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"I Don't Want to Hear About Your Dick": Communicatively Managing Stigma Surrounding Foreskin Restoration

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“I DON’T WANT TO HEAR ABOUT YOUR DICK”: COMMUNICATIVELY MANAGING STIGMA SURROUNDING FORESKIN RESTORATION

BY

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This thesis is approved as a creditable and independent investigation by a candidate for the Master of Science in Communication Studies and Journalism degree and is acceptable for meeting the thesis requirements for this degree. Acceptance of this does not imply that the conclusions reached by the candidate are necessarily the conclusions of the major department.

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This thesis is dedicated to my wife who supported me throughout this process and continuously motivated me to complete this degree. I couldn’t have done it without you.

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CONTENTS

ABSTRACT

"I DON'T WANT TO HEAR ABOUT YOUR DICK": COMMUNICATIVELY MANAGING STIGMA SURROUNDING FORESKIN RESTORATION

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Goffman (1963) defined stigma as an individual being unable to receive social acceptance because of a specific characteristic by being marked based on a characteristic, which can visible or invisible. This study examined how men undergoing foreskin restoration communicatively manage the stigma associated with restoring their foreskin. Through 13 interviews, I was able to thematically code using Meisenbach's (2010) stigma management communication typology which served as an excellent theoretical fit. My results suggest that men undergoing foreskin restoration deploy several sub-strategies to manage stigma, as well as utilize multiple strategies simultaneously. Furthermore, my results indicate the possibility of new stigma management strategies as well as the concept of forced disclosure, which would make an excellent addition to the previously mentioned typology.

Chapter 1

Introduction

Circumcision is generally thought to be a permanent surgical alteration of the male phallus, removing the delicate foreskin from the glans, typically in infancy (Domashevskiy & Domashevskiy, 2016). Circumcision is not something that finds itself in the realm of societal conversation or thought, due to the normalcy and permanence of circumcision (Zoske, 1998). For those who oppose circumcision and/or are unhappy with their circumcision status, they may enact foreskin restoration to reclaim the lost tissue. This process is referred to as foreskin restoration, which is the process of stretching the prepuce remnant, or loose shaft skin, to regenerate new skin to simulate a foreskin through years of consistent stretching (Collier, 2011; Kennedy, 2015).

For men who do engage in foreskin restoration, there are online support groups that exist on social media. One of which includes the hidden Facebook group "Foreskin Restoration," which has approximately 1,600 members. I have contacted one of the administrators and, after several Facebook Messenger conversations, have joined the group. The administrator indicated that about two men join every day, and noted that this growth has increased from one new member a week six months ago (T. Brown, personal communication, October 18, 2017). The fact that the group is hidden within Facebook's group options is fascinating and speaks volumes about the activity, especially since the group exists on a social media platform that many people use. Since the creators of the Facebook page had the choice as to the visibility of the page and opted to keep it hidden, says a lot about the secrecy and taboo nature of foreskin restoration and how public these men are willing, or unwilling to take their conversations.

Even though routine infant circumcision (RIC) is "the most commonly performed surgery in the United States" (Van Howe, 1997, p. 111), it is also one of the most controversial surgeries in the United States (Domashevskiy & Domashevskiy, 2016; Richters, 2006). There are extensive debates regarding the legal, ethical, and medical reasoning behind RIC (Domashevskiy & Domashevskiy, 2016). Richters (2006) identifies two central areas from which the controversy over circumcision arises. First, medical experts disagree on the necessity of the procedure. Second, infants are unable to give consent to the circumcision procedure. This raises both legal and ethical concerns about the procedure, and leaves men with a physical artifact of an unchosen medical procedure (Richters, 2006). Men that dislike the effects of their unchosen circumcision are left with a choice: live with the circumcision and dislike its effects or engage in foreskin restoration, or surgical foreskin reconstruction, to reclaim the removed foreskin tissue. Although scholars have given extensive attention to issues related to circumcision, relatively little attention has been paid to the process of foreskin restoration. In particular, no research has examined whether and how men communicate about this process.

The communicative research that surrounds foreskin restoration is nearly nonexistent, and offers a multitude of research opportunities. One avenue of research potentially worth exploring regarding foreskin restoration is the relationship between body dissatisfaction and stigma surrounding the practice. In chapter one, I will provide a background of the problem regarding circumcision and foreskin restoration, then move on to the statement of the problem where I will introduce the communication components of the study, and lastly I will state the value of the study and potential implications for the communication discipline.

Background of the Problem

Circumcision. Circumcision is not a procedure that is new to modern society and is one of the oldest forms of body modification in history (Darby, 2005; Gollaher, 1994). The earliest recorded incident of circumcision was found in an Egyptian tomb from 2400 B.C. but the origins of its meaning is still not understood (Gollaher, 1994). In Greek history, the first written reference to circumcision was found in the "History of Herodontus" (484-420 B.C.E) that likens it to genital mutilation and is found unpleasing and barbaric within Greek culture (Hodges, 2001). Today circumcision is often associated with the Jewish tradition. As Earp (2014) stated, the Jewish tradition of circumcision was relatively minor with simply removing the overhanging tip of the foreskin, leaving most of it intact to cover the glans. These early forms of circumcision being primitive involved crude tools and were rather simple compared to modern methods.

Today circumcision has taken a more obtrusive method to complete the procedure. Earp (2014) described this modern process as "substantially more invasive: it removes one-third to one-half of the motile skin system of the penis (about 50 square centimeters of sensitive tissue in the adult organ), eliminates the gliding function of the foreskin" (p. 4). Medical advancement was able to increase the amount of foreskin and motile penis skin that can be removed, leaving the unprotected glans to become dry and less sensitive (Hodges, 2001; Zoske, 1998). There is a clear difference between historical and modern circumcision methods which may be a source of controversy surrounding the practice.

Circumcision, which can be considered genital mutilation (Earp, 2014; Earp, 2015), represents a gender inequality, as women are by law protected from genital mutilation within the U.S. (Earp, 2014). Within the western culture of the United States, approximately half of newly born males are being circumcised today with the highest trend of an estimated 75% circumcision rate in the Midwest (Gollaher, 1994; Owings, Uddin, & Williams, 2013). This issue affects all males born within the United States, as it is the most commonly practiced surgery (Van Howe, 1997). Domashevskiy & Domashevskiy (2016) noted that the American Pediatric Association allows parents to make surrogate consent for circumcision. Surrogate consent completely takes the child's decision and voice out of the conversation. As Zoske (1998) said, "it is fundamentally an elective amputation of healthy genital tissue driven by the power of tradition and performed without a patient's consent, occurring when he is most vulnerable and completely dependent" (p. 189). The important element there is the vulnerable and dependent state of the child who is having the surgery done unto them without consideration of their opinion regarding their penis, as they are the ones who will live with the consequences of the operation. Yet, due to the perceived normalcy of circumcision, some parents decide to perform the surgery on their sons—without their son's consent—to have them fit in with their peers and believe it best for their son (Sardi, 2011).

Because of the high rate of circumcision, one could make the claim that it is a cultural norm within the United States. For many men, this lack of consent for circumcision stole a piece of their masculinity and foreskin restoration is their way of reclaiming genital autonomy and restores much more than their foreskin (Collier, 2011;

Griffiths, 2006; Kennedy, 2015). Some men feel as though they are victims from circumcision (Collier, 2011; Kennedy, 2015) and have to reclaim their masculinity (Kennedy, 2015), emotional wholeness, and aesthetic body imaging (Kennedy, 2015; Schultheiss et al., 1998) through the act of foreskin restoration. Some men feel that there is unfairness in their own genital mutilation, based on gendered circumcision, and seek to redefine their masculinity through foreskin restoration (Kennedy, 2015).

Foreskin restoration. Foreskin restoration in Greek times was motivated by the cultural preference for a long foreskin as well as avoiding persecution during times of antisemitism (Collier, 2011; Kennedy, 2015; Schultheiss, Truss, Steif, & Jonas, 1998). Hodges (2001) noted that Greek society even preferred a long overhanging foreskin with tapering of the skin past the tip of the penis. Since all men and penises are different, not every foreskin had this appearance, and for those who had been circumcised or had a short foreskin, they would then use a kynodesme (leather string) tied around their foreskin to their waist to apply tugging pressure to lengthen their foreskin (Hodges, 2001; Kennedy, 2015). With the minor circumcision practice of the Jewish tradition, this simple method to stretch the remaining skin to overhang the glans would not have taken much effort.

Today with modern circumcision however, foreskin restoration requires more time as well as effort due to the amount of motile skin removed (Collier, 2011) and the modern practice of foreskin restoration only gained popularity as early as the 1980's (Schultheiss et al., 1998). The reasoning of ancient restoration in Greek times varies from modern reasoning, as Collier (2011) pointed out it is for physical sensitivity, emotional reasons, and aesthetic appearance which could stem from body dissatisfaction. The

organization National Organization of Restoring Men (NORM) shares techniques and device reviews to inform men who are new on their journey, or otherwise interested in learning more about the process (Griffiths, 2006). Not only this, but Griffiths (2006) shares information regarding medical concerns about the process, and safety information to avoid skin lesions and tearing.

Collier (2011) also pointed out that because genital cosmetic surgery is on the periphery of medical practice, few physicians will perform foreskin reconstruction, and those doctors who do perform the operation turn down most patients and suggest foreskin restoration using stretching and weighted methods instead. The history of the foreskin reconstruction surgery which involves a skin graft dates back as early as 50 AD in roman times, and gained some popularity in the 19th century in Germany (Collier, 2011). Unfortunately, due to the aforementioned lack of surgeons able and willing to do it, few men undergo the operation, and because the results are oftentimes unappealing and functionally inadequate, other skin expansion methods are preferred (Collier, 2011; Kennedy, 2015; Schultheiss et al., 1998).

Foreskin restoration is a taboo subject not often found in popular discourse (Kennedy, 2015). Furthermore, media messages referencing the foreskin itself typically do not offer a positive perspective. As Young (2006) stated, the image people might have of the male foreskin could only come from popular television shows, some of which provide a negative representation such as disgust or uncleanliness. Kennedy (2015) also suggested that mainstream science and healthcare discredit advocacy groups who aim to influence public opinion against circumcision. Because circumcision is so culturally normative, some generations of women can go their entire lifetime without encountering

an intact penis with a foreskin (Kennedy, 2015). Therefore, the context in which men undergo foreskin restoration is complex: the process of circumcision occurs without communication or consent from the male child receiving the procedure, popular media messages share potentially negative information regarding the male foreskin, and mainstream health science rejects alternative information regarding circumcision harms. Within this context, some men undergo foreskin restoration—perhaps motivated by body dissatisfaction—and may find it difficult to discuss, potentially due to stigma surrounding foreskin restoration. Currently, there is not an understanding of how men are talking about foreskin restoration and if/how they are managing stigma.

Statement of the Problem

Historically there is little investigation into the research of foreskin restoration, especially from a communication standpoint. Because of the cultural normalcy of circumcision (Earp, 2014; Zoske, 1998), men restoring their foreskin then are going against normal cultural standards. However, Kennedy (2015) claimed that the act of foreskin restoration could be considered the act of correcting a physical deformity much like people who seek rhinoplasty or other cosmetic alterations. This notion of correcting a deformity caused by a non-consented surgical alteration creates an interesting cultural tension where being circumcised is normal, and cosmetic alteration is acceptable, but altering ones circumcised status may not fit into acceptable norms, making it a stigmatized behavior.

Body dissatisfaction. Body dissatisfaction may arise from wanting something that is a stigmatized marker outside of cultural norms (i.e., restoring foreskin), or conversely, running counter to social norms could cause one to develop body

dissatisfaction related to circumcision. Silberstein, Striegel, Timko & Rodin (1988) focused on both men and women regarding body dissatisfaction, giving early focus to men, who had been understudied up to that point. They determined that men and women do not differ in degree of body dissatisfaction, but rather the direction of their dissatisfaction where women wish to be thinner, and men to be heavier (more muscular) (Silberstein et al., 1988). Cafri and Thompson (2004) indicated that research investigating male body dis/satisfaction is increasing. Historically, research focused on thinness (among women), whereas muscularity later became the early focus for male research in body dissatisfaction. Cafri and Thompson (2004) noted that the importance of body dissatisfaction in men lies in the adverse effects for men trying to reach high muscular definition, which can be more harmful than just weight loss. Unfortunately, one area understudied in this line of research is the specific components of a person's body that is the cause of dissatisfaction.

Another interesting idea of body dissatisfaction stems from Adams, Turner, and Bucks' (2005) research article where they pointed out that men, much like women, participate in self-comparison with media portrayals of image ideals. This could then suggest, that body dissatisfaction could stem from seeing images of intact male foreskin in pornography, or being dissatisfied with the cultural normalcy of a circumcised penis as Young (2006) noted with the negative portrayal of the male foreskin. Then perhaps having feelings of dissatisfaction of circumcision could be in part due to the self-comparison behavior.

It is unclear if body dissatisfaction plays a role in a man's decision to undergo foreskin restoration. One study conducted by Bossio and Pukall (2017) examined body

dissatisfaction and circumcision status and found that some men (approximately 30 percent) did report body dissatisfaction because of their circumcision. However, they failed to address and examine foreskin restoration, leaving future research to examine this inquiry. Just as there is limited discussion about foreskin restoration in the scholarly literature, similarly, men who undergo foreskin restoration do not often discuss it. Perhaps this lack of discourse about foreskin restoration may stem from its stigmatized nature, i.e., that foreskin restoration is a stigmatized practice.

Stigma. Goffman's (1963) work, *Stigma: Notes on the Management of a Spoiled Identity,* laid the foundation for much of the stigma research that has since followed. This early work focused on physical, visible marks that designated a person as having a stigmatized identity. Although Goffman (1963) did suggest that there may be unobservable or transparent stigmas which leave no visible marker to identify the individual. More recent work with stigma has investigated unseen stigmas such as AIDS, mental illness, and homosexuality (Corrigan & Mathews, 2003; Crawford, 1996; McLaughlin, Bell, & Stringer, 2004). The connection of concealable, and chosen stigma and their connection to foreskin restoration will be further explored in the following chapter and will provide unique theoretical implications yet to be discovered.

The importance of stigma research stems from a variety of sources, and has noted that stigma itself leaves a multitude of effects on its targets such as isolation, and mental and emotional distress (Crocker & Major, 1989; Link & Phelan, 2001). It is important to understand stigma because of the negative consequences associated with having them, furthermore, the amount of stigmatized identities ranges from visible physical traits to hidden/concealable traits which many people can have. When related back to foreskin

restoration, Kennedy (2015) pointed out that often times men will feel isolated during their restoration process because of the secrecy and discretion the practice requires. This isolation may be a result of the stigmatization of this practice.

Relating the practice of foreskin restoration to the two concepts of stigma management communication and body dissatisfaction is a unique challenge for research. Namely, the fact that this topic is not discussed by people on a regular basis and usually only finds itself online in very specific places (Kennedy, 2015). Even if people were openly talking about foreskin restoration there would still not be an understanding of *how* they talk about it, if they feel stigmatized by doing it, and how they are managing the stigma surrounding the process. The literature suggests that pop-culture references that the foreskin itself is stigmatized (Young, 2006), but knowing how men who want to regain their foreskin perceive that stigma and manage it is not understood.

Definitions

Several definitions warrant explanation to better understand the review of literature and remaining chapter.

Foreskin restoration. For the purpose of this research study, the primary focus of foreskin restoration will be what Collier (2011) described as the stretching of the foreskin remnant through the use of weights, manual stretching, and constant tugging pressure to regenerate skin producing a functional foreskin. This process of foreskin restoration done without surgical means is also performed without medical advice or supervision (Collier, 2011; Kennedy, 2015).

Body dissatisfaction. Body dissatisfaction (BD) occurs from body image dysfunction and perceptual distortion resulting in attitudinal dissatisfaction (Skrzypek,

Wehmeier, & Remschmidt, 2001). Individuals become dissatisfied with their body based on attitudes and perceptions they have of their physical appearance. This dissatisfaction can manifest itself within an individual regarding their entire physical self or individual physical characteristics.

Stigma. According to Goffman's (1963) definition of stigma, it involves an individual being unable to receive social acceptance because of a specific characteristic by being marked based on a characteristic, which can visible or invisible. Stigmatizing communication finds itself in everyday discourse. Smith (2007) described this as negative communication to perpetuate negative feelings/thoughts towards the stigmatized individual or behavior.

Stigma management. Meisenbach (2010) proposed the theory of stigma management communication, which establishes a typology for communicating the management of stigma. Her typology established four quadrants of stigma management; acceptance internally, challenge internally, accept publicly, and challenge publicly (Meisenbach, 2010). The communication an individual participates in regarding their stigma falls into one or more of these quadrants.

Value of the Study

The knowledge about the communication surrounding foreskin restoration is scant and not plentiful enough to provide meaningful insight into discourse about foreskin restoration. There has been research conducted in regards to whom restorers have communicated their dissatisfaction regarding circumcision with. Overwhelmingly, participants communicated their dissatisfaction solely with parents and significant others (Hammond, 2012). However, the survey ran short regarding exactly what communication

surrounding foreskin restoration is like. Because a significant amount of men, with estimates ranging from several thousands (Earp, 2014) to tens of thousands (Schultheiss et al., 1998), are currently pursuing foreskin restoration, and because of its long historical practice through times of Jewish persecution (Kennedy, 2015), there is legitimate support justifying the study of this topic. Not only this, but because this topic has yet to be studied through the lens of stigma management and body dissatisfaction, a unique perspective can be added to the body of literature and theoretical implications.

Beyond the context for foreskin restoration, contributions to the literature of stigma itself will offer greater insights into concealable and chosen stigmatized identities. Never before has there been a study that is examining a stigmatized behavior, which is not only concealable, but also self-inflicted or chosen by the individual. I would suggest, through the course of the study, I will find that men feel that their practice of foreskin restoration is stigmatized, but because of the practice's secrecy they do not feel dissuaded to perform it. Not only this, but they have feelings of body dissatisfaction based on their circumcision which will impact their perception of stigma and the foreskin restoration process. Lastly, I think that my findings will also offer new insight into Meisenbach's (2010) stigma management quadrants where men may be able to move between management styles or operate within more than one at a time.

The conversation about foreskin restoration (which currently seems limited) requires greater attention, and focusing on the perspective of restorers is a great place to start. Gathering a rich understanding of this discourse could set forth a framework that could benefit the conversation for others who have yet to disclose their foreskin restoration decision to parents or significant others by shedding light on experiences of

other men who have done so. There could even be implications as to the cultural perspective and attitudes towards circumcision and the foreskin in general.

With the literature being limited regarding the application of stigma research and the body dissatisfaction applied to foreskin restoration, this study will be a novel use of these two concepts. A recent study by Bossio and Pukall (2017) sought to look at circumcision status and body/sexual image satisfaction, but did not focus attention on foreskin restoration as part of their study. Not only this, but the theoretical implication of body dissatisfaction overpowering the potential stigmatization of the foreskin restoration practice is a fascinating concept, one which the proposed study aims to investigate. Little to no investigation exists where researchers have studied a stigmatized behavior where a person's body dissatisfaction is so great they are willingly taking on a stigmatized identity marker, one which is concealable.

This chapter has introduced the topic of stigma and body dissatisfaction related to foreskin restoration with definitions as they will serve as the basis for this study. Chapter two will include a review of prior research in the area of foreskin restoration, body dissatisfaction, and stigma. Chapter three will serve as the proposed methodological section and will prepare the researcher to begin studying this phenomenon.

Chapter 2

Literature Review

The purpose of this study and research is not to focus on the positive or negative aspects of the foreskin, but rather the specific communicative issues surrounding men who want to restore their foreskin. The conversation of foreskin restoration, and the impacts of the process on men's lives, need further analysis. This is especially true regarding communication research and will be the primary focus here. To understand the purpose of this study, it is important to begin with an explanation of foreskin restoration, body dissatisfaction, and stigma research to outline the review of literature.

Foreskin Restoration

Foreskin restoration is not a new phenomenon, as Jewish men have done so to avoid persecution for centuries (Schultheiss et al., 1998). Foreskin restoration involves the stretching of the remaining prepuce tissue to create a covering of the glans (Collier, 2011). This of course is the non-surgical method, which is the primary focus here, as it is the most popular method of restoration noted by Collier (2011). Surgical foreskin restoration requires skin transplantation and often produces results that are cosmetically unappealing thus making them unpopular (Collier, 2011; Kennedy, 2015). The primary focus for this study will be on non-surgical restoration, which involves stretching the penile skin with tape, weights, or other means to create stretching of the skin to generate growth (Collier, 2011). Kennedy (2015) noted that about 15 commercially available devices can be purchased to facilitate non-surgical restoration without medical direction or advice.

There is limited research into foreskin restoration, specifically within the communication discipline. Research that has investigated foreskin restoration typically have not focused on the communication element. Such inquiry includes Money's (1991) study of foreskin restoration and sexual orientation, Hodges' (2001) account of historical foreskin restoration, along with Collier (2011) who focused on the practice itself. Kennedy (2015) found that men who are restoring their foreskin do tend to talk openly online about their process, however, further insight into communication surrounding the topic is scant. One study conducted by Hammond (1999) examined men's thoughts on their circumcision but found little regarding communication findings. They did find, however, that the majority of their 546 respondents had heard of foreskin restoration.

Alternatively, research into communication and circumcision typically focuses on communication that surrounds the medical procedure prior to executing it. For example, some research into circumcision has looked at the ethical (consent) and medical issues (necessity) of the practice (Domashevskiy & Domashevskiy, 2016; Earp, 2014; Zoske, 1998), and gender inequality of the practice compared to the protection women receive with female genital mutilation within the US (Earp, 2014). As noted earlier, circumcision occurs without consent of the infant (Richters, 2006), however, Fay, Grande, Donnelly, & Elwyn (2016) found that when parents and physicians utilized "option grids" to discuss the operation, parents and physicians were more engaged in the decision-making process. The use of option grids still left the infant boy out of the conversation (Fay et al., 2016).

Body Dissatisfaction

The reasons for pursuing foreskin restoration are varied, and Kennedy (2015) noted that "foreskin restoration is, above all else, about restoring a man's sense of

masculinity and self-worth. Having been victimized, his manhood attacked, he must reclaim his body as his own" (p. 51). If men who are restoring feel dissatisfied with their bodies and masculinity, then perhaps this could be motivation. Body image is a complex construct referring to affective, cognitive, and behavioral characteristics of a person's reaction to his or her perception of their physical appearance (Cash & Pruzinsky, 2002; Davison & McCabe, 2005). Body dissatisfaction (BD), then, occurs from body image dysfunction and perceptual distortion resulting in attitudinal dissatisfaction (Skrzypek et al., 2001). If a man is dissatisfied with his penis and circumcision status, it could be suggested that the dissatisfaction causes enough distress to lead him to undergo foreskin restoration. There is some recent evidence to support this as Bossio and Pukall (2017) found through a survey of 811 where 367 were circumcised as infants, 64.2% were dissatisfied with their circumcision status. The cause of that dissatisfaction is unknown but there could be a connection with media imaging.

Media plays a role in developing body dissatisfaction amongst individuals (Botta, 1999; Myers & Crowther, 2009) and with media portrayal of the male foreskin/circumcision leaning negatively could influence body dissatisfaction (Kennedy, 2015; Young, 2006). Young (2006) specifically noted that out of the 64 popular TV shows, 22% made direct reference to the adult male foreskin being disgusting. Bottamini and Ste-Marie (2006) stated that most studies investigating body dissatisfaction and media messages have focused on female participants, and when studying the male population used the same instruments and measures as used on the female participants. Furthermore, Bottamini and Ste-Marie (2006) stated that "internalization of the perceived mass media portrayed ideal may increase body dissatisfaction and result in behavioral as

well as psychosocial consequences" (p. 123) which is consistent with other findings of media messages affecting body dissatisfaction (Adams, Turner, & Bucks, 2005; Cafri & Thompson, 2004; Schick, Calabrese, Rima, & Zucker, 2010). With constant exposure to these often-unrealistic physical ideals, individuals may only see negative messages, which lead to poor body image and dissatisfaction as well as the resulting negative emotions associated with them (Adams et al., 2005).

Interpersonal communication surrounding BD starts at a young age for most people (Kichler & Crowther, 2009). Studies support that negative communication regarding weight and appearance from family members can leave a lasting impression on children regarding their body dissatisfaction (Kichler & Crowther, 2009; Rodgers, Faure, & Chabrol, 2009). Barker and Galambos (2003) found that teasing about one's weight or appearance is the most common form of negative communication influencing body dissatisfaction. Rodgers et al. (2009) also found that for boys, negative comments coming from their father led to higher BD, however, comments from their mother led to more weight-loss and weight control behaviors. Cafri and Thompson (2004) indicated that research involving male body dis/satisfaction has increased in recent years. Adams, Turner, and Bucks (2005) concluded through their study, that future research could focus on the specific bodily foci men are dissatisfied with, as research is limited in that area. This is where my study will attempt to investigate whether or not a lack of foreskin causes body dissatisfaction.

Some research does focus on this specific bodily focus mentioned previously, however, more inquiry may be helpful. One such study suggested that women who are dissatisfied with their genital appearance suffer from self-consciousness, low sexual

esteem, and BD, may seek cosmetic alteration (Schick et al., 2010; Veale, Eshkevari, Ellison, Cardozo, Robinson, & Kavouni, 2013). Furthermore, Schick et al. (2010) concluded that messages about "ideal" genital appearance and the rising popularity in cosmetic labia alterations could be increasing dissatisfaction amongst women.

Wiederman (2002) summarized a massive study of 52,000 men and women questioning their satisfaction of their genitalia, and found that over half of the men survived were unhappy with the size of their penis. However, there is limited research in identifying if circumcision results in dissatisfaction. One study that attempted to investigate this potential link was from a poll conducted by an anti-circumcision advocacy group that surveyed 1,000 men where 67% disclosed feelings of dissatisfaction of their circumcision to their partner (Hammond, 2012). Recently published work by Bossio and Pukall (2017) directly examined the link of circumcision status and body dissatisfaction but did not find a significant difference between circumcised and intact men. However, their findings did suggest that men who were happy with their circumcision status reported higher body/sexual image satisfaction, conversely suggesting that those who are unhappy with their circumcision status have lower body/sexual image dissatisfaction (Bossio & Pukall, 2017). This internal struggle faced amongst people with body dissatisfaction may not always remain within the individual, their behavior or a certain characteristic may be perceived negatively within an interpersonal setting. The behavior or the certain characteristic someone is dissatisfied with might be a stigmatized identity marker.

Stigma

According to Goffman's (1963) definition, stigma involves an individual being un-allowed to receive social acceptance because of a specific characteristic. This social discrimination and stigma could lead to severe long lasting psychological and physical impacts on the stigmatized individual (Puhl & Brownell, 2003). How this stigma is communicated is described by Smith (2007) as communication to create stigma attitudes of undesirable traits, features, or characteristics, which provoke responses of disgust, anger, or fear of the stigmatized. These stigmatized features or characteristics exist in two variations, seen and unseen stigmas (or visible and concealable) which their visibility plays a powerful role in the degree to which they are perceived (Saguy & Ward, 2011).

Furthermore, stigma resides in a specific context as Major and O'Brien (2005) noted "stigma is relationship- and context-specific; it does not reside in the person but in a social context" (p. 395). This important distinction lends itself towards communication suggesting that stigma is in fact socially constructed and thus, relies on communication to be shared and attributed. Major and O'Brien (2005) also stated that through social interaction and communication, shared understanding of social stigmas and social statuses are formed. Stigma research is vast and extensive.

Visible stigma. One such example of a clear visible trait of an individual is tattooing; a practice which is historically stigmatized and looked down upon in western society (Wohlrab, Stahl, Rammsayer, & Kappeler, 2007). Tattoos are becoming more common place, as well as being accepted in the work place (Martin & Dula, 2010; Miller, McGlashan, Nicols, & Eure, 2009) however, facial tattoos and piercings are perceived negatively by coworkers and customers (McElroy, Summers, & Moore, 2014; Miller et

al., 2009). Tattoos are an interesting practice, and play a unique role in stigma research, namely the choice in pursing tattoos while stigma exists surrounding tattoos and piercings, especially of the face. There are other visible stigmas throughout society, some of which are more visible than others and the impacts negative stigmatizing messages have on individuals is varied (Major & O'Brien, 2005).

Stigma surrounding body size, a visible and typically unchosen stigma, is one such example where psychological and physical impacts can be negative for the stigmatized individual (Puhl & Brownell, 2003). Puhl and Brownell (2006) further stated that "participants reported being stigmatized by a variety of interpersonal sources, the most frequent being family members, doctors, classmates, and sales clerks" (p. 1812). Anderson and Bresnahan (2013) concluded that body stigma messages affect large bodied individuals as much as it does small bodied individuals and body types that fall outside "gender norms" such as "weak" men and "buff" women.

The stigma surrounding body image has led some to seek cosmetic surgery to reduce their size or alter a physical characteristic they find not ideal. Motakef, Motakef, Chung, Ingargiola, and Rodriguez-Feliz (2014) proposed the following:

> there is, without question, a stigma in American culture attached to cosmetic surgery and a hidden condescension toward patients undergoing these procedures… Individuals who choose to undergo these procedures often find themselves condescended to or shamed, and even accused of having psychological problems, which in turn influences them to hide or deny that they have gone under the knife. (p. 854)

This stigma surrounding cosmetic surgery finds itself within foreskin restoration as Collier (2011), suggested. If the act of cosmetically altering one's body results in a form of stigma, then perhaps a connection to foreskin restoration may exist.

The stigma surrounding foreskin restoration surgery is not limited to cosmetic alteration, but to the foreskin itself (Laumann, Masi, & Zuckerman, 1997). Laumann et al. (1997) surveyed approximately 2,000 people as to their circumcision status and found that due to the high circumcision rate, there is potentially stigma associated with the foreskin as people may go their whole life without encountering an uncircumcised penis. Kennedy (2015) asserted, "when it comes to cultural ideals of the penis in the U.S., the foreskin is largely absent. In fact, circumcision literally erases the foreskin from our imaginings of the penis" (p. 40), where again, this could contribute to the stigma that surrounds the foreskin. The image people might have of the male foreskin could only come from television shows, some of which provide a negative representation (Young, 2006). One could argue that the foreskin could fit within either the visible or concealable category of stigma, namely because a man's penis would only be visible during private encounters. However, the foreskin is a physical component of the penis, which could then place it in the visible category.

Concealable stigma. The second category of stigmas are that which are unseen. Goffman (1963) distinguished stigmas that are seen and unseen due to transparency and observable features. More recent research has aimed to study the stigma surrounding AIDS and HIV, mental illness, disability and homosexuality (Corrigan & Mathews, 2003; Crawford, 1996; McLaughlin et al., 2004). Each of these stigmatized characteristics of people are not visibly apparent and would require self-disclosure, which has been

specifically researched with homosexual status highlighting the term selective disclosure (Corrigan & Mathews, 2003). Corrigan and Mathews (2003) through their research concluded that homosexuality and mental illness are comparable in their stigmatization. These stigmatized traits are more common than one might think, Ragins (2008) stated that a large portion of the workforce consists of people living with a stigmatized condition or trait, which is unseen. There is, however, a lack of inquiry directed at understanding concealable stigmas (Herek & Capitanio, 1996).

One major difference between individuals with visible and concealable stigmas is the ability to conceal the part of their identity that is stigmatized (Ragins, 2008). Corrigan and Mathews (2003) comparison of mental illness and homosexual stigma has further support as well, as Bos, Kanner, Muris, Janssen, & Mayer (2009) indicated that people utilize selective disclosure of mental illness, which is also utilized by people coming out (Corrigan & Mathews, 2003). Further research into concealable stigma has offered insight into the cognitive and communicative nature surrounding the issue. People who are working to maintain concealment of their stigmatized identity undergo greater mental distress than others who are not attempting to conceal a stigma (Smart & Wegner, 1999; Quinn & Chaudoir, 2009). This constant attempt to maintain concealment of this identity causes individuals to be "preoccupied with covering up what no one can see" (Quinn & Chaudoir, 1999, p. 485).

Another important element of concealable stigmas are the interactions between stigmatized individuals, and non-stigmatized individuals. One such interaction as posited by Quinn and Earnshaw (2013) is *anticipated stigma* which they described as "the negative treatment people with CSIs (concealable stigmatized identities) believe they

might receive if others know of their identity" (p. 3). Fearing discrimination and other negative interactions based on the perception of a concealable identity, again falls back onto the distress felt by those actively maintaining secrecy (Smart & Wegner, 1999; Quinn, & Chaudoir, 2009). With foreskin restoration, constantly working to physically hide the process while utilizing devices to restore, could produce the distress mentioned previously. Not only this, but to conceal the process from other individuals and avoid disclosing the process to avoid negative encounters requires consistent work.

Men who are undergoing foreskin restoration, then, do not need to disclose their doing so. Kennedy (2015) pointed out that men who utilize a device to restore are pleased with the discretion they offer to not reveal themselves going through the process. In this study, I argue that that the male foreskin and cosmetic body alterations are stigmatized within US culture, and thus, foreskin restoration qualifies as a stigmatizing behavior. As the researcher of this study I would offer my thoughts towards suggesting that foreskin restoration is a concealable stigma based on the privateness of the restoration practice.

Self-inflicted stigma. As addressed earlier, some activities or behaviors can be visibly seen such as piercing or other body modification which may be stigmatized (McElroy et al., 2014; Miller et al., 2009). Participating in behavior that results in stigma would seem counterintuitive, as it would discredit individuals from mainstream society (Goffman, 1963). There are however, a number of such activities and identity markers that result in such stigmatization from veganism/vegetarianism (Walter, 2013), voluntary childlessness (Hook, 2012), and abortion (Cockrill & Nack, 2013; Norris, Bessett, Steinberg, Kavanaugh, De Zordo, & Becker, 2011; Major & Gramzow, 1999). Cockrill and Nack (2013) found in their study of stigma and abortion, the importance of a person

to rationalize their behavior intra- and interpersonally in order to deal with the stigma surrounding the behavior. There is little research however, in studying foreskin restoration as a self-inflicted stigmatized identity marker, assuming the argument of restoring one's foreskin is stigmatized. Much of the previously mentioned self-inflicted stigmas can also be concealed by the individual; the same could be said about foreskin restoration as well since it is both concealable as well as a choice made by the individual.

Stigma and disclosure. The unique element of concealable stigma is that individuals can decide if they wish to disclose their identity (Quinn & Chaudoir, 2009; Quinn & Earnshaw, 2013; Smart & Wegner, 1999). Quinn and Chaudoir (2009) discussed that disclosure of a concealable identity can result in both positive and negative outcomes for the individual disclosing their stigmatized identity. Beals, Peplau, and Gable (2009) found in their study of disclosing homosexual orientation, that people felt more positive and reported higher self-esteem on days when they disclosed their orientation even if they received a negative response from whoever they came out to; also, they noticed that there could be a correlation with perceived social support and disclosure as well. Previous research suggests that disclosure of a concealable stigmatized identity benefits an individual's health by allowing people to gain social support (Beals et al., 2009; Chaudoir and Fisher, 2010), meaning that someone must first disclose their identity marker to receive social support. Disclosing such a concealable stigma may be difficult for some people, as Vogel and Wester (2003) found that disclosing distressing information can lead to emotional discomfort.

There is limited research to support that stigma exists among men who are undergoing foreskin restoration, and if circumcision increases body dissatisfaction then

perhaps it is enough to motivate men to undergo the process. Several limited areas in the research exist, first being that stigma surrounds the male foreskin which Laumann et al. (1997) and Young (2006) suggested. In addition, cosmetic alterations also seem to have stigma associated with the procedures (Motakef et al., 2014). This stigma could be connected to the genital dissatisfaction women face who seek labia surgery and other genital cosmetic alterations (Schick et al., 2010) which could be compared to the potential stigma and BD men face undergoing foreskin restoration. Research is limited regarding if there is stigma surrounding men undergoing foreskin restoration and the communication that exists around it. Understanding how stigma communication operates and its connection to foreskin restoration is an important element to the purpose of this study.

Stigma Management Communication Theory

To first understand this theory, it is important to understand Smith's (2007) theory of stigma communication, which she stated as communication to create stigma attitudes of undesirable traits, features, or characteristics which provoke responses of disgust, anger, or fear of the stigmatized individual. Stigma management communication (SMC) theory on the other hand, goes beyond what stigma communication is and offers management strategies for the stigmatized individual. Meisenbach (2010) proposed the theory and created the following criteria, which are acceptance of the stigma or denial of the stigma. This typology offers the following SMC strategies: *accepting* the status quo of the stigma and its applicability to themselves. *Evading responsibility* for the stigma where the individual accepts the applicability of the characteristic to self, but seeks to divert responsibility away from self. *Reducing offensiveness* of stigma in which an

individual accepts the stigmas applicability to self, but attempts to change how others perceive the stigma. *Avoiding,* wherein an individual accepts societal acceptance of the stigmatized marker, but challenges that it applies to them. Lastly, *denying,* where one simply denies or ignores the stigma—both its existence and applicability to self. Four quadrants emerge: acceptance internally, challenge internally, acceptance publicly, and challenge publicly (Meisenbach, 2010) (Appendix A).

To further connect Meisenbach's typology to my study, I suggest that a man undergoing foreskin restoration may accept that his behavior is stigmatized based on the cultural normalcy of circumcision, and challenge the publics opinion on the stigmatizing of foreskin restoration. This would categorize him within the *Reducing offensiveness* (Meisenbach, 2010) typology. Unfortunately, communication regarding men's perceptions of foreskin restoration and stigma is not well-understood, so there is not a sense as to which stigma management communication strategies they will use.

SMC theory is relatively new in communication research but several studies have utilized the framework or added research to the theory. Notably, Reichert (2012) applied SMC in a review of literature surrounding depression in college students and help-seeking behavior. Reichert (2012) sought to expand the application of SMC in a unique context studying college students and the stigma associated with seeking help, and suggested that SMC can be an effective tool in anti-stigma mental health intervention practices. Another study to utilize and test the SMC theory was conducted by Dorrance-Hall (2016) who aimed to study marginalization and stigmatization within families. Her study found that SMC fit well into the framework of resilience for marginalized family members (Dorrance-Hall, 2016). Dorrance-Hall (2016) noted however, that stigma

management communication strategies fall short covering all coping strategies with being a marginalized family member. No study has yet to utilize the theoretical model proposed by Meisenbach in the context of stigma communication and foreskin restoration.

Research Questions

Stigma management communication theory fits the context of this study regarding how individuals manage stigma through communication, which parallels components of the study. Disclosure, body dissatisfaction, and stigma surrounding foreskin restoration are the basis of the conceptual fit I am suggesting. If there is stigma associated with the male foreskin, and restoring one's foreskin results in a concealable stigmatized identity, then perhaps there is a connection between men's body dissatisfaction as it relates to their genitals (and circumcision specifically), and disclosure of their process to others. The research questions seek to uncover a rich understanding of the communication surrounding the phenomenon of foreskin restoration. The following research questions will serve as the foundation for this study:

RQ1: What is the nature of communication surrounding foreskin restoration?

RQ2: How do men experience perceived body dissatisfaction related to foreskin restoration?

RQ3: How do men manage stigma communication in relation to their foreskin restoration?

These questions seek to understand previously understudied components of stigma research and body dissatisfaction. Because foreskin restoration is such a unique phenomenon, applying these two concepts should reveal interesting theoretical and practical implications, which I would argue these questions will offer the best insight

towards better understanding the concepts and phenomenon of foreskin restoration. This chapter has reviewed literature on foreskin restoration, stigma research, and body dissatisfaction. In order to study communication surrounding foreskin restoration there must be a study to examine and answer the proposed research questions. The next chapter will outline exactly how I will be conducting such a study.

Chapter 3

Methodology

The purpose of this study was to investigate communication revolving around foreskin restoration from the perspective of men undergoing the process. This is a unique area of study and utilized a small sample size from the limited population fitting within the parameters outlined within this chapter. For this chapter I will first identify the type of methodology used, discuss the sample and sampling used, the instrumentation for the study, and the analysis used after data were collected.

Design

This study is a naturalistic qualitative design utilizing interviews. I am glad to have gained an in-depth and rich understanding of the experiences men have gone through during their foreskin restoration process. Qualitative design using interviews was the best fit to accomplish that, Frey, Botan, and Kreps (2000) quoted Van Maanen in describing qualitative design as "interpretative techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more-or-less naturally-occurring phenomenon in the social world" (p. 262). With limited population size, understanding meaning is going to be more appropriate than frequency as this sample size is be small.

Interviews were conducted via Skype©, for recording and communication with the participants. Skype (or similar interface) allowed the researcher access to participants from all over the country, as identifying people within the sample is difficult. Kennedy (2015) noted that discretion and privacy is an important element to foreskin restoration, thus identifying individuals is difficult. Frey et al. (2000) stated that typically interviews

are conducted in an environment that is comfortable for the interviewee. By conducting interviews in a comfortable setting selected by the participant, such as a home or office, allowed participants to be at ease with the subject matter under discussion. Because of the nature and sensitivity of the topic at hand, ensuring participants are comfortable is an important element to a successful interview.

Sample

The sample within the study was a nonrandom purposive sample from a small population. Frey et al. (2000) asserted "naturalistic researchers rely almost exclusively on nonrandom samples" (p. 274), thus fitting nicely into my research design. Participants were eighteen or over, male, and must be currently undergoing, beginning, or have completed non-surgical foreskin restoration. Collier (2011) pointed out that the typical restoration process using a variety of techniques could take anywhere between several years to a decade to complete with committed dedication. This inclusion of men throughout the different process phases allowed for a larger sample, as well as different perspectives. Gathering this variety of experiences also offered support to the population validity, which Frey et al. (2000) described as the accuracy to which the findings can fit the generalized population. With a greater range of experience and stages these men are in during the interview, the greater the validity of the findings against the population. There is no reliable number of how many men have gone through or attempted foreskin restoration, but Kennedy (2015) stated that there is a "significant amount".

