one, when it's just a social decision that's not to do with a religious rite… there might be like mis- like, I didn't realize that it was such… that it had changed. I didn't realize that so few people were getting circumcised - getting their children circumcised. I think that that piece of knowledge is… would go a long way to even reducing it further."

Rebecca was also intrigued with learning about the reduction in rates of the procedure, and felt this would be valuable information for other prospective parents to have, asking "Why is it changing that people are maybe not doing it so much now versus were doing it more in the

past?" Her husband Miles was similarly curious about this phenomenon, and stated that parents-to-be should be informed:

> "what are the percentages of children that are, are doing it, or not doing it, uh, what is the percentage of, of children that are getting it done whose parents are (circumcised), that would be kind of interesting to - to hear."

"It might be better for people to study things themselves and come to their own conclusions."

Some participants recommended that expectant parents conduct their own research. Quinn stated, "I don't think that the information is necessarily unavailable. I think that it's probably available if someone's making the decision and wants the information, but it might - you might just need to find it". Noah strongly recommended that individuals seek objective information:

> "The reading a bunch of um, articles on the internet, or um, or in magazines, or - or whatever, uh… I think to a certain extent people expect that if someone is in print, that their opinion is more valid than their own, but they're - they're the same as you and me. And whether or not they've come to their decisions based on study or just based on having a very forceful opinion is sometimes really difficult to determine, so um, it might be better for people to study things themselves and come to their own conclusions."

"Always be supportive of the parent's decision."

Participants expressed frustration at the bias they had encountered and strongly recommended that anyone discussing the decision with expectant parents – including care providers, friends, and family members – reserve their judgement. According to Quinn, family members and friends "should be helpful by being non-judgmental":

> "I have had friends who have circumcised their kids and I've been like, 'Ugh! Uh, okay, move on' (laughs) because they did it, it's done, what's the point in me having a different opinion and voicing it? It's not up to me, so…"

Likewise, her husband Noah advised that "people can be helpful by um, reserving their opinions for their own decision-making, and um, presenting facts when it's up to somebody else".

Rebecca felt fortunate that she would be supported no matter what decision she and Miles made regarding circumcision for their son:

> "Within our family I know both our parents, um, and our siblings would all support us on whatever our decision is, so um, we're not worried about that at all, or them being upset, or anything like that, so… which is nice, too, to know that , yeah, we don't have the pressure from them coming at all so it's good."

She described hoping that the friends and family of other prospective parents would be equally supportive and advised individuals to reserve their judgment:

> "Knowing other people's experiences is nice but um, I think it is a very personal decision for the parents to make, um… so I think as long as - I think you should always be supportive of the parent's decision on what they want to make. It's fun - fair if you want to give your opinion in there but, um, not chastising them if they make a decision maybe that you wouldn't make."

Kelli suggested that health professionals "explain it (circumcision) to you without being for or against it".

CHAPTER FOUR

Discussion & Conclusion

Discussion

The overall purpose of this study was to explore the decision-making process of expectant parents who were deciding whether to have their sons circumcised soon after birth. The study sought to address two research questions: 1) What are expectant parents' beliefs and attitudes concerning, and previous experiences with, male circumcision as well as of the penis as circumcised and/or intact?; and 2) Do expectant parents' beliefs and attitudes shape the process of deciding whether to circumcise an infant son, and if so, how? Through in-depth interviews, participants revealed their own experiences concerning circumcision, including disclosing their own (or their current and previous partners' as applicable) circumcision status and how this contributed to their beliefs. All participants articulated their thoughts on the procedure, and discussed how their beliefs and attitudes have impacted upon the decision-making process.

