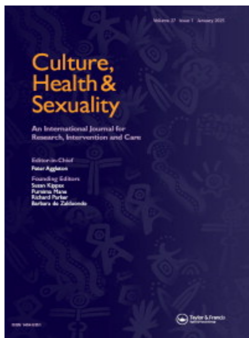

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Exploring the relationship between medically unnecessary childhood penile circumcision and adult mental health

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ABSTRACT

There is increasing recognition of the need to address the diverse experiences of individuals subjected to medically unnecessary, non-voluntary genital cutting in childhood. This includes children with intersex traits undergoing 'normalisation' surgeries and those with anatomically normative genitalia, such as female genital cutting or male circumcision. While most research on non-therapeutic childhood penile circumcision centres on the physical risks and benefits, far less attention has been given to the potential long-term mental health impacts, particularly from a psychotherapeutic perspective. This article adds to the existing literature by amplifying the voices of individuals who feel silenced. It presents a qualitative analysis of five interviews with men who believe their childhood circumcision negatively impacted their mental health. The analysis identifies three super-ordinate themes, highlighting the need for grief and trauma work to process unresolved psychological distress. However, the study acknowledges that these experiences may not reflect those of the broader circumcised population. Finally, the research underscores the importance of counselling professionals being adequately informed to support individuals reporting circumcision-related mental health challenges, and offers recommendations for effective therapeutic interventions aligned with existing theories of grief, trauma, and attachment.

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Introduction

Genital cutting or surgery is practised in various cultures, but these experiences are often evaluated *via* separate discourses which obscures important factors beyond sex or gender (Earp, Abdulcadir, and Shahvisi 2024). Earp and Steinfeld (2018) argue that the mental health and sexual well-being consequences of genital cutting are influenced by internal and external factors. The former include the child's age, emotional resilience, and cultural identification, while the latter include the psychological context, the extent of tissue removal, pain management, and any complications arising during the procedure.

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Historically, discussion of child genital cutting reflects dominant gender norms, with the patriarchal stereotype of boys as stoic and tough making it hard to see them as the 'victims' of genital cutting practices (Johnsdotter 2018). This perception can hinder scholars and professionals from acknowledging that boys, like girls and those with variations of sex characteristics may experience genital cutting or surgery as an act of violence, rather than a routine or insignificant procedure (Fox and Thomson 2009). In consequence, many studies on childhood penile circumcision focus on medical risks and benefits, offering a limited physical perspective, rather than addressing the broader implications of childhood penile circumcision for lived experience and mental health (Tye and Sardi 2023).

Against this background, the aim of this paper is to offer guidance to mental health professionals supporting clients who feel traumatised by penile circumcision and the associated loss of personal agency over an intimate part of their body (Buckler 2024). The study amplifies the voices of men who feel that '*they* made the cut', a phrase referring to their inclusion in a group whose mental health has been impacted by circumcision. The word 'they' as used here draws attention to the decision-makers – typically third parties – who imposed this permanent alteration on them without the individual's consent. Moving away from medical, cultural, and religious debates, this study centres on the lived experiences of those reporting long-term psychological effects.

There is a small but significant literature examining the psychological consequences of male penile circumcision. Hammond and Carmack (2017) surveyed 1,008 circumcised men online who felt violated by the procedure and who mistrusted the medical profession, many reported sexual intimacy issues linked to foreskin removal. The foreskin contains two highly sensitive structures: the ridged band and the frenulum, both of which are rich in Meissner's corpuscles which detect light touch and stroking. Male circumcision removes the ridged band and often damages or destroys the frenulum, representing an ablation of the most sensitive penile parts (Sorrells et al. 2007).

Little guidance exists for practitioners supporting clients affected by penile circumcision. In their study conducted online, Watson and Golden (2017) found that many therapists lacked a knowledge of the foreskin's functions and dismissed clients' concerns, which damaged trust and the therapeutic relationship. Regardless of their stance on male circumcision, therapists should use unconditional positive regard to accept clients' emotions without judgement (Rogers 1957). For clients struggling with feelings of violation or isolation, unconditional positive regard creates a safe and validating space for healing and growth, even when the topic is unfamiliar or contentious.

To date, most survey research assessing the psychological aspects of circumcision had relied on anonymous, self-selected samples making the verification of response accuracy difficult to determine, in contrast, qualitative analysis based on interviews/observation captures detailed experiences rather than generalisable data. For example, McFadyen (1998) described how circumcision caused her son to experience significant emotional distress, she observed emotions such as rage in consequence to his foreskin removal. Boyle and Ramos (2019) found similar evidence of strong emotional responses in Filipino boys: 51% of medically circumcised, and 69% of ritually cut boys exhibited

symptoms consistent with a diagnosis of post-traumatic stress disorder (PTSD), as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (APA 2013).

This brief review highlights lack of research into the lived experience of people whose mental health has been adversely impacted by circumcision, from a psychotherapeutic perspective. It sets the scene for a small-scale study of the lived experience of non-therapeutic childhood circumcision, and the impact it can have on mental health in adulthood. The objective of this work was to provide guidance to mental health professionals on how best to support individuals who have been negatively impacted by this procedure.

Methodology

This study adopted an ontological stance that assumed the existence of multiple perspectives, with identified themes reflecting the diversity of individual experiences (Creswell and Poth 2018). Accordingly, it is the *felt experience* of individuals, and the way(s) in which they interpreted these experiences, that informs the epistemology of the study.

Participants were recruited from two online support groups: the UK charity 15 Square and the Reddit 'Circumcision Grief' forum, all participants had undergone childhood circumcision and reported mental health impacts in adulthood. Interpretative phenomenological analysis (Smith, Flowers, and Larkin 2022) was well-suited to the study as it aims to provide a detailed, non-judgemental understanding of participant experiences. Five participants were interviewed using a semi-structured data collection instrument, which enabled them to recount their experiences in their own terms.

Creswell (2014) suggests that purposive sampling of the type employed in this study allows for insight into a phenomenon by selecting individuals with similar lived experiences. This idiographic approach allows for a deeper understanding of diverse views within a relatively homogenous group (Smith, Flowers, and Larkin 2022). In this study, all participants were based in the UK, where the prevalence of male penile circumcision has been estimated to be around 20% (Morris et al. 2016). The age of participants ranged from the mid-20s to late 70s, pseudonyms are used to ensure confidentiality. Informed consent was obtained from participants prior to interview, and all were provided with detailed information with regards to the study and a right to withdraw at any time. Ethical approval was provided by the Psychology Ethics Committee of Staffordshire University.

Analysis

Data analysis followed the procedure outlined by Smith, Flowers, and Larkin (2022).

To ensure rigour, the study adhered to Daniel's (2019) TACT framework, which places a focus on trustworthiness, auditability, credibility, and transferability. Trustworthiness was ensured by sharing verbatim transcripts with participants to verify accuracy and enhance credibility. The study was auditable, with detailed procedures for data collection, analysis, and interpretation being clearly outlined. Since transferability can only be confirmed through replication (across contexts, groups of men, or

over time), this study focused on the lived experiences of one particular group of men, as reported in one context, at one moment in time.

The analysis commenced with multiple readings of each transcript followed by a descriptive, exploratory noting of significant points. Experiential statements were then developed from these notes and imported into NVivