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“Fitting In and Getting Off: Elective Adult Male Circumcision in the United States”
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A majority of men in the United States are circumcised, although it is not a large majority; the best estimate for a national average from the National Center for Health Statistics is 65%, although this number varies geographically (National Center for Health Statistics 2005). This number only counts those individuals circumcised as infants. Thousands of men seek elective genital surgery every year, some for a first circumcision, and others for revision or adjustment of an earlier circumcision. This vague number is a conservative estimate, based on the limited available data about rates of adult circumcision. Between 1995 and 2000 one clinic in a southern U.S. town of approximately 50,000 performed over one hundred adult circumcisions (Fink et al 2002). Reliable national statistics are not readily available, but from what little data is available, a highly speculative range from several hundred to a couple thousand men annually is not unreasonable.

This paper is the preliminary report of findings from an ongoing ethnographic survey of adult men in the United States who elect circumcision for themselves. This is a medical anthropological project, which is to say that there is a focus on the collection and analysis of qualitative data, and it is concerned generally with the interaction between the medical system and social and cultural values, with a particular focus on relations of

power. There are several reasons why this is an important line of inquiry. First of all, the current medical and social scientific literature on adult circumcision is limited at best. Second, scholarly attention to male circumcision in Europe and North America tends to focus exclusively on infant circumcision, and while adult and infant circumcision are fundamentally different practices in certain respects, they are closely related in other respects. Third, and most importantly for medical anthropology, adult circumcision represents an intersection of social and cultural values and medical practice played out on the bodies of individual men. This intersection of embodied experience, bodily praxis, the individual, society, and medical practice bring into focus several of the primary concerns of medical social science in one practice.

In this paper I do not directly address any of the issues raised by infant circumcision in the United States. In my view, the issues raised by infant circumcision are fundamentally about the individual right to bodily self-determination. I personally see no issues raised by the practice of adult elective circumcision that are not raised generally by any other adult, elective aesthetic surgery, and I see no direct connection to any of the issues that make infant circumcision a problematic practice from a rights perspective. As such, I want to make clear at the outset that my goals in this paper are to understand what motivates some men to undertake this particular surgery, and to give voice to their experience; my goal is not to challenge their justifications or anything about the practice itself, and I am not passing judgment on their choices. I am seeking to understand what is important to the people making the choices, and how that motivates them to make the choices that they do. I am not opposed to circumcision in and of itself, and I take no issue personally or professionally with elective body modifications of any

kind. From my way of thinking, the problems with infant circumcision have to do with rights and consent rather than anything about circumcision itself. So I have no issue with men who elect this procedure as adults. And I feel a responsibility to the men who volunteered to participate in this research, a responsibility to make sure that their voices come through in my reporting in such a way that accurately represents their motivations and experiences.

When we talk about adult circumcision, we are talking about things that actual living people in the world have done and we are talking about experiences that other people have undergone. I see two fundamentally different ways of talking about elective circumcision: we can talk about it in terms that the men whose lives we're discussing would recognize and relate to, or we can talk about in terms that the men themselves might not recognize as describing their experience. I take the first approach, and as such, my analysis is always grounded in the words of the men themselves. The most important window through which we have to look is provided by the stories that the men themselves tell. This is part of what distinguishes an anthropological approach. With all of this in mind, you will not ever hear me describe these men as deviant, nor bearing a false consciousness about the nature of circumcision or its effects, although their choices may indeed be transgressive by certain social standards.

I want to quickly talk about my sample and my methodology, and then I'll outline some of my preliminary findings and discuss their relevance. I have collected a terrific amount of data, and this paper represents just the first preliminary report of my findings, because the data collection and analysis is ongoing. For this research I focus exclusively on non-religious circumcision because U.S. Americans have their own social tradition of

circumcision, and I am not convinced of the utility of including unrelated practices together in an analysis of meaning and cultural value; while they all have a modification of the genitals in common, they are motivated by different ideas about what is appropriate, and why.

Although I have had over forty volunteers thus far, the data for this paper was drawn from a group of fifteen respondents. My data was collected from live ethnographic interviews conducted in person, or over the telephone, or using an internet based instant messaging program. In every case, the interviews were recorded or transcribed. Participants were solicited from an internet discussion group dedicated to adult circumcision and also by referral, and informed consent was obtained from all participants, in accordance with the research design approved by the Institutional Review Board of American University. My survey is by no means exhaustive. My survey does not aim to be statistically representative, in part because it is impossible to know with any degree of certainty the total population of men electing circumcision. With a purposive sample this size any statistical correlations between demographic variables like age or income, and why an individual chose circumcision would not only be restricted to the sample itself, it could potentially distract attention from the real significance of this project, which is the focus on the meanings and motivations of the men themselves.