Relating Findings to the Theoretical Framework

This study addressed a largely unexplored area of sociological theories of embodiment, especially with respect to Connell's theory of body-reflexive practice and how "the physical sense of maleness and femaleness is central to the cultural interpretation of gender" (2000, p. 52). The findings largely supported these theories, particularly Connell's view of gendered identity through the lived experience of the body. Framing the findings within Merleau-Ponty's phenomenological work on bodies – "We are in the world through our body, and… we perceive that world within our body" (Merleau-Ponty, 1962, p. 206) – was especially helpful in analyzing the interviews with the three male participants, who discussed their personal lived experiences of being intact/circumcised and how they took their own status into account in some form during

the decision-making process. For example, Noah felt that his own intact status had never presented him with any difficulties in function and everyday life, leading him to the conclusion that there would similarly be no reason for his son to undergo the procedure. Interestingly, his partner Quinn speculated that had Noah been circumcised, she believed that he might have chosen the same for his son.

Aaron placed a high priority on bodily experience in the decision-making process in a way that supported Connell's theory of body-reflexive practice and his emphasis on the body as a means through which gender identity is formed. The high value Aaron placed on aesthetics and his personal perception of his circumcised penis as pleasing aesthetically to his current and past sexual partners was his primary reason for wanting his son to be circumcised. He relied so completely on his own bodily experience of being circumcised that it seemed to prevent him from examining the issue from other angles. Although Aaron briefly acknowledged that overall, circumcised penises may be less sensitive sexually than uncircumcised penises, he decided that because he had not personally experienced a decline in sensitivity, this would not affect his decision. As Connell has postulated, Aaron's sense of self and of being in the world was strongly connected to his physical sense of maleness and his perception of the superiority of his "nice looking penis."

> The physical sense of maleness and femaleness is central to the cultural interpretation of gender. Masculine gender is (among other things) a certain feel to the skin, certain muscular shapes and tensions, certain postures and ways of moving, certain possibilities in sex. Bodily experience is often central in memories of our own lives, and thus in our understanding of who and what we are. (p. 52-53)

Following Connell's conceptualization of body-reflexive practice, Monaghan's (2002) descriptions of a hierarchy of masculinities made particular sense for Aaron's lived experience. Monaghan detailed a "plurality of masculinities *and* intra-gender relations that effectively include and exclude different kinds of masculinity… hierarchies exist between men embodying superordinate and subordinate masculinities and the body is the primary vehicle in negotiating this perilous landscape" (p. 340). Aaron believed that possessing a circumcised penis bestowed a superordinate masculinity that posits circumcised men as more attractive to, and thus successful with, the opposite sex in presumed heterosexual relations. Aaron repeatedly remarked that the circumcised penis looked better, and that uncircumcised penises would 'turn off' women sexually, analogizing the foreskin to ugly deformity. Aaron prided himself on embodying this superior masculinity, and described the multiple compliments he received by sexual partners on the aesthetic value of his circumcised penis. Aaron's perspective supports Richter's (2006) view of circumcision as a historically body-modifying procedure designed to:

> exaggerate the visual difference between male and female. Reducing the ambiguity and untidiness of the penis turns it into a neat phallus more specifically fitted for what is seen as its purpose in a gendered sexual culture focused on coitus. (p. 248)

'Focused on coitus' is certainly an apt description of the direction that Aaron's decision-making process took, dominating the interview and taking precedence over all other potential concerns. It is noteworthy that this perspective even overrode the fact that his partner was grappling with the decision.

Interestingly, while Miles recognized how his own bodily experience of being circumcised contributed to his strong impulse to have his son circumcised, he felt embarrassed that that should be a consideration at all – for himself or for others. He articulated that most men

probably put a lot of weight into whether they themselves are circumcised, but believed that it should not be a factor in the decision-making process. In her work on masculinities, R.W. Connell (2005) might account for this. Connell asserts that while the body is "inescapable in the construction of masculinity… what is inescapable is not fixed. The bodily process, entering into the social process, becomes part of history (both personal and collective) and a possible object of politics" (p. 56). Further, Connell describes a modern movement of men "who have attempted to reform their masculinity, in part because of feminist criticism" (p. 120). This involves a 'moment of separation', where men choose to "separate themselves from the mainstream masculinity with which they were familiar, and to reconstruct personality to produce a new, non-sexist self" (p. 130). It is entirely possible that Miles' embarrassment of his own instinct (as well as embarrassment on behalf of men in similar situations in society overall) reflects this attempt to reject this component of mainstream masculinity.

In the interviews, the participants who articulated the desire for their sons to 'match' the un/circumcised status of the father also stated that 'family tradition' was not important to them in making their decision. It is interesting that this incongruence was not annotated by any individual. Although those interviewed suggested this is a 'personal decision' for parents, it is important to note that this personal decision does not exist within a vacuum. The desire to continue the trend of 'matching', or to 'look like Dad' – regardless of whether this is seen as continuing a family tradition – connects to the importance of sense of belonging, as mentioned earlier above concerning relevant literature. This sense of belonging to the father also means belonging to larger cultural groups and practices/norms, as personal decisions are always embedded within a larger system of social practices. It is worth mentioning that in this study participants did not go into depth regarding this significance.

Some participants discussed how they had first learned of the procedure or that there were both circumcised and uncircumcised penises in general. Male participants specifically remembered thinking that the bodies they had grown up with were reflective of every male body out there (i.e., that being circumcised or uncircumcised was not just the norm, but that it was standard). Likewise, female participants recalled that the intact/circumcised status of their first male sexual partner determined how they believed all penises were. These early beliefs support Merleau-Ponty's theorizing of embodiment. As Crossley (1995b) points out, "our body is our way of being-in-the-world, of experiencing and belonging to the world. It is our point of view on the world" (p. 48). It was clear that participants experienced and perceived their world through their lived bodily experiences, and/or through their experience in sexual relationships with other embodied subjects.

Intriguingly, all female participants felt that their lack of the lived bodily experience of possessing a circumcised or uncircumcised penis meant that they would need to defer to their respective male partners to make the decision – or, in the very least, it was their initial instinct that their partners had 'gender jurisdiction' over the decision. Whether they truly agreed with the assessment or not, it was a primary instinct when considering the decision. This is accounted for by Connell in her view of gender "as a way in which social practice is ordered. In gender processes, the everyday conduct of life is organised in relation to a reproductive arena, defined by the bodily structures and processes of human reproduction" (1994, p. 14). Connell emphasizes in her theorizing that bodies *do* matter – "their materiality (including material capacities to engender, to give birth, to give milk, to menstruate, to open, to penetrate, to ejaculate) is not erased" (p. 14). Following this, correspondingly what bodies *cannot* do, or what they cannot be, also matter. Connell argues that gender relations are formed in part by the

engagement of the materiality of bodies in social practice. This in turn establishes and reinforces positions of power between and across genders. Connell's conceptualizing is supported by the present finding that female participants felt that their male partners had inherently more power in this decision. The fact that these women identified this as their instinct, yet also articulated disregarding it on an intellectual basis, connects well with Goffman's approach to embodiment, which describes that "social meanings which are attached to particular bodily forms and performances tend to become internalized and exert a powerful influence on an individual's sense of self and feelings of inner worth" (Shilling, 2003, p. 83). While this concept of male 'gender jurisdiction' was not allocated importance by the participants to their own self-worth, this theorizing certainly could account for their feelings of worth in this decision-making process.

Relating Findings to the Literature Review

Many of the factors that participants considered in their decision-making echoed the literature on circumcision. Most individuals discussed recent history of the procedure and how circumcision was a "non-decision" for many families – it was just something that was done at the time. Participants discussed changing norms and speculated upon reasons why the trend to circumcise had changed, speculating that increased cost might be one reason. Some related the downward trend of circumcision rates to the beginning of demedicalization of birth and a movement toward embracing 'more natural' parenting practices.

Participants' beliefs about the procedure, as well as of the penis as circumcised or intact, were strongly interwoven into their decision-making. Some participants, such as Miles, Rebecca and Kelli, believed that the circumcised penis was more hygienic and less prone to infections –

even though they recognized that this belief was not based on facts or research they had encountered. In fact, they indicated that they were unsure if this was truly the case.