Sampling

This study used purposive sampling, which is described by Frey et al. (2000) as the nonrandom selection of participants based on a certain characteristic. This is essential

when considering the specificity of foreskin restoration, and not only that, but integrating a network sampling design which reached the desired population. Kennedy (2015) stated that men talk candidly online within support groups (forums) where they have built an online community amongst themselves. Frey et al. (2000) also posited that "in cases of difficult-to-reach populations, or when discussing very sensitive personal topics, researchers often use network (or snowball) sampling" (p. 274). I was able to interview 13 participants, which was within the 12-15 goal determined for a rich understanding of the concepts. Specifically, I reached out to the Facebook group "Foreskin Restoration" for participants. I was able to gain access to the Facebook group after contacting an administrator of the page and shared a recruitment post. From there a question-pro screening survey was shared with participants to gather willing participants, from there email correspondence was used to schedule interviews.

Instrumentation

Semi-structured interviews were conducted to collect data in this study. According to Frey et al. (2000), interviews are used to gain in-depth information about people's lived experiences from a small representative sample of the population of interest by using prepared questions. This allowed for a very detailed and rich understanding of the perspectives and thoughts of men who are restoring their foreskin. Probing questions were utilized as well during the interview to help participants provide a very detailed answer to the interview questions. The "semi-structured" interview protocol included the following questions:

1. Tell me your thoughts on circumcision.

2. What are people's attitudes toward circumcision, foreskin, and/or foreskin restoration?
3. Can you describe your process of foreskin restoration?
4. Have you told anyone that you are undergoing foreskin restoration?
5. Is there anything else you'd like to share about foreskin restoration?

This portion of the interview protocol was distributed to the participants prior to the interview on Skype, and does not include the prepared follow up questions, those are included in appendix B. These questions were used to gather an understanding and provide an answer towards the research questions: What is the nature of communication about foreskin restoration? Does body dissatisfaction impact perception of communicated stigma associated with foreskin restoration? And, how to men manage stigma communication in relation to their foreskin restoration?

As the researcher, I conducted the interviews myself without the aid of an outside interviewer or team. Not only did conducting the interview myself prove to be enjoyable but it also allowed me to become completely immersed in the data and supported better thematic analysis. Frey et al. (2000) commented that rapport between the interviewer and interviewee is important, so too is understanding the potential for bias emerging through the process. The way the interviewee saw me as the researcher and interviewer was important, so by reinforcing the idea that we share the common interest in the process of foreskin restoration could have helped that rapport. Doing so, however, could have influenced other aspects of the research that I have addressed through other validity checking steps which will be discussed later.

Analysis

Because the study is a qualitative design, and interviews were the primary source of data collection, transcription was necessary for data analysis to be possible. I transcribed four interviews, my sister (a trained transcriptionist) transcribed three interviews, and undergraduate research assistants transcribed the remaining six interviews. For the coding process, I used the constant comparative method of analysis which exhaustively categorizes the data until no new categories or themes emerge (Frey et al., 2000). Frey et al. (2000) calls the point of exhaustion, "saturation," which means no new themes emerge, thus finalizing the process. Once I felt that saturation of themes occurred through constant comparison and descriptive coding, I moved into the interpretative coding phase.

For this study, I used second-order explanations to take participants' colloquial interview responses and connect them with the theoretical framework of the study. Frey et al. (2000) describes this process as "explanations of participants' attitudes, behaviors, and other things, as seen through the researcher's eyes" (p. 281). At this stage, I used Smith's (2007) stigma communication theory and Meisenbach's (2010) stigma communication management theory to help make sense of the data. During this phase, the themes also expanded, combined, collapsed, and were re-organized as I worked with my advisor to present a clear explanation of how the data fit with the theory. Once I arrived at a finalized version of the coding scheme, complete with my researcher explanation and exemplar participant quotes, I engaged in member-checking. Member-checking involves sharing the results of the analysis with the participants, so that participants can provide feedback about the accuracy of my interpretations (Frey et al., 2000). To conduct

member-checking, I e-mailed all 13 participants with an overview of my findings. Three participants provided responses; all of the responses indicated that my interpretations accurately represented their experiences.

CHAPTER FOUR

Results

This chapter presents the findings from the constant comparative analysis of 13 skype interview transcripts. For clarity, each participant will be referred to by a random number not associated with the chronological order of the interview process. The thematic analysis was guided by three research questions, which included:

RQ1: What is the nature of communication surrounding foreskin restoration?

RQ2: How do men experience perceived body dissatisfaction related to foreskin restoration?

RQ3: How do men manage stigma communication in relation to their foreskin restoration?

Throughout the interview process there was a rich amount of data collected and provided ample information to answer the research questions. There was one theme that dealt with stigma communication and answered RQ1: *Stigma Communication about Foreskin and Foreskin Restoration.* Then, the remaining major theoretical themes answered RQ3 and were based on the four stigma management communication strategies: *Accepting, Avoiding, Evading Responsibility, Reducing Offensiveness, Denying, Ignoring/Displaying.* Using Meisenbach's (2010) typology, subcategories of these strategies were also identified where appropriate. Finally, in addition to the themes that align with the theoretical frameworks, my analysis yielded one additional theme that is not covered by the theories, but does connect with the concepts from RQ2: *Motivation to Engage in a Stigmatized Practice*. In the results presented below, I first engage with

the stigma communication theme, then stigma management communication themes, within which RQ3 is also answered.

Stigma Communication about Foreskin and Foreskin Restoration

To answer RQ1, I asked participants about communication related to foreskin restoration, and foreskin itself. In answer to the question, the participants' responses suggest that communication about foreskin and foreskin restoration can be considered stigmatizing. I argue that communication about foreskin and foreskin restoration should be considered stigmatizing, because participants' responses aligned well with two aspects of Smith's (2007) conceptualization of stigmatizing communication: marking and labeling. Smith (2007) argues that stigmatizing communication functions to "mark" the stigmatized individual through calling attention to a negative attribute. Additionally, through labeling, stigma communication depersonalizes those who are stigmatized and often links them to social peril (Smith, 2007). Participants' responses reflect these aspects of stigma communication.

Marking foreskin. Participants generally reported that societal views about foreskin 'marked' foreskin as negative and involved a sense of disgust. This contrasted with views on circumcision as necessary and "clean." The participants expressed that, culturally, the foreskin itself is characterized as gross, unclean, dirty. For example, Participant 1 said, "they (society) think it is nasty and disgusting." Echoing that disgust, participant 8 said, "most people would be like, 'Ew, you need to cut that off'." Participant 2 contextualized the expression of disgust over foreskin by expressing women's perspective on the issue, "Women go, 'Ew. Oh. That skin. Well that's nasty under there.

It's dirty under there'." These comments suggest that the foreskin is stigmatized, i.e., that it is a mark of disgrace (Goffman, 1963). However, because the foreskin is typically concealed, the "mark" of being intact is often affixed through communication. Smith (2007) argues that when a person is marked through stigma communication, this elicits disgust. Thus, these descriptions of the foreskin as disgusting, nasty, dirty, or something that needs to be removed, illustrate that the foreskin is stigmatized and communication about foreskin can be stigmatizing.

Labeling men who restore foreskin. When participants talked about perceptions of foreskin restoration, their comments often included negative labeling affixed to men who undergo foreskin restoration. The labels often suggested that the person restoring his foreskin suffers from mental illness. For example, Participant 4 said, "I think generally people would think that [foreskin restoration] is crazy." Participant 12 also felt that men undergoing foreskin restoration are "considered crazy;" Participant 7 described how people see men undergoing foreskin restoration as "a bunch of wackos, and that we're obsessive, compulsive…just fixated on our foreskins." Participant 8 put it bluntly when he said, "I just think that people think we're fucked in the head, you know?" Linking a person to mental illness through words like "wacko" or "crazy" represents a stigmatizing label (Smith, 2007).

Stigmatizing labels created discursive distance between men with "a perfectly normal penis" (Participant 4) and those who restore their foreskin that "fall in that group of people that are considered deviants" (Participant 1). Men who undergo foreskin restoration were labeled as a "snowflake" (Participant 12), "perverted" or "gay" (Participant 1), and "pedophiles" or "unamerican" (Participant 9). Even the process of

restoration was stigmatized as a "fetish" (Participant 7), as "playing with your penis" (Participant 1), or as form of self-inflicted "torment" (Participant 4). Clearly this is not a positive image people have of men undergoing foreskin restoration, and perhaps might contribute to the underground nature of the topic and why men may not be as expressive regarding the topic. These labels show the undesirable traits which are intended to elicit disgust, anger, or fear as Smith (2017) described in her theory of stigma communication. Having these labels surround foreskin restoration supports that stigma communication exists regarding the practice, and that it is stigmatized. Because this stigma communication exists, these men are faced with managing stigma and have several strategies to do so. In the next section, I describe the themes that aligned with the stigma management communication strategies from Meisenbach (2010) theory, moving through the themes by quadrant: 1) accept public understanding of stigma and its application to self, 2) accept public understanding of stigma but challenge application to self, 3) challenge public understanding of stigma but accept its application to self, and 4) challenge public understanding of stigma and its application to self.

SMC Strategies: Acceptance

In the first quadrant of stigma management communication, people accept that a stigma that applies to themselves will incorporate it into part of their identity (Meisenbach, 2010). Furthermore, a stigmatized individual also accepts the social expectations and perceptions of the stigma (Meisenbach, 2010). Throughout the data, several of the accepting strategies occurred across participants, sometimes being used simultaneously or in conjunction with one-another. Displaying the stigma itself was one

such strategy, as well as bonding with stigmatized. I will first discuss instances where participants displayed and/or disclosed the stigmatized attribute.

Display/disclose the stigmatized attribute. For this topic, the display or disclosure of the stigmatized attribute does not necessarily refer to displaying the restored foreskin. Disclosure can also refer to disclosing that one is undergoing the process of foreskin restoration. This context is unique, because the men were choosing to take on an identity that they perceived to be stigmatized. The self-inflicted stigmatized identity could then be disclosed strategically, if desired. However, as Meisenbach (2010) notes "the potential lack of choice about displaying a stigma means that not every stigma display is a strategic SMC example" (p. 279). This was certainly the case for a few of the participants in this study who were forced to disclose their practice when others discovered tangible evidence of the process.

Sometimes participants felt the disclosure was easiest with a stranger, rather than someone in a close relationship. As Participant 8 said, "I've already shared more with you than my wife or my friend." Participant 1 had a similar experience. He had not told anyone he knows about foreskin restoration: "The thing is, I could talk to a complete stranger about this over my family." Meisenbach (2010) used the example of a fund raiser choosing to ask near strangers for money to illustrate how sometimes sharing a stigmatized identity with a stranger can be easier than sharing with someone in a close relationship. A similar phenomenon occurred for this stigmatized practice, where some men felt more comfortable disclosing this stigmatized identity with near strangers than with those in close relationships. Participant 12 even had this to say, "first of all, that was probably the most nervous out of all the people I've discussed it with was with my wife.

So I had this whole speech planned out, I had all sorts of stuff save on my iPhone she could read through about circumcision and the damage it does and all that. I basically went through and told her exactly what was happening."

For men who chose to disclose this chosen stigmatized identity to someone in a close relationship, the motivation was often to obtain some type of social support. Participant 8 said, "I told her [my wife], like, in the first week that I started, mainly because I really, really wanted her validation. I really wanted her support." Similarly, Participant 10 said, "I've never talked to my [ex-wife] about it, but I have talked to obviously my partners, my girlfriends. They've been very supportive. I think it's all about attitude and how you come across it, so they've been very supportive." This idea that disclosure of the stigmatized identity can elicit social support was shared by Participant 3, who immediately told his wife and found support from her. He said, "I think the strongest restoration tool is having the support of your partner." Similarly, Participant 13 said, "I wanted [my wife's] support. I wanted her to be with me and see the change I am going through. And to have her support has meant everything in the world to me." Participant 12 talked about foreskin restoration with his mother, who played a role in his circumcision. He said she "was very supportive," although he expected an apology for the circumcision and did not get one.

These examples of social support demonstrate both emotional support and identity support (Quinn & Chaudoir, 2009) that can come from such disclosure. These examples illustrate a potential positive outcome of disclosure: acceptance of the stigma attribute by the non-stigmatized individuals. In a different type of example, Participant 4 explained that he told a masseur about his process because he believed the masseur noticed some

changes. When the participant told the masseur, the masseur "just thought it was interesting." Meisenbach (2010) alludes to the possibility of disclosure producing positive outcomes, but notes that previous research has not found extensive evidence of this effect. Thus, this finding contributes important information to the scholarship on stigma management communication.

In contrast with men who *chose* to disclose this identity, a few participants recounted how their foreskin restoration process was discovered, leading them to feel forced into disclosing. Forced disclosure is specific to concealable stigmas in the sense that because foreskin restoration is concealable and a private behavior, it can go almost unnoticed in the public eye. However, in shared private space or encounters, disclosure may be forced upon the restorer. Participant 11 admitted that he felt "caught" when his partner discovered that he had ordered a restoration device. Two participants spoke about the inability to conceal this practice indefinitely. Participant 3 told his wife, because he "can't hide it from her." And Participant 7 said, "you cannot hide these things for too long." For example, Participant 13 sensed that his wife knew something was going on, because she would see him "get up and go adjust [himself] or something."

For two participants, the forced disclosure occurred because the participants' sons noticed the devices being used for the process. Participant 10 shared his experience:

> I think I was kind of pressured to share it with my son, because he found the device…I sat down with him and said, 'I want to share with you what's going on.' Well he basically said, 'oh yeah I saw that…I know what that's used for.'