Accordingly, my methodology is based on qualitative data collection and analysis, using grounded theory and established techniques of narrative analysis. While I do collect some quantitative information, I largely eschew quantitative data analysis in favor of narrative analysis. Why do I shun statistical modeling of my data? Because modeling the mathematical relationships between various aspects of my participants' behavior and

their identity doesn't really tell us much about the actual lived experience of any given individual in that group. Let me use an example from another study to make this point.

Collins et al conducted pre- and post- op surveys of men being circumcised as adults and reported their findings in the Journal of Urology in 2002. They found no statistically significant difference in pre- and post-operative sexual function in their sample of fifteen men. But what does that really tell us? Let's look closer at their data. Participant one in the Collins study reported the same level of sexual satisfaction both before and after his circumcision: in both cases he chose "neutral or mixed" level of overall satisfaction from the four choices available. Participant ten also reported a "neutral or mixed" level of satisfaction both before and after his circumcision. So far, so good. No change in level of sexual satisfaction reported from these two participants, this is consistent with the overall findings. If we look at the other responses of these two participants, however, something interesting emerges: participant one reported lower levels of sexual satisfaction for every specific item on the survey. Participant ten reported the same or higher levels of satisfaction for every specific item on the survey. So here we have two men, both circumcised as adults. For neither man did circumcision appear to change their overall level of satisfaction, but one man clearly has experienced negative sexual effects, and another man clearly experienced positive sexual effects. If everything about sex is worse for someone, what good is it to lose that detail in the overall big statistical picture? Not much, in my opinion. Likewise, if everything about sex is better for someone, how well is that reflected in a finding of no statistical significance? Using mathematics to try and extrapolate general conclusions from a series of highly individual, subjective experiences is, in my opinion, a dubious undertaking

when it comes to things like sexual satisfaction and bodily self-image, hence my insistence on qualitative data. Last point on methodology, the questions I use in my interviews and surveys are all open ended; no multiple choice, no scales of one to five. The few surveys reported in the medical literature have relied primarily on multiple choice questionnaires. The written version of my paper goes into quite a bit more depth on methodology, but for now let's get into my findings.

The history of American circumcision's transformation from a nineteenth-century medical treatment to a twentieth and twenty-first century social practice is well known to most of you here. While the justifications are no longer exclusively medical, the procedure itself remains medicalized, insofar as it is performed by medical professionals, excepting those cases when a particular religious practitioner is required to fulfill religious requirements. A similar state of affairs is current in most cases of adult circumcision, insofar as the procedure is primarily performed by doctors, even when there is no clear condition to be treated. This moves adult circumcision into the realm of other elective, aesthetic surgeries, which are commonly performed in the United States.

Male circumcision is widely considered to be a social norm in the United States (Waldek 2003:458-459), however, the complex composition of U.S. society calls into question the validity of applying a concept like social norm theory to a population as large and heterogeneous as that of the United States. Even within an apparently homogeneous group, such as those men electing circumcision for themselves as adults, there is a good deal of variability in both the characteristics of the men themselves, and in their motivation for and experience of being circumcised as adults. The title of my paper, "Fitting In and Getting Off," refers to two major themes that appear throughout the

narratives of my informants. These two categories are not mutually exclusive, of course, and it appears that very often, fitting in is an important part of getting off. That is to say, that social conformity and the self-confidence and comfort that come from perceiving oneself as normal or ordinary is, for many men, an important component of successful sexual relationships. We can think of these two broad themes as existing together on a continuum; on one end of the continuum are men for whom getting circumcised is primarily a social conformity thing and on the other end of the continuum are men for whom it is related primarily to their sexuality. It is important to note that based on my analysis no one appears to occupy either extreme of this continuum exclusively; that is to say that adult circumcision never appears completely dissociated from either sexuality or social relations, but always incorporates aspects of each. And these two factors co-exist with several others in many of the men.

Individual experiences vary quite widely. For example, among my respondents were several British men. Two of these men, let's call them Peter and Greg, are within a year of age, both are in their early fifties at the time I communicated with them. Both have similar levels of education, and are married, straight men. Both their fathers were circumcised, but when they were each born, circumcision was not available through the British National Health Service. Peter started thinking about circumcision when he was in his mid-twenties, and at age 49 decided for sure he would do it, having the operation at age 50. Greg, on the other hand, never thought about it until he was diagnosed with balanitis xerotica obliterans (BXO), following a year of painful and troublesome symptoms that responded poorly to conservative treatments. Peter wanted to be circumcised because he believed it would improve his appearance, and he reports now a

delight in being naked and an improved self-image. Greg, on the other hand, reports feeling self-conscious about being different from most of his friends, and a corresponding avoidance of 'locker room' type situations. Greg even feels a "little bit more naked" when he's walking around his own bedroom. Peter, on the other hand, now happily attends nude beaches to show off his exposed glans. Both men report improved sexual relations with their wives following the procedure.