Participants outlined many of the concerns researched in the dominant 'risks versus benefits' literature to a large degree, including risk of infection such as the worry about increased likelihood of STIs and phimosis, and a medically-based need to get circumcised later in life as an adult, as well as the surgical risks that can potentially accompany any surgery of the body. Participants highlighted their concerns about their prospective sons being in pain during and after the procedure, and how this could potentially interfere with the ease and enjoyment of their time with their newborns in the immediate post-partum period.

Discussions about the sex and gender aspects of circumcision featured prominently in interviews with participants. While participants did not directly analogize the foreskin to unclean feminized flesh exemplifying what Judith Butler calls "bodily permeabilities unsanctioned by the hegemonic order" (1993, p. 168), Aaron did analogize the foreskin to deformity.

Participants' desires to have their child's genitalia match that of their fathers also reflected findings in the existing literature. Individuals stated the common assertion and almost automatic belief that, as Rebecca stated, "If the dad is circumcised, you circumcise the baby". While some found themselves in conflict with this position, all acknowledged the power and weight this belief carried for them in the decision-making process. Although research in this area is limited in depth due to close-ended, quantitative responses, the desire to 'look like dad' was a primary identified reason for choosing to circumcise or not circumcise (Adler, Ottaway, & Gould, 2001).

The 'locker room defense' (Van Howe, 1997), or parental concern of their sons fitting in with peers (Oh et al., 2002) and "wanting him not to look different" (Brown & Brown, 1987, p. 216) was also found in this study. Miles expressed concern that the reversal of circumcision rates in recent years will mean that if he chooses to circumcise, his son may well be the one who does not 'fit in' and that he "might be singled out in a hockey shower or something".

Quinn and Noah approached the issue from a higher set of values. They placed the issue within the context of human evolution: if the body is born with foreskin, there must be an evolutionarily-sound reason for that to occur. They saw the procedure as a mutilating one, changing the body from something that is not, as Noah stated, "true to the species". They also addressed the issue from the child's perspective, and were the only participants to do so. They felt that the decision was not up to them – it was up to their son to decide whether circumcision is the right choice for him. Noah indirectly placed the issue within a human rights context by stating that whether research shows circumcision to be advantageous or detrimental is ultimately irrelevant – "How do you present the baby with the facts so that they can make a decision?" He viewed the child as having agency and the right to exercise it at a time when he can weigh the evidence himself. He also referred to the fact that "some cultures circumcise women um, specifically, to remove their ability to enjoy sex, uh, because it's immoral, and uh… that would be what I would call gruesome".

An important finding of the present study was that expectant parents do not trust professional advice regarding circumcision to be objective. In a recent US study, 18% of a sample of new mothers who were undecided about whether to circumcise felt that physicians and/or nurses were biased, with the majority perceived to have pro-circumcision leanings. The present study revealed an even stronger parental perception of bias among healthcare providers -

all who participated in the present study believed that health care professionals, including physicians, midwives, and doulas are biased, either for or against circumcision. They also perceived written professional information about the procedure to be biased. This is a significant finding, as it suggests that expectant parents mistrust professionals with regard to this issue and, therefore, may dismiss useful information.

Although these findings support previous (limited and quantitative) research on the decision-making process for neonatal circumcision, they also go beyond it. Overall, parents are indeed making the decision based on reasons other than health benefits/risks – i.e. personal and partners' experiences, family members' and friends' experiences, attitudes and beliefs about circumcision and the intact/circumcised penis, etc. This study was able to look into these reasons with greater depth and analysis than previous literature has due to the study's qualitative methodology.

Strengths and Limitations of the Current Study

The present study has several strengths. While previous studies have briefly surveyed parents about the reasons they chose to circumcise (and, in one instance, why they opted not to circumcise), no other study has reflected the depth and complexity of this decision for prospective parents. Additionally, all previous studies have been quantitative – which, while useful, are unable to provide insight into the meaning of the process for parents.