For participant 10, the disclosure experience ended up being neutral. However, participant 3 experienced a negative reaction when he disclosed his practice to his son

after his son noticed a device that connects a knee brace to a strap used to lengthen the foreskin. In his words:

> Since I do work at home in the summer wearing shorts and a strap [connected to the device and knee brace], it's pretty obvious that dad's doing something weird. On the last day of school-so he couldn't go back to school and tell all his friends how weird his dad was-I told him what I was doing and he said, 'I don't want to hear about your dick!'

Participant 10's son's reaction recalls some of the stigma communication (Smith, 2007) elements discussed above with respect to communication about foreskin restoration. The use of the term "dick" and mentioning that he did not want to "hear about" it suggests that the son is implicitly labeling his father as "perverted." It almost evokes Participant 7's comment that foreskin restoration is seen as "playing with your penis." In addition, his comment seems to reflect the stigma communication message reactions of disgust and anger (Smith, 2007). Whether this reaction was generated because the practice is stigmatized, or because it deals with reproductive organs, or some combination of both, the son clearly feels that this topic is an inappropriate one to be discussed between father and son.

Bonding with other stigmatized people. In addition to the social support the participants sought through self-disclosure, participants also sought social support from other men who are engaged in foreskin restoration. One important component most of these men have mentioned is social media, and online support groups being an important part of their restoration process. Since these men were recruited from the Facebook page

"Foreskin Restoration", online avenues play a large role in their lives and the culture of being a part of foreskin restoration. Participant 10 had this to say:

> Back then (early 2000's) you know that was pre-internet, it was really the birth of the internet so a lot of the stuff was all information and I think that that's probably why I didn't stick with it as much as I should have, but then you come here to 2015 and the internet is now every day and social media is huge, which is a huge motivational factor where you're connecting with people on social media, it connects people big time. And this subject really helps people, and me, to connect with people. So, I'm really glad that I have started this process and really enjoy the changes, really positive changes.

Most men have mentioned NORM as well, either being part of it as a moderator, member, or simply know of it. Being associated with the "intactivist" movement likely plays a role in continuing and supporting each other. Participant 2 discussed the importance of the Facebook group and its role in the activism these men support, "I think there might be some good activism there that's going to spur out of this group [foreskin restoration page] because there's a lot of people with very strong feelings about starting to organize in their areas". This organization he is referring to is the NORM group which many states have local chapters.

More specifically with the online support and bonding that occurs for these men is the idea of mentoring. Participant 7 had this to say about his role online, "I'm a mentor, I do mentoring online, so Skype and email and other videos." Going through the process themselves and finishing in his case, allows him to take on the role of being a mentor and provides new restorers a source of knowledge and support. Participant 13 said he would

say he is also a mentor to restoring men, "[s]o support is very crucial, very important in a restoring man's life. And honestly, only another restoring man truly understands a restoring man… Yes, I am a mentor to younger restoring men, older restoring men. As long as you're breathing you can restore." Supporting one another through foreskin restoration seems to have created bonding through mentorship and the online community seems to be the best way for these men to initiate that.

SMC Strategies: Avoiding

The second quadrant of SMC strategies involves accepting the public understanding of stigma, but challenge its application to oneself. In this quadrant, the strategy of avoiding stigma from Meisenbach's (2010) stigma management communication contains several sub-strategies. Several of the sub-strategies that exist in the quadrant emerged from my data, hiding, avoiding stigmatizing situations, lying, stopping or eliminating the stigmatizing attribute, and making favorable comparisons.

Hiding. Foreskin restoration can be hidden both discursively and physically. Discursive 'hiding' occurs when men choose not to disclose their practice with others. Men explained that they did not want to share their identity because they feared being "judged" (Participant 6), being perceived as "deviant" (Participant 1), or anticipated that the conversation would be "awkward" (Participant 5). Participant 12 explained that he did not disclose his practice to his father who is "very religious," because:

> Our family has never been open to talking about stuff like that. And so, my dad being as religious as he is, you know, my 'birds and the bees talk' from my dad was that masturbation is a sin and that's not good. So right then with the whole

> Harvey Kellogg thing, I decided not to bring it up to him, cause I know exactly what his stance on it would be.

Participant 12's mention of Harvey Kellogg is a reference to Dr. Harvey Kellogg, the late nineteenth and early twentieth century health activist, doctor, nutritionist, and businessman. Dr. Kellogg was a practicing Seventh-Day Adventist who opened the Battle Creek Sanitarium in Battle Creek, Michigan. Dr. Kellogg's religious beliefs strongly condemned masturbation as sinful. Indeed, *Mental Floss* explores the link between Dr. Kellogg's beliefs on masturbation and health activism in an article titled, "Corn Flakes were Invented as part of an Anti-Masturbation Crusade" (Soniak, 2012). This link to Dr. Kellogg's religious beliefs and negative attitude toward masturbation again implicitly invokes stigma communication (Smith, 2007) about foreskin and foreskin restoration by linking it to a negatively stereotyped sexual practice like masturbation.

Men undergoing foreskin restoration can also physically hide the stigma, because foreskin restoration is concealable. For example, participant 2 when asked how he restores currently and in what setting (public, at home, or work) "during the day I've worn both devices under my jeans. I'm retired so in the summer I don't go to work, but I wore it through the day at work and I still wear it out in public now. I guess my jeans are lose enough that I can put it in there and hide it without it being obvious to everybody". Most men who I interviewed mentioned either engaging in manual tugging, which they did in private for short periods of time, or as participant 2 mentioned, using a device which can be worn under clothing for extended periods of time. This ability to engage in the activity in private would mean, then, that they can pass as a non-stigmatized individual because no person could tell that they are undergoing foreskin restoration.

Avoiding stigmatizing situations. A different, but closely related sub-category of the avoidance strategy, is avoiding stigmatizing situations. This differs from hiding the stigma, because the man physically removes himself from social situations where the stigmatized identity may be revealed rather than hiding the stigmatized identity within a social situation. This need to physically remove oneself to engage in the stigmatized activity was more prevalent for men using the manual method to restore their foreskin, because "you have to be more actively engaged with the manual process and more dedicated to doing it as often as you can" (Participant 4). Participant 5 described how he avoided stigmatizing situations by physically removing himself and occupying a solitary space:

> Basically, I just do it in the bathroom … sometimes when I'm at work or in school something like that. But most of the time I'm doing it at home, you know when I'm watching something on TV, or YouTube or something like that, away from other people obviously. <laughs>

Lying. This strategy involves individuals explicitly denying their associated with a stigmatized group (Meisenbach, 2010). Even when faced with possible confrontation and a forced disclosure encounter, participant 5 said:

> I've seen from stories I've read where people wear devices to work or something and something slips off or something, and a co-worker sees what you're doing and then guys try to play it off because they don't want to be seen as doing something weird or anything like that.

They must pass off what they are doing as something else, i.e., lie, to avoid the stigma associated with foreskin restoration.

Stop or eliminate stigma attribute. Meisenbach (2010) defined this strategy as ending the stigmatized behavior (if possible) to escape managing the stigma in a different way. Regarding foreskin restoration you do not simply stop restoring to utilize this strategy, rather, you achieve the end goal of restoration. One participant used the strategy of eliminating the stigma attribute (i.e., undergoing foreskin restoration), because could pass as an uncircumcised, or intact, man at a doctor's office. He described an experience he had with a physician post-restoration:

> The first visit I went to [my doctor] and he said, "(participant name) can I retract your foreskin?" I said yes you can. So he retracted my foreskin and said, "looks nice." First time in 57 years I went to a male doctor and I fooled him to think I am an uncut man. That was an emotional high for me, him thinking I was never circumcised.

By completing—and not disclosing about—the process of foreskin restoration, the participant was able to eliminate the stigma attribute (i.e., undergoing foreskin restoration).

Making a favorable social comparison. In Meisenbach's (2010) typology, making a favorable social comparison is done with the goal of derogating the compared group to elevate the stigmatized group. Many participants engaged in this strategy by derogating circumcision (as another practice to modify male genitalia) to contrast it with foreskin restoration. For example, participant 3 described circumcision as "barbaric" and a "human rights violation." He said, "I can't believe people think they have the right to cut off parts of other people's bodies." Participant 7 described circumcision as "unethical" and "abusive," going on to say that he "equate[s] it with rape and sexual

abuse." Participant 10 explicitly labeled circumcision as "a crime to a baby boy," because the baby is "not consenting to it." Participant 10 also classified circumcision as "completely cosmetic." By derogating, and stigmatizing, circumcision for being unnecessary and done without consent, the participants set themselves up discursively to present foreskin restoration as a consensual process done out of necessity (i.e., in response to circumcision). The idea that the process becomes necessary only because of circumcision resurfaces in the next theme of evading responsibility.

In addition to building up foreskin restoration by tearing down circumcision, at least one participant compared foreskin restoration to other practices he found socially acceptable to cast a more positive, or neutral, light on the stigmatized practice of foreskin restoration. I argue that this type of social comparison—where the stigmatized practice is compared to a similar practice that is less-stigmatized—should also be considered a viable stigma management communication strategy. Participant 1 classified foreskin restoration as a type of body modification and compared it to other forms of body modification, such as tattoos, piercings, and breast augmentation, which are gaining social acceptance. Participant 1 elaborated on this point:

> The thing is, [foreskin restoration] is a body modification…A man's got a penis. He's stuck with what he's got. You CAN modify it. You know if you want to pierce it, tattoo it. Well that goes into a different group of body modifications. But you know, in general we color our hair to make us look prettier, pierce our ears, pierce our nose, pierce our cheeks. It's just a body modification thing, and this is just another version of it.

Participant 1 was making a comparison of foreskin restoration to socially acceptable cosemetic alterations in order to look “his best”. Participant 1 specifically compared foreskin restoration to breast implants, which some might feel is “wrong too.” He explained the reasoning behind both practices, “A women takes pride in her breasts. Well a man is a man. He takes pride in his penis. What it looks like. How it looks and acts. It’s just different for different people”. Validating the practice of foreskin restoration by using comparisons to more favorable behaviors seems to be used by some of these participants. Sometimes, however, people are unable to effectively deploy certain strategies and must instead, rely on others to better serve their purposes or managing stigma.

SMC Strategies: Evading Responsibility

This theme represents the third quadrant of strategies from Meisenbach’s (2010) stigma communication management theory, where a person challenges the public understanding of the stigma but accepts that it applies to him/herself. One strategy in this quadrant is called ‘evading responsibility.’ A sub-strategy of evading responsibility that appeared among these participants was the provocation sub-strategy. In this sub-strategy, stigmatized people attempt to provide a justification for acquiring the stigmatized identity by explaining that they were ‘provoked’ to it through some external cause (Meisenbach, 2010). Most of the men had quite a bit to say regarding their thoughts on circumcision, which serves as the starting point for the discussion provocation regarding foreskin restoration, because without circumcision, foreskin restoration would not be possible.

Provocation is a strategy that allows people to distance themselves from the stigma because they assign responsibility for the stigma to someone or something else

beyond their control (Meisenbach, 2010). That is, they can reason that they acquired this stigmatized identity because something outside their control provoked them to do it, or gave rise to the need for them to do it. In the case of foreskin restoration, the clear provocation is circumcision, because without it, they would have no reason to perform the restoration process. Participant 3 explained that foreskin restoration, for him, "goes back to the whole uneasiness of people doing something to me [circumcision] that I didn't have a choice[consent] in." When discussing why he is dissatisfied with his circumcision, and reasons for restoring, participant 8 said, "I had to see a therapist about it, that's how much it[learning about circumcision] bothered me. Like, this was taken from me without my consent, I was put through that much trauma." Often, the language men used to describe foreskin restoration conveyed that in response to an external, uncontrollable occurrence, they were enacting a behavior that would allow them to return to a previous, undefiled state of the body. Men talked about "regaining" (Participant 10), or being "whole again" (Participant 8), or a desire to "have it [the foreskin] back" in order to become "whole and complete people" (Participant 2).

Some men's discourse frames foreskin restoration as something that must be done in response to circumcision. For example, Participant 13 said, "I knew what I had to do to correct my circumcision. That's when I found foreskin restoration, I knew in my heart I had to undo the wrong that was done to me." Participant 3 said, "it would be nice if [foreskin restoration] were more accepted, but it would be nice if [foreskin restoration] were not necessary." Participant 8 said, "we shouldn't have to do it [foreskin restoration]." The fact that these men are using words like "necessary" or "have to" when talking about foreskin restoration is a strong connection to evading responsibility.

Removing consent from their circumcision would suggest that by undergoing foreskin restoration, they are removing the responsibility of having to do foreskin restoration.

SMC Strategies: Reducing Offensiveness

The strategy of reducing offensiveness also appears in the third quadrant of Meisenbach's (2010) stigma management communication, where stigmatized people accept the stigma for themselves, but challenge the public understanding of the stigma. One way for people to do this, and a strategy that emerged from the interviews, is minimization of the stigma. Meisenbach (2010) asserted that one way in which people can do this is by showing others how their behavior is not hurting anyone else. No participant directly said that their practice was not hurting anyone else, but from the conversations and interviews there was still support for this strategy.

Minimizing. When questioned further as to why participant 4 took some time before sharing his restoration with his partner, he said: "I just feel like it's something personal. It's me. It's mine. It's not really any of his business". Being a personal activity and personal journey, the individual responsibility of it has little impact on others, even if there could be an impact on their partners, at least for participant 7, that doesn't seem to matter. Participant 7, after disclosing his restoration to his husband, said "[my husband's] concept of foreskin is like it's gross. He blew a gasket when he found out I was restoring. I told him I really don't care. It's not about you, it's about me". Even at the potential cost of damaging his relationship, his drive to pursue foreskin restoration and emphasize how personal it is showcases minimization of the act of foreskin restoration itself. Participant 3 said: "Through restoration, I'm not doing anything. It's not sexual. It's all medical".

Although no participant directly said that their behavior didn't hurt anyone, they focused on how the process is personal and is something they are doing for themselves.