The history and current condition of routine infant circumcision in Britain is very different from that of the United States, but these two gentlemen illustrate an important point, namely that it is impossible to identify particular variables that will predict whether a man is or is not inclined to seek circumcision as an adult. Similar demographics, but Peter wanted circumcision because he liked it, while Greg would not have considered it had it not been for a medical condition. And it isn't really possible to identify variables which might predict with any kind of certainty how a man will feel about the procedure once it's done; Greg felt that he had no choice in the matter because of his condition, but he reports no regrets and some definite advantages, especially in terms of his sexuality.

When U.S. parents are making the decision whether or not to have their newborn sons circumcised, the circumcision status of the father appears to play an important role in their determination. However, the condition of the father is not determinative, which is to say that some uncircumcised men have their sons circumcised and vice versa. When I first undertook this research, one of the things I was most interested in exploring was whether the circumcision status of a man's father correlated in any way with his decision to seek circumcision for himself. While my U.S. born informants were somewhat more likely to have been left uncircumcised if their father was uncircumcised, they all share an

appreciation for the aesthetics of the circumcised penis, and a desire to fit in and appear normal, as well as acknowledgment of the erotic and sexual appeal of being circumcised.

One of my informants named Bruce wrote “I truly wish it had been done at birth”; he was born in the rural Midwest in the early 1950’s and neither he nor his father had been circumcised at birth, which according to him was uncommon in his region at the time he was born. However, he also reports being embarrassed at the sight of other boys when he was growing up, so while it may not have been common, it certainly was not unheard of by that time. Bruce reports that he first started thinking about getting circumcised when he was a teenager, and that he was too embarrassed to even try and have sex with anyone until he was himself circumcised in his early thirties.

Regret for the decision is not expressed by [any] of the men who volunteered to participate, but there are mixed or ambivalent responses from some. This does not always have to do with the decision itself. Cliff, for example, is an educated gay professional in his mid-60’s who was born and lives in the Pacific Northwest. He was circumcised as a child, but with very little skin removed, leaving him with an unsatisfactory appearance. At the age of 20 he began considering circumcision, or re-circumcision if you will, and finally carried it out at age 64. After doing quite a bit of research and discussing the procedure with others online, Cliff requested his urologist to perform a “high and tight” circumcision that left his frenulum and as much inner foreskin as possible intact. This request was based on Cliff’s experience of the inner foreskin as “the home of sensitivity” and his discussions with other men circumcised as adults. But Cliff was disappointed with the results because the urologist removed a good deal of inner skin, although he still reports an improved self-image.

It appears to me that Cliff found himself caught in the uncomfortable intersection between medicine and culture at which circumcision dwells in the United States. Cliff says his main reason for wanting an adult circumcision was the visual appearance. A urologist is not an aesthetic surgeon though, and throughout the discussion group in which I met Cliff, men described urologists as not being as concerned with the visual outcome. However, the visual outcome is clearly very important to many people. This situation raises issues that are commonly discussed in the context of other aesthetic surgeries such as breast augmentation or rhinoplasty, namely the tension between psychologically therapeutic surgeries and physiologically therapeutic surgeries. If a surgical modification which is not physiologically necessary carries profound mental and emotional benefits, is it medically therapeutic? Is it appropriate for doctors to perform? There are no simple answers to these questions, but they are raised by the experience of people like Cliff, and they are important questions for both medicine and social science.

Cliff's experience also represents the continuum of motivating factors that I mentioned earlier. Cliff says the primary reason he wanted to be re-circumcised was visual; but he also says that he finds circumcision itself to be erotic. He wanted to watch the procedure as it was being performed, but his urologist would not permit this. Instead, Cliff was sedated and put in surgical restraints which, according to him, "was just not the way I wanted it to happen." Cliff's desire to be awake and to see the procedure represents a challenge to the traditional authority of doctors over the material details of a surgical procedure. Cliff wanted to watch because for him getting circumcised was about more than just the results of the procedure, it was also about the experience of the procedure itself. This tension mirrors the conflict I just discussed between elective

aesthetic surgery and surgeries deemed physiologically necessary by physicians. Who decides what kinds of procedures are appropriate, and who decides what are appropriate ways to carry out those procedures? The answers to these questions are constantly negotiated between individual patients and doctors. We don't have time to go into too much more depth, but I can give you some overview of the trends in my sample.

Eight of the fifteen men reported that aesthetics or appearance were their primary reason, two reported social conformity as a primary reason, and only one reported sexuality as a primary reason. Six men reported social conformity as a secondary reason, and four men reported something related to sexuality as a secondary reason. No one who reported social conformity as a primary reason gave aesthetics as a secondary reason. Like I said before, rather than crunch these numbers to model findings statistically, I think it's more useful to frame the results in the terms of the continuum I mentioned between social conformity and sexuality, between fitting in and getting off.

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