This study also has limitations that need to be considered in drawing conclusions from its findings. First, although a small sample size is warranted for studies utilizing interpretative phenomenological analysis (Smith & Osborn, 2008), it is important to note that the findings from this study cannot be generalized to the population as a whole.

An effort was made to recruit participants from a variety of socioeconomic and cultural backgrounds through recruitment posters and presentations in several prenatal education sites/classes, including private sector businesses and publicly funded health offices. However, only three sites (two birth doula collectives and one family centre run by a registered nurse) responded and were willing to display posters and/or invite presentations. All study participants had attended prenatal education classes delivered by these organizations for a fee. Also, most participants had completed university degrees (two had Masters degrees), and most were employed professionals. Additionally, all participants were in long-term heterosexual relationships and ranged in age from 22 to 36 years. Five participants self-identified as Caucasian, while one male identified his ethnicity as "English Canadian." No participants identified strongly with any particular religion. Therefore, this group of participants was not representative of the city's diverse social-economic range. Some participants sensed a bias from their prenatal instructors, particularly doulas, who they viewed as being more supportive of 'natural' parenting practices. While participants were aware of this, it might have impacted their own opinions on circumcision. Although the researcher did not reveal her personal views about circumcision participants may have attempted to answer in a way they thought would please the researcher. Self-selection bias may also have occurred; those who chose to participate may have been those who are more comfortable speaking about this potentially sensitive subject matter. Finally, the reliability of the researcher's interpretations of the interviews was not assessed.

Directions for Future Research

Future research in this area is clearly warranted. The circumcision decision may affect every prospective parent expecting a boy to some degree, and while a plethora of research exists concerning risks versus benefits of the procedure, there is a substantive lack of qualitative

research into the process of decision-making and factors they involve for those faced with the choice whether to circumcise.

Several findings from this study can be explored in greater depth with further research. The issue of sons growing up with genitalia not matching that of their fathers was a theme seen throughout participant responses, ranging from agreement that this is a significant issue, to disagreement and methods of coping with this difference from father to son. An interesting question for further research might be to ask whether sons who do grow up with a different un/circumcised status from their fathers view it as an issue. Similarly, how do parents handle this matter of difference with the child – if it is explained, how so? It might be interesting to study this issue in particular with families with multiple sons, especially if different decisions have been made for each child, and to inquire as to why the decision has changed and how this is addressed with the children. Returning to the issue of belonging, or the importance of sense of belonging, future research should make an effort to examine more thoroughly how belonging is affiliated with certain religious or social groups. This was not explored with depth given the confines of the present study.

Congruent with earlier documented literature, it seems apparent that many boys do not grow up knowing that they are un/circumcised – a proportion seem to believe that their penis is representational of the way all penises are, until a friendship with a male peer proves otherwise through conversation or exploration. Future research might address this discovery amongst male children or adolescents and how peer relationships are affected by this, and the results of this discovery – i.e., what did the child feel about the procedure or difference once learned? At the point of discovery, do children engage with their parents about the decision that they had made?

The concept of "gender jurisdiction", as presented by female participants in this study, is fascinating and deserves further scholarly attention. Are there other issues that spouses designate as gendered, where one partner is automatically attributed more decision-making power with the couple's children? How do same-sex and same-gender couples approach these issues of "gender jurisdiction", including circumcision? Are there generational differences or a shift in attitudes about the significance or relevance of this "gender jurisdiction"? All are worthy research questions to be considered.

Implications for Practice

This study's findings may be useful to a wide range of health care providers and professionals involved in pregnancy, birth, and postnatal care – including obstetricians, surgeons, family physicians, paediatricians, midwives, nurses, and doulas – as they all support families facing the circumcision decision. As all participants described bias they had encountered during this process, health care professionals need to be aware of how their personal opinions on the subject, whether explicitly stated or implicitly conveyed, may affect expectant parents' trust in their care providers. Additionally, it is important that these professionals recognize the perceived bias that simply being employed in their field may carry– such as the perception that medical professionals like obstetricians may lean towards advocating for circumcision, while doulas and midwives may oppose it in favour of 'more natural' birthing and parenting practices. Finally, reading about the experience of others may be helpful to other prospective parents who are facing this decision.