Transcendence. The next strategy used by participants that falls within the reducing offensiveness theme is transcendence. Meisenbach (2010) noted that this strategy is justification for the stigmatized behavior in which the stigmatized "call attention to how the stigma attribute can be a means that lead to a valuable end" (pg. 283). This strategy although not explicitly stated by each participant, is a notable strategy mentioned by some, and perhaps would be agreeable to all who participated. Participant 8 when talking about motivation regarding the process, since it is a long journey, said, "The results and the benefits are really huge and awesome, so that puts it in perspective what's ahead of you". He was really focused on keeping the journey in mind during the discussion, because "it's a long, hard journey. It's not an easy fix, or something that takes ten minutes to take care of" as participant 1 said. When discussing why he wanted to undergo foreskin restoration, participant 13 said: "I knew what I had to do to correct my circumcision. That's when I found foreskin restoration. I knew in my heart I had to undo the wrong that was done to me, and the only way I could do that was foreskin restoration to become whole again".

Wholeness and regaining the foreskin appear to be integral to this process and is an example of the ends justifying the means. Participant 13 also made a point to differentiate himself, as a "restored man" with a completed restoration process, compared to "intact men" who are not circumcised, which serves as a badge of honor who many men seem to carry. The badge of honor as Meisenbach (2010) mentioned is a form of the transcendence strategy and in this case acts as an internal part of the community, as

participant 12 answered if he considers himself intact or restored: “I have thought about this question a lot actually, if I were talking to another restorer I would consider [myself] restored, but you know, Joe Public who knows nothing, I would consider myself intact. Now if I’m meeting with somebody that maybe I’m trying to get them to restore, yeah I would definitely say I am restored”. Making an effort to use different labels when discussing this process to different individuals represents the importance of the “badge” as well as the sensitivity of the topic. Participant 13 also went on to say: “We restored men are kind of neutral there because you are not circumcised no more, I don’t feel circumcised no more. I am a restored man and I do feel that I am uncut now. Circumcision to me feels like a past life at this point”. They have created a clear label for themselves as “restored” but will perhaps only use such a label amongst themselves as they are the ones who will understand the significance of the term, restored.

Transcendence can also find its way into the process as well as the end result, at least in regard to foreskin restoration. When discussing his progress Participant 2 said “like other guys, you have these little subtle things end up being huge to you. It’s like it’s a part of being me I never knew could exist”. He further went on to say:

> I’m thinking, Hey, I’m starting to become whole. It has affected me, or I get these, “ah ha” moments. I never would’ve freaking thought that these little things that have happened to me, even at my age are popping up. It’s like, there is something to being whole again. Never would’ve guessed it. Never would’ve expected it. From the remarkable sensation, I can’t believe were robbing our boys. People don’t know what we’re robbing them of.

The journey itself, the process of foreskin restoration leads to the valuable end of being restored, but the process itself seems to be valuable to these men and serve as motivation, as well as be the badge of honor that going through the process was worth the stigma. Participant 13 even shared a story from another restoring man: "I've known a very dear friend of mine, he passed away two or three years ago, he was 86 years old still restoring. He wanted his foreskin back before he passed away", the need to be whole again was so strong that this man performed foreskin restoration this late in his life until he died. Participant 13 was not sure how far along his friend was, but he assumed he was close to full coverage.

SMC Strategies: Denying

The final quadrant of strategies in Meisenbach's (2010) theory refers to situations where the stigmatized person challenges the public understanding of the stigma, as well as its applicability to the self. Meisenbach (2010) noted that individuals in this quadrant use the strategy of denial, which has sub-strategies of simple denial, discrediting the discreditors, and providing evidence or information. All of these sub-strategies were used by participants in this study.

Simple denial. Participants in this study sometimes discursively negated the stigma attached to foreskin restoration by pointing out what it is "not." Participant 10 said that foreskin restoration is "not some fetish thing" and "not something weird." Similarly, Participant 2 denied the stigma attached to foreskin restoration by saying that undergoing foreskin restoration "Doesn't mean you're nasty; doesn't mean you're dirty." These quotes are saying that foreskin restoration-and those who practice it- are not like the stigma messages they encounter, thus denying public understanding of the stigma.

Discrediting the discreditors. Meisenbach (2010) explains that one way to deny stigma associated with a practice is to discredit those who seek to discredit the practice. That is, the stigmatized person can question the credibility of those who generate or maintain the stigma. In this case, since some of the stigma about foreskin restoration is linked with general stigma toward foreskin and the nonnormative status of being uncircumcised, some men choose to challenge circumcision as the status quo. In essence, men who choose this strategy are working to dismantle the commonly held belief that circumcision is necessary and neutral. Actively participating with groups who oppose circumcision seems to be a starting point for challenging public opinion regarding the stigma with the foreskin, and foreskin restoration. NORM (National Organization of Restoring Men) is perhaps the largest advocacy group who promotes foreskin restoration and leads in education regarding the practice.

Many participants mentioned NORM in some capacity. Participant 10 was even a head facilitator for a state's chapter. Participant 10 "supported an online [anti-circumcision/pro-restoration] group that hosts events at baby showers, expos." In his work with that group, he says, "I choose to focus on restoration and helping people understand the truth [about circumcision and foreskin restoration]." Participant 10 felt that his efforts "put light to what circumcision really is." Although most participants did not express this specific strategy, many did allude to a need for educating the public or providing them with additional information as a way of changing public opinion.

Providing evidence or information. Many participants described their communication with others as almost educational, or sharing information, which is one of

the denial strategies from Meisenbach's (2010) model. For example, participant 2 when asked how the conversations about disclosing his decision to restore he'd said:

> When I talked to my brother-in-law we were talking about the babies, and I used my grandson's birth. I told him what I had found out, found on the internet. Told him what had happened with my son [circumcision experience]. Explained the process with my daughter and her husband and their decision not to do that. I told him I had lost sensitivity and found out that to gain sensitivity back you can restore.

Disclosing foreskin restoration began with a conversation surrounding circumcision sparked by a birth in the family. Participant 3 also said: "I told my older son in a follow-up conversation about him wanting to be circumcised. When he got married we talked about kids and circumcision. He's absolutely opposed to that, thank God". The conversation about their decision to restore starts with circumcision, and because participant 3 left his sons intact, and they had mentioned wanting to fit in and be circumcised, he decided to share his process of foreskin restoration to try and change their minds. Participant 10 said:

> With my daughter, why did I decide to tell her? I think it was basically because I knew that she's young, she has time to take the information and do her own research. What I have on my side is time, there was no immediate birth or pregnancy, baby boy coming on the way where it would be more of a, me babbling the culture of circumcision... I just really want them to make good decisions and there's nothing wrong with keeping a baby boy totally intact.

Many of the men who participated in the study have their own children and have credited their disclosure to them for wanting to save their grandsons foreskins, and sharing their decision to undergo foreskin restoration acted as evidence to support their beliefs opposing circumcision in the hopes their family will leave them intact.

Sometimes conversations are not just with family, but also with strangers and acquaintances. Participant 13 had this to say:

> It started mainly with talking about circumcision and how I felt against it. My son, he was circumcised but very very loosely, and I regret doing that to my son, but he understands. Therefore, he has left his sons intact. And my daughter I told her and my son-in-law, and I think my wife actually told my daughter. But I told my son in law about it, and they seemed very receptive to the idea and hopefully as my grandkids have kids of their own they will leave them intact also…
>
> Sometimes in just very personal conversations, one on one with people if they mention circumcision I will mention that I am against it and if it goes more in-depth I will tell them they can restore and if it goes more in-depth I will tell them I am a restored man also. Different levels of conversation that you get into. If they seem really receptive to (opposing) circumcision, then you start into the restoring aspect then you can tell a lot of times whether you go into telling them you're a restored man or not as the conversation gets more in-depth.

Foreskin restoration, along with intactivism, seems to lead these men to start the conversation about foreskin restoration with their beliefs and attitudes towards opposing circumcision. When discussing the future of the movement, and improvements to educating about foreskin restoration, participant 5 said: "I think they go hand in hand,

they call it intactivism, and restoring, I think both of them go together you can't really have one without the other, so if you kind of combine the two a little bit better than they are that would help both situations I think".

> When participant 11 told me about how he told his partner, he'd said
>
> You know I don't even really remember <laughs>. It's been like I've said, it's been about six years cause I didn't (tell him) at first. I think when I ordered the DTR (dual tension restorer) was when I told him that I was restoring and he's like 'what is that?' so I went through the whole process of well this is what it is this is how you use the DTR and this is what I am doing this is why I am doing it kind of thing so. Interviewer: So, you were kind of caught? Participant: <Laughing> Yeah".

In addition to describing past experiences sharing information or evidence, most men also used their interview time to share things with me that could hopefully be used for future educational efforts. Participant 1 offered this suggestion: "I would suggest sex education in schools. Even the health education in schools, there is none anymore". This education would then hopefully change the minds of people who hold stigmatizing thoughts towards the foreskin and/or foreskin restoration. When talking about how society talks about male health and foreskin restoration participant 2 said: "It [foreskin restoration] is something that guys should openly talk about. Doesn't mean your nasty, doesn't mean your dirty. We're guys. We're made a certain way and we've got certain things. Why not be knowledgeable about it?" They believe that the public misunderstands what the foreskin is, and the harms of circumcision.

SMC Strategies: Displaying the stigma

The final strategy discussed by Meisenbach (2010), called ignoring or displaying, falls within the fourth quadrant, where stigmatized people challenge the public understanding of the stigma as well as its applicability to the self. In this study, I interpreted some participants' responses as fitting within the 'displaying' stigma strategy. Just as foreskin restoration can be hidden physically and discursively, so too can it be displayed both physically and discursively. When men reveal their restored foreskin to their partners, this is a form of displaying the stigma. Participant 3 while describing his restoration routine said, "I also do some manually tugging. Usually at night. The wife and I sitting in bed together." Although she can witness the process of restoring, and isn't having the finished restoration revealed to her, this is still a display of the stigma during the process.

Likewise, men can discursively display the stigma by taking on the identity of a "restored" man. Participant 13 described the process of discursively displaying the stigma in terms of the level of self-disclosure and intimacy in the relationship (Altman & Taylor, 1973), saying, "if [the conversation] goes more in-depth I will tell them I am a restored man." Using the term "restored" functions to establish the transcendence strategy. But, when used interpersonally as a label applied to the self, it also allows the man undergoing foreskin restoration to display the stigma discursively. Participant 12 explored the nuances of this label when he explained that,

> If I were talking to another restorer I would consider [myself] restored. But you know Joe Public who knows nothing, I would consider myself intact. Now if I'm meeting with somebody that maybe I'm trying to get them to restore, yeah I would definitely say I am restored.

These participants displayed their stigma through the self-identified label of being "restored." However, some men note that this label is only meaningful among other men who are restored or who are considering it, i.e., other men who are or may become stigmatized in the same way. Thus, this strategy may not be reaching its full potential as a means for denying stigma. While this theoretical lens provided an excellent fit for this study, several additional themes emerged which SMC theory could not account for.

Motivation to Engage in a Stigmatized Practice

In answer to RQ2, body dissatisfaction, both in terms of appearance and performance, motivated men to engage in the stigmatized practice of foreskin restoration. Body dissatisfaction (BD) occurs from body image dysfunction and perceptual distortion resulting in attitudinal dissatisfaction (Skrzypek et al., 2001). Interestingly, in expressing their body dissatisfaction with their circumcised penises, some men used stigmatizing communication. Specifically, they referenced the scar left from their circumcision (i.e., a mark) or used a label to indicate that a circumcised penis is non-normal (i.e., label; Smith, 2007).

Various participants used stigmatizing communication to describe their dissatisfaction with their penises, due to circumcision scarring. Participant 11 mentioned that he "never liked the look of the scar line" and Participant 8 said, "ever since I was a kid I hated that scar." Participant 13 even linked the mark of the scar with the idea that the scar itself is unnatural or not normal, saying he did not like, "the overall look of the scar that you know is not supposed to even be there." Participant 8 used a specific label to call attention to the abnormal appearance of a circumcised penis when he said, "I always thought that circumcised penises looked kind of, I don't know, odd?" Participant 8

continued, saying, “I wish I didn’t have that scar”, you know? I always thought it was stupid looking… It’s just, it looks stupid. <laughs> It just looks unnatural, like I’ve been modified, you know?” This is consistent Bossio and Pukall’s (2017) findings that circumcision can lead to body dissatisfaction in men.

More important than the appearance of their body, is the element of sexual dissatisfaction of a body part, that being their penis and the loss of sexual satisfaction and sensitivity. Participant 7 discussed sexual dissatisfaction with his partner and brought up foreskin restoration: “he thought that my sensitivity problems could be cured by Viagra or Cialis, I said I don’t have an erectile problem, I have good erections for a man my age. I have sensitivity issues. And those don’t get cured by drugs. That part he could not grasp and still doesn’t”. He also went on to say while discussing his dissatisfaction with his sensitivity issues:

> Well, yeah I was dissatisfied <laughing as in a way of saying “of course I was”> because again I was my, basically my sex life was over and not only penetrative sex but also masturbation I mean it was going to the point where it was very difficult to climax and to put it this way, I don’t know if this is important, but I felt like I was wearing three condoms, now that’s how much loss of sensitivity was. I mean I was going bareback but still I felt I had several condoms on.

Other men, like participant 3 also felt compelled to share their foreskin restoration because of a similar sensitivity issue:

> A little over two years ago, being fifty-three and not every sexual encounter is turning out to be the fireworks that it was in your twenties and thirties. After a couple of sessions with the wife, it left some things to be desired. I started looking

> into general penis health and sexual health and ran across restoration again, but this time they were talking about the DTR and so I gave that a look and decided that I would like to go ahead and do that. One of the other things that play into the timing was there was a six year gap between the first time I heard of it and when I decided I wanted to do it. One of the big things there was being comfortable with my marriage. Six years earlier I didn't know if I could take something like that to my wife and not have her laugh at me. As the kids got older and we didn't have to focus on them as much and could focus on ourselves a little more and rebuilding the marriage, it got the point where I felt comfortable enough bringing it up to her.

The issue of sexual dissatisfaction caused by reduced sensitivity is enough of a reason to not only undergo foreskin restoration, but is also a motivating factor in disclosing his decision to do so with his wife. Participant 10 also had a similar reason for beginning foreskin restoration:

> I think I have to be honest with you Josh, and this is where men probably don't want to admit this, but I don't think I was, I don't think sex was, sexual intercourse was as enjoyable as I thought it was going to be. I made the connection that sex for me as a circumcised man is, I was missing it… I wasn't enjoying sex, I was not as good at it as I wanted it to be or wished I would be and I think that that motivated me big time.

Although he did not use this language and rational for disclosing his decision to restore with his children or partners, as he said he wanted to be honest with me as to what is motivating him to restore.

Participant 13 who has completed his foreskin restoration to full coverage, which for most men seems to be the goal, had this to say about motivation:

> Just knowing that I was circumcised, and I wanted to do something about that. At about age 35 I started losing sensitivity, at the time I was 40 I had lost more sensitivity and by the time I was 45 years old I had lost complete sensitivity to the point it was like touching a broom stick. I knew I had to do something different in my life to get sensitivity back. Through foreskin restoration, doing the research, I have gained sensitivity back one hundred percent.

Being dissatisfied with sexual performance of their penis through loss of sensitivity played a major role in their decision to undergo foreskin restoration in the hopes of regaining that sensitivity, and for the men who are complete or made large strides have begun to regain that sensitivity and sexual satisfaction back. Participant 1 while discussing his dissatisfaction with his circumcision had this to say: "my circumcision was so tightly cut that my skin would tear when I was having sex or as I was pleasuring myself. That's not a comfortable situation to be in when you've got a rip on your penis. You know you can't exactly put a Band-Aid on it." Although this response did not indicate why he wanted to restore, there is significance in his dissatisfaction of his circumcision having this negative of an impact on his sexual experience.

The lens provided by Meisenbach's (2010) theory of SMC served a useful purpose in investigating stigma management among men undergoing foreskin restoration. In the next chapter, I unpack the results, consider the implications of the findings, explain the limitations of the study, and offer directions for future research.

CHAPTER 5

Discussion

The general research question guiding this study concerned the nature of communication surrounding foreskin restoration (RQ1). Thankfully, during the interview process the participants were able to provide a very rich and deep wealth of knowledge and perspective that makes answering these questions possible. Indeed, the participants expressed their hope that this study could bring greater awareness of this practice to academia, as well as the broad public. Their ultimate hope, although not a focus or goal of my study, was for greater awareness of this practice to prompt systematic change regarding routine infant circumcision.

My analysis of participants' responses focused on the ways that men communicatively managed stigma about foreskin restoration (RQ3) and whether/how body dissatisfaction entered that experience (RQ2). My theoretical analysis of participants' responses suggests that foreskin restoration is stigmatized and difficult to talk about—if it is discussed at all. My analysis revealed that participants engaged in foreskin restoration utilized several strategies discussed by Meisenbach (2010) and performed stigma management through communication. In this way, my study provides a unique contribution to the SMC literature, because it is the first to directly test the full theory. Because of the strong conceptual fit with the theory of SMC, the discussion here will focus the theoretical fit of SMC, as well as address previously cited research in chapters 1 and 2 with the gaps my research fills in, which provides answers to all the research questions.

Quadrants, Strategies of SMC and Foreskin Restoration

The strategies these men used correspond to most of the major strategies within all four quadrants of stigma management communication created by Meisenbach (2010). The six strategies Meisenbach (2010) created fall within four quadrants: acceptance of public understanding of stigma and acceptance of applicability to self, acceptance of public understanding and challenge of applicability to self, challenge of public understanding of the stigma but accept applicability to self, and lastly, challenge of public understanding and challenge applicability to self. In this chapter, I highlight the strategies and their corresponding sub-strategies used to communicatively manage the stigma of foreskin restoration to demonstrate the theoretical fit of the data and offer answers to the research questions.

Quadrant 1: Accept public stigma and accept applicability to self. The first quadrant includes one major strategy: acceptance strategy. Two of the sub-strategies in this quadrant that appeared in this study were displaying/disclosing stigma and bonding with stigmatized. Men elected to disclose/display the stigmatized attribute of foreskin restoration to manage the stigma associated with undergoing the process. Consistent with Vogel and Wester (2003), disclosing a concealable stigma is difficult, and for many of the participants this meant disclosing their foreskin restoration to close relationships were the hardest to tell, where total strangers would be easier to talk to. Men's experiences revealed different motives for disclosing their stigmatized identity. For some participants, disclosure was used to preemptively disclose the practice to avoid being "found out." Being found out, or forced to disclose a stigmatized identity, was a unique element to this study. Forced disclosure, as Meisenbach (2010) notes, is not a "strategic" way to manage

communication about a stigmatized practice. However, it is still a form of disclosing the stigma attribute. For other participants, the motivation for disclosure was to gain social support. This practice is consistent with findings on homosexual orientation disclosure in previous research (Beals et al., 2009; Chaudoir & Fisher, 2010).

Like seeking social support through disclosure, the second sub-strategy within this quadrant is "bonding with stigmatized." In this strategy, stigmatized individuals reach out to others with the stigmatized identity to gain a sense of social support and community. The participants in this study found community online through the Facebook group "Foreskin Restoration" as well as other online avenues such as forums on Reddit and other message board formats. Some participants discussed the importance of the online community in terms of its support system, source of motivation and learning, as well as mentorship amongst men undergoing foreskin restoration within these online communities. Finding this support online and discussing foreskin restoration online is consistent with Kennedy (2015) who discussed how men talk about foreskin restoration candidly online.

Quadrant 2: Accept public stigma and challenge applicability to self. The next quadrant is accepting public understanding of stigma, but challenging its applicability to the self. This quadrant includes one major strategy: avoiding. Many of the sub-strategies in this quadrant were used by participants in this study, including: hiding/denying the stigma, avoiding stigmatizing situations, lying, stopping or eliminating the attribute and making favorable comparisons were found to be used in the study by these men. This quadrant had the most sub-strategies found to be used by men undergoing foreskin restoration, which was not something predicted at the start of this study. Hiding, for

example, is unique in the study of SMC and this context, because foreskin restoration is an example of a concealable stigma, or can be hidden easily. However, men chose to discursively hide foreskin restoration by not disclosing it to others which again, is unique when studying SMC.

Hiding this concealable stigma through not disclosing their practice of foreskin restoration further supports how stigmatized this practice is, as participants wanted to avoid being judged or perceived as deviant. This is consistent with Quinn and Earnshaw (2013) who noted that the *anticipated stigma* of having people find out of their concealable stigma causes distress within the stigmatized individual. Thus, by working to hide foreskin restoration could lead to the emotional distress noted by Quinn and Chaudoir (2009) when an individual must maintain secrecy of a stigma. This would mean that working to keep foreskin restoration concealed would cause distress all the while causing distress of anticipated stigma if one were to be found out.

The next sub-strategy of removing oneself from a stigmatizing situation was less prevalent but still insightful. Men who engaged in the manual method- which was a starting point for most men- needed to go to a private area to engage in the process. This is unique considering the concealability of the practice, both techniques require privacy to apply (a device) or perform (manual methods), but the "hands free" nature of devices certainly plays a role in how often and how consistent men excuse themselves to privacy. Related to this strategy is that of lying. Participant 5 anecdotally shared the only case that specifically and explicitly mentioned "playing it off" (lying) to avoid a stigmatizing encounter. Perhaps if a man was unable to excuse himself in time where a device slipped off, or another similar situation occurred, and he were discovered, then lying perhaps

would be an alternative strategy to use other than disclosing. This case does seem to warrant a claim that a forced disclosure encounter could be handled this way, but because of the publicness of device use, as well as those who may see this sort of accident may not prove to elicit disclosure. Further development of SMC (Meisenbach, 2010) may be required to warrant a claim regarding the use of these sub-strategies in this context.

The final sub-strategy worth noting is that of making favorable comparisons, something many participants mentioned in some fashion. Men engaging in foreskin restoration are making the social comparison of the process being better than that of circumcision, stigmatizing the practice which has lead them to restoring in the first place. This unique flip in terms of stigmatizing the stigmatizer using a social comparison between foreskin restoration (stigmatized) against circumcision (status quo) is unique but would require further support to substantiate it as an addition to SMC strategies. Meisenbach (2010) cited a strategy from Ashforth, Kreiner, Clark, and Fugate (2007) where the stigmatized might "condemning the condemner" thereby accusing the condemner of wrong doing, is similar to the strategy I observed. Even though this "flip" is likened to social comparison, I would even argue that because of its poor fit within this quadrant, that perhaps it is better suited to quadrant 4 which will be discussed later.

Quadrant 3: Challenge public stigma and accept applicability to self. The third quadrant of accepting applicability to self and challenging public understanding of the stigma includes two major strategies: evading responsibility for the stigma and reducing offensiveness of the stigma. Within each of these major strategies, a prevalent sub-strategy emerged from participants' responses. Within the evading responsibility strategy, many participants used the sub-strategy of provocation of the stigma—or

explaining why the stigma arose. In regard to foreskin restoration, this is exceptionally important in how men explained *why* they chose to pursue foreskin restoration. By laying responsibility for their restoration process on the societal normalcy of circumcision (Van Howe, 1997), they are essentially blaming society for why they must undergo this process.

In this study, the sub-strategy of provocation complemented the sub-strategy of transcendence (which falls under the major strategy of reducing offensiveness). I would argue that transcendence is the most important component of men's motivation to restore. Regaining wholeness was a powerful theme that emerged from several interviews, often being discussed by participants several times. This was consistent with Collier (2011), Griffiths (2006), and Kennedy (2015), who claimed men undergo foreskin restoration to regain emotional wholeness. This is to say, that these men feel that they have no choice in pursing foreskin restoration because it is necessary to regain the emotional wholeness that circumcision has removed from them.

Quadrant 4: Challenge public stigma and challenge applicability to self. In the final quadrant, which challenges both public understanding of the stigma and applicability to oneself, there are two major strategies: denying and ignoring/displaying. Within the denying strategy, a common sub-strategy used by participants in this study was relying on logic through providing evidence and information regarding foreskin restoration to others. Men who used this sub-strategy were hoping to educate people about the practice of foreskin restoration to introduce the topic, as well as reduce its stigma. This discursive strategy was unique in that these men would start these conversations with their thoughts on circumcision, often using another sub-strategy of

discrediting discreditors by refuting pro-circumcision ideology, and trying to change people opinions on circumcision. Some men even likened people to sheep being brainwashed by societal norms to blindly accept circumcision as good. These strategies often served as a tool for their disclosure of their foreskin restoration with friends and family, which is a unique way in which they lead into the conversation. This strategy functions similar to advocacy for the cessation of circumcision where participants mentioned organizations like NORM, and the intactivist (Kennedy, 2015) movement.

As the preceding paragraph illustrates, participants found themselves sometimes combining, building upon, or moving in and out of strategies depending on the situation. In other words, the strategies sometimes work together, even though this reality is not thoroughly considered in Meisenbach's (2010) original conceptualization of SMC. Unfortunately, it is not clear how effective each of the strategies were—separately or in combination. Thankfully for the men involved in the study, there were no negative interactions based on their disclosure of their restoration, or interactions with others, but this outcome cannot be assumed for all men.

Body Dissatisfaction. Although body dissatisfaction did not play as large a role as initially thought at the conception of this research study, there were instances where participants discussed its role in the restoration process. These findings are consistent with Bossio and Pukall (2017) where body dissatisfaction can stem from circumcision status, however, it was not a significant contributor for these participants to begin foreskin restoration. Several men did discuss how the appearance of their scar line was unappealing; it acted as a contributor to their overall dissatisfaction with their circumcision. Future researchers might further integrate body dissatisfaction into their

interview protocol to more explicitly investigate bodily dissatisfaction regarding foreskin restoration. Future research should carefully consider the complicated nature of body dissatisfaction, body function dissatisfaction, and sexual dissatisfaction and the ways that these concepts intersect.

Through the course of analysis, the six strategies of SMC (Meisenbach, 2010) emerged with 14 sub-strategies being deployed by the participants. An interesting concept of forced disclosure emerged as well as the importance of the sub-strategy transcendence, both as stigma management as well as motivation to restore. From here, I will explore the broader contributions to the disciplines of communication, sexology, and men's health.

Discipline Contributions

This study offers implications across a multitude of disciplines and areas of study such as communication, human sexuality, men's health, health communication, circumcision, psychology, sociology, religion, social activism, and the list goes on. For this discussion however, I will focus on communication, sexology, and men's health (including circumcision).

Communication. The results of this study suggest that stigma management does indeed occur for men who are undergoing foreskin restoration. Of the 23 sub-strategies within SMC theory, 14 showed up through the interviews and were consistent with the typology created by Meisenbach (2010). Furthermore, this study provides support to Meisenbach's (2010) theory of SMC and its applicability to qualitative research design. There is remarkable consistency between how these men used the strategies and how well they fit the theory. There is also support for SMC theory in people's communication

about foreskin restoration and that the theoretical framework is useful for analyzing qualitative data. That is, it can be used as a theoretical framework to guide deductive coding of communication data about experiences with stigma. The findings in this study are consistent with previous research that found support for SMC. Previous research has offered insight into SMC, such as Eckstein, and Cherry (2015) whose study of male victim blaming in intimate relationships and stigma within that context suggested that SMC would be useful as a theoretical framework. Reichert (2012) suggested that SMC would be a practical application for the context of coping with the stigma of mental health and college students because of the theory's versatility regarding context.

Gathering support for SMC theory and its conceptual fit with the results, researchers may now create quantitative measures of these SMC strategies. Quantitative measures of SMC could measure which strategies are used, in which contexts, with what frequency. Additionally, researchers could quantitatively measure outcomes of this communication by examining variables like relational satisfaction or self-esteem. Another point of quantitative investigation would be comparing which management strategies for chosen or unchosen stigmas, as well as concealable or unconcealable stigmas. In sum, quantitative data could provide insights into general trends in the differences in and effectiveness of SMC across types of stigma (chosen/unchosen, concealable/unconcealable) and contexts of communication. Such findings could also be used to help develop persuasive messages designed to reduce stigma.

The findings in this study also suggest areas for refinement and extension of the SMC theory. First, I suggest that the SMC theory be refined to better account for forced disclosure. Meisenbach discussed disclosure of a disability without explicit statement of

the stigmatized (2010) which serves as "forced disclosure" although not explicitly stated as such. Within this context, however, chosen concealable forced disclosure is a unique component that offers implications into the theory. The closest comparison to this (besides the chosen element) is forced outing of a person's sexual orientation (Pollack, 1991). Forced disclosure is unique with concealable stigma because a person has to actively hide their stigma to avoid being found out, and when faced with being found out must make a decision with disclosure. Since some men said that "they" will find out anyway, they may have felt obligated to share their restoration which could be similar to other concealable stigmas as well. Future researchers would do well to account for forced disclosure of a concealed stigma to better understand its role in managing the stigma and disclosing it to others.

Second, I suggest the SMC theory expand to account for instances where multiple strategies are used simultaneously and/or where one strategy is used to provide an opening for using a different strategy. This results of this study suggest that multiple strategies are used throughout communication interactions surrounding foreskin restoration, as well as simultaneously to manage the stigma associated with foreskin restoration. At the same time, stigmatized persons may shift in and out of strategies, even within the same encounter. Sometimes, it seemed that men first discussed their thoughts and beliefs of circumcision (i.e., provocation), which led to discussing foreskin restoration (i.e., displaying). This unique way of "testing the water" which offers practical strategies for other taboo topics as well. The SMC theory should be expanded to account for these combinations and shifts of strategies.

The unique method of "testing the water" through stigma management communication could also provide insights into communication about other taboo topics. This findings from this study might mirror how people discuss other taboo topics and where/how disclosure occurs. The men interviewed in my study generally kept disclosure to family and close relationships which may hold true to other topics as well. This offers insight into communication privacy management research (Petronio, 2004). Furthermore, research into both communication privacy management and stigma management communication could gain insight incorporating disclosure to strengthen the theoretical frameworks respectively. Additionally, the sensitivity of the topic of foreskin restoration also provides insight into disclosure of other sensitive topics.

Sexology. Because of the nature of foreskin restoration, and the sexual element mentioned throughout interviews, there could be implications in the field and study of human sexology. Participant 3 mentioned how this process has desexualized his penis within his relationships, he'd said,

> It's also made a huge difference in the relationship with my wife. Prior to restoring, the penis was viewed as strictly sexual. If it was exposed, it was like, 'Oh my God he wants sex again.' The process of restoration has really allowed the both of us to talk about what it means to have an organ on your body.

Restoring the foreskin itself is not only a unique behavior, but it also produces a unique restored foreskin which is structurally different from an intact foreskin. This certainly plays a role in how men talk about their penis, if they say "intact" to people unfamiliar with foreskin restoration, or "restored" to people familiar or close with them. That is also to say, that depending on the stage which a man is in, and depending on his

sexual activity with a long-term partner or new sexual encounters, plays a role in the disclosure of their restoration practice. This could be compared to sexual transmitted diseases like HIV/AIDS (Kalichman, Rompa, DiFonzo, Simpson, Kyomugisha, Austin, & Luke, 2001) where there is not a clear defined way to disclose having such a stigmatized condition. Along with sexual activity and relationship status, it may not be necessary to disclose having gone through and finished restoration with a new partner. Not only this, but because of the age of men undergoing foreskin restoration, loss of sensitivity in older men caused by circumcision and foreskin restoration being a tool to counteract this, provides insight into male sexuality.

Many of the men interviewed also stated that today's average person is unaware of the structure and function of the foreskin, something which could provide insight into the study of human sexuality. Kennedy (2015) stated that the male foreskin is removed from the cultural image of the male body within the United States, which is consistent with my participants' perspectives. If the foreskin is understudied or misunderstood, then perhaps people will be less likely to consider leaving infant boys intact, the ultimate goal of many men undergoing foreskin restoration. The communication discipline could then play a role in offering language these men use to provide advocacy in creating awareness of the foreskin, and circumcision cessation.

Additionally, another implication this study could provide the study of sexology is the concept of body dissatisfaction, and more importantly the findings of sexual performance that emerged from the data. Initially I thought that the appearance of circumcision would cause bodily dissatisfaction and lead men to undergo foreskin restoration. This aspect did play a role in some men's motivation and was mentioned

several times. However, the dissatisfaction arose from sexual function which these men would lay blame on their circumcision. This complicates body dissatisfaction, sexual dissatisfaction, sexual performance/function, and how these issues are discussed. Future studies should seek to understand the complicated nature of these intersecting topics.

Men's health. This study focused very clearly on a male feature which has implications with men's health. Several men discussed health issues because of their circumcision, such as tearing of their skin from erections causing painful sex, and an inclusion cyst caused from circumcision (though rare). These men discussed positive benefits from foreskin restoration which for the men with painful erections eliminated skin tearing caused by a tight circumcision. Not only this, but men also discussed a more natural glans which eliminated the need for lubrication during vaginal intercourse. This also reduced pain for women during intercourse, improving their sexual life as well.

The results from this study illustrate the ways that restoring men talk negatively about circumcision and positively about the process of foreskin restoration. Building on this, the results of this study could be used in informational campaigns about circumcision and/or foreskin restoration. Furthermore, if a researcher were interested in developing persuasive messaging about foreskin restoration, they could use these findings to help develop those messages. There is also potential to create messages to counteract the stigma about foreskin restoration and change stigma attitudes towards restoration.

***Circumcision*.** Because foreskin restoration follows male circumcision, the results of this study also provide insight into the practice of circumcision. The participants of this study all held negative perceptions of circumcision and hope for its cessation. Some

men interviewed had a negative experience with their own son's circumcision and cited that as a rationale for opposing circumcision. In many cases, men's negative attitudes toward routine infant circumcision arose from the inability of the infant to provide consent for this procedure. This topic deserves additional investigation by health communication researchers interested in health care decision-making, informed consent, and ethical communication about medical procedures. The results in the current study were derived only from men dissatisfied with the procedure of routine infant circumcision. Thus, moving forward, health communication researchers should bring multiple perspectives and experiences (e.g., physicians, medical ethicists, happily circumcised men) into investigations of this practice to better understand not only the topic, but also communication about it.

Finally, communication researchers could use the findings from this study to develop campaigns to encourage foreskin restoration, using the language/idea of "wholeness". Since some of SMC strategies perform as advocacy, the words used by these men while using those strategies could directly offer insight for advocacy groups like the intactivist movement. Even by understanding that SMC has advocacy strategies, men undergoing foreskin restoration could use this information as a tool to be more vocal and active in advocating circumcision cessation within their own lives if they're not part of established advocacy groups.

Limitations and Future Studies

Several limitations emerge from this study which warrant identification and discussion. The first limitation of this study is recruiting, because the population who is performing foreskin restoration is hard to reach due to the taboo and hidden nature of this

topic. Luckily with online forums and support groups that Kennedy (2015) noted being a place where restoring men seek community and talked candidly, recruitment was expedited by using the social media platform Facebook. Purposive sampling in research through online means may have led to selective sampling bias where participants chose to participate within the study. This is not inherently bad, however, if a participant had a strong perspective or opinions not shared by the entire population it may sway the results. However, because of the small population and the underground nature of the subject, purposive sampling was the best option for this study. Frey et al. (2000) indicated that purposive sampling accompanied with network sampling are best suited for hard to reach populations with sensitive topics, such as foreskin restoration.

Another important limitation is the sample size itself and applicability on the population of restoring men. Demographic information regarding education level, socioeconomic status, racial/ethnic characteristics, etc., was not collected. A sample size of thirteen participants is significant and sufficient for qualitative research, but the results should be interpreted with caution because I cannot make claims about the representativeness of this sample. For example, since all participants were from the United States, the results presented here may not represent the experiences of men in other countries undergoing foreskin restoration.

Additionally, the limitation of including new, current, and finished restorers provided a very broad perspective, but may also be a limitation to the results. Specifically, men at these different stages are experiencing very different stages of a long process that can take upwards of a decade. New restorers sometimes did not notice changes beyond the physical changes of foreskin restoration, whereas men who

completed the process noted a variety of changes both noticeable by others, and unnoticeable. Perhaps limiting to men who are finished, or several years in or "half-way there" would be beneficial to future studies.

Another limitation was not asking about sexual orientation or sexual activity from participants. Participant 1 brought up a unique point about intimacy and restoration, "a lot of the guys I talked to are my age. They're in their late 50's early 60's. Their wives have gone through menopause. Sex isn't a big issue for them. In fact, the intimacy is like, 'leave me alone.'" This anecdotal perspective provides support for this limitation. Without understanding the participants' sexual orientation, sexual activity, and/or relationship status, I am unable to have further understanding of how these men talk about sexual and body dis/satisfaction regarding foreskin restoration with their sexual or romantic partners.

In terms of the interview protocol and analysis of the data, a few limitations emerge. First, the interview protocol was not specific in adequately asking about dissatisfaction of participants penises regarding circumcision. Not only this, but protocol question 3 asked, "describe your process of foreskin restoration." This question needed to be prefaced by informing the participants of my familiarity with the overall process of restoration, so that each participant did not describe the full physical process. I also wish I would have included a question asking about their perceptions about the stigma messages about foreskin restoration. Some participants discussed this when talking about the messages they have heard, but it would have made a good prepared follow up to include in all the interviews. The analysis could have benefited from an additional coder to ensure intercoder reliability. This is not to say that I did a poor job in reaching

saturation or that member checking was not a useful exercise, but this would mitigate any coding discrepancies that limit single coder analysis. This would certainly be a suggestion I would suggest for future research.

Future Studies. There are two elements here to discuss, future research into foreskin restoration, as well as future research using SMC with concealable chosen stigma identity markers. Firstly, future research into foreskin restoration should consider a larger sample size to gather a larger amount of data. Studying this phenomenon from a qualitative perspective has produced a deep and rich understanding of foreskin restoration, but perhaps a quantitative study could produce equally interesting results. A larger sample will also aid in validity due to the unknown total population size quoted previously.

When studying foreskin restoration, future researchers should also investigate cognitive dissonance (Festinger, 1957) as an element in their study. This concept came up briefly in the analysis of interviews, this cognitive dissonance was perceived by participants to be in others regarding circumcision harms. Perhaps a better theory would serve useful with cognitive dissonance in others, but to quote participant 10, “guys don’t even want to go there” when discussing circumcision harms and “avoid the truth”. Many of the men believe that a reason circumcision continues is because people do not understand its harms, and the benefits of the foreskin, so they avoid information that would suggest these claims.

Additionally, masculinity and the image of the ideal male also came up within the interviews. The idea of the ideal male having a foreskin was cited by Hodges (2001) in Greek society, but some men did discuss the perceptions of people in the United States

removing the foreskin from our imagining of the ideal man, which is consistent with Kennedy (2015). Regaining wholeness came close to discussing masculinity but in this study did not provide enough data to warrant the theme of masculinity. Future studies could investigate masculinity related to foreskin restoration more specifically to see if it is an important component to foreskin restoration.

The other area future research should investigate is SMC theory and concealable chosen stigma identity markers. Other possible topics which are similar to foreskin restoration could be, cross dressing, the sexual act of couple swinging, and pornography with both its consumption and production. All of these behaviors are concealable and stigmatized in varying degrees of course. Previously offering insight into the element of forced disclosure and its importance within SMC, could prove useful in studying these other phenomena. Clearly the uniqueness of forced disclosure complicates SMC and research in disclosure itself, but hopefully future studies can use these findings to better understand concealable chosen stigmas.

Conclusion

Foreskin restoration is not a practice which in known by many people, and as a result, lives within the shadows of everyday communication. This taboo, stigmatized behavior is perhaps misunderstood by the public, but for the men undergoing foreskin restoration, they have created and enacted ways in which they counter the stigmas they face and hear. The findings from this study suggest these strategies fit well within the SMC typology. Managing the stigma of foreskin restoration clearly takes on several forms, but the greatest takeaway is that these men wish to get the topic out in the spot light, and hopefully not have the practice be necessary for so many men.

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APPENDIX A

Table 2 Stigma management communication strategies

	Accept that stigma applies to self	Challenge that stigma applies to self
Accept public understanding of stigma (status quo)	I. Accepting —Passive (silent) acceptance —Display/Disclose stigma —Apologize —Use humor to ease comfort —Blame stigma for negative outcomes —Isolate self —Bond with stigmatized	II. Avoiding —Hide/deny stigma attribute —Avoid stigma situations —Stop stigma behavior —Distance self from stigma —Make favorable social comparison
Challenge public understanding of stigma (change)	III. Evading responsibility for —Provocation —Defeasibility —Unintentional IV. Reducing offensiveness of —Bolster/refocus —Minimize —Transcend/reframe	V. Denying —Simply —Logically —Discredit discreditors —Provide evidence/info —Highlight logical fallacies VI. Ignoring/Displaying

Table reproduced from Meisenbach (2010) p. 278.

APPENDIX B

Interview Protocol

1. Tell me your thoughts on circumcision.
    a. How do you feel about your own circumcision?
        i. Do you feel dissatisfied with it?
2. What are people's attitudes toward circumcision, foreskin, and/or foreskin restoration?
    a. Example: Have you heard or seen messages (in the media or from other people) or had conversations about circumcision, foreskin, or foreskin restoration?
        i. If so, who said these things? What did they say? Where did this occur? What effect did they have on you, if any?
    b. Alternative phrasing of Q2a: What do people say about circumcision, foreskin, and foreskin restoration?
3. Can you describe your process of foreskin restoration?
    a. Why did you decide to begin the process?
    b. Aside from the physical changes, do you feel this process has had any effects on you?
4. Have you told anyone that you are undergoing foreskin restoration?
    a. If no, why?
    b. If yes…
        i. What motivated you to share your decision?
        ii. Who did you talk to?

iii. What did you say?

iv. What was the outcome of that conversation?

5. Is there anything else you'd like to share about foreskin restoration?