Conclusion

The present findings demonstrate that expectant parents base their decisions not on the risk-versus-benefit approach that dominates research on circumcision, but on personal factors.

Many rely on their own past experiences, as well as those of their partners and others close to them, along with their overall beliefs and attitudes about circumcision and their perception of the penis as circumcised and uncircumcised. This study revealed how complex the process is for those who are considering it for the first time. Most participants made an effort to consult their partners, although the cosmetic importance of circumcision was so significant to one participant that it did not allow any room to validate his partner's thoughts on the subject. Some participants' beliefs reflected commonly-held assertions such as that the uncircumcised penis is somehow less hygienic and uglier than its circumcised counterpart. Others connected to their beliefs in nature and human evolution – i.e., that the body can clean itself and that boys are born with foreskins for a biological reason. Participants also considered who has the right to make the decision – is it up to the child, the parents, or family tradition? A key theme underlying the decision-making process was that of bodily experience; female participants often felt that their male partner had more authority on the issue, although some disagreed with this assertion on an intellectual level. This study revealed the importance of previous experiences with un/circumcised penises – "if that's the way you see your first penis, that's the way penises are" - in shaping opinions about the procedure. All participants perceived bias from healthcare providers and birthing professionals and they strongly requested a greater quantity and depth of information from all sources of those involved in the pregnancy and birthing experience.

Considering the highly personal nature of this decision-making process and the degree to which some individuals may struggle with this complex and confusing decision, qualitative research is essential to understanding the lived experience relating to this phenomenon. This study is not exhaustive or conclusive to the decision-making process, but it can be used as a starting point from where future research can begin. In order to best help prospective parents as

they engage in what can be a difficult decision for them and their families, deeper understanding of this process is required.

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Appendices

Appendix A: Recruitment Poster

Appendix B: Interview Guide

1. Please tell me about what the decision-making experience has been like for you about whether to circumcise your son.
   - Possible probes:
     - When did you first begin to think about the question of whether to circumcise?
     - What are some of the issues that you have considered?

2. Have you involved anyone else in your decision-making?
   - Possible probes:
     - Who have you talked with about it?
     - What do you think about their advice/opinion?

3. How important have your own experiences with circumcision been to your decision-making?
   - Possible probes:
     - How did you first learn of the procedure?
     - How important have your spouse's and family members' experiences with circumcision been to your decision-making?

4. Have you reached a final decision about whether to circumcise your son?
   - Possible probes if yes:
     - What is your decision?
     - What mattered most to you in making the decision?
     - How comfortable are you with your decision?
     - Do others in your life support your decision?

5. What do you think would be helpful for other parents who are making this decision?
   - Possible probes:
     - Would written material (news articles, Internet searches, books, etc.) be helpful?
     - How could doctors, midwives, doulas, nurses, etc. be helpful?
     - How could family members, spouses, and friends be helpful?

6. This concludes our interview. Is there anything you would like to add about your thoughts about circumcision or about the decision-making process?

Appendix C: Consent Form

UNIVERSITY OF MANITOBA

Faculty of Human Ecology
Family Social Sciences

Winnipeg, Manitoba
Canada R3T 2N2

Letter of Consent

Research Project Title: Making the Cut: A Phenomenological Study of the Parental Decision-Making Process for Neonatal Circumcision

Researcher: Kendra Monk
M.Sc. Candidate, Department of Family Social Sciences
University of Manitoba

Background:

1. I am a graduate student doing a study to explore how parents who are expecting boys make the decision about whether to circumcise their new sons.
2. I invite you to join this study.
3. Joining the study is up to you. If you join, you can choose not to answer certain questions. Or you can join now and quit later.

What you will be asked to do:

1. If you say yes, you will be interviewed by me (the researcher) for about 30-60 minutes.
2. Your answers will give information about your background, your thoughts about circumcision, and how you are making the decision about whether to circumcise.
3. The interview will be audio recorded.
4. After the interview, I will give you a $25 gift certificate to Babies R Us as a thank you for your time.

Your privacy:

1. Your prenatal instructor(s) and other staff will not know you joined this study.
2. Your name will not be on any of my notes or labeled on audio recordings, so no one will be able to tell which answers are yours.
3. All notes and other data will be kept in a locked filing cabinet that only I have access to.
4. When I have completed all of the requirements for my Master's degree, all data will be destroyed.
5. If my results are published, no names will be used in the reports.

Your rights:

1. This study has been approved by the University of Manitoba Joint-Faculty Research Ethics Committee.
2. If you join the study, all of your legal rights will be respected.
3. If you would like information about circumcision, I have a resource sheet I can give you at the end of the interview.

Who to contact:

1. If you have any questions at any time during the study, you should feel free to ask.
2. You can contact me at (phone number removed) or (email address removed).
3. You can also contact my advisor, Dr. Joan Durrant, at (phone number removed) or (email address removed).
4. If you want to talk to someone else, please contact the Human Ethics Secretariat at (phone number removed) or (email address removed).

Giving your consent:

- If you agree to take part in the study, and if you understand what you will be asked to do, please sign below on the first line.

_____

Participant's Signature Date

_____

Researcher's Signature Date

Appendix D: Resource Sheet

Manitoba-based Internet Resources

- http://www.docsmb.org/advocacy-services/billing/surgical-procedures-and-services/56-neonatal-circumcision-insured-or-uninsured
    - "Neonatal Circumcision – Insured or Uninsured?", produced by Doctors Manitoba, updated May 2012. Information about Manitoba health insurance for neonatal circumcision.
- http://www.manitobaparentzone.ca/pregnancy/preparation-and-learning/index.html#circumcision
    - "Circumcision", produced by ManitobaParentZone. Contains handouts concerning risks and benefits of the procedure, facts about newborn circumcision, and how to care for a baby after a circumcision.

General Internet Resources

- http://familymidwiferycare.ca/wp-content/uploads/2010/06/circumcision-handout-for-parents-2010.pdf
    - "Circumcision: Information for parents", produced by Family Midwifery Care of Guelph, 2010. Handout for parents that compares medical risks and benefits and contains care instructions for both the circumcised and uncircumcised penis
- http://www.racp.edu.au/index.cfm?objectid=7424E1CD-0C3B-2516-C2EC3ACB1099A79A
    - "Circumcision: A guide for parents", produced by The Royal Australasian College of Physicians, revised February 2012. Explains function of the foreskin, and facts, figures, risks, and benefits about circumcision.

Health Organization Position Statements, Reports, & Other Information

- http://pediatrics.aappublications.org/content/early/2012/08/22/peds.2012-1989
    - "Circumcision policy statement" from the American Academy of Pediatrics, released August 27, 2012
- http://www.caringforkids.cps.ca/handouts/circumcision
    - "Circumcision: Information for parents" by the Canadian Paediatric Society, last updated November 2004
- https://www.cpsbc.ca/files/u6/Circumcision-Infant-Male.pdf
    - "Circumcision (Infant Male)", produced by the College of Physicians and Surgeons of British Columbia, 2009
- http://bma.org.uk/-/media/Files/PDFs/Practical%20advice%20at%20work/Ethics/Circumcision.pdf
    - "The Law and Ethics of Male Circumcision", produced by the British Medical Association, 2006
- http://www.racp.edu.au/index.cfm?objectid=65118B16-F145-8B74-236C86100E4E3E8E
    - "Circumcision of Infant Males", produced by The Royal Australasian College of Physicians, 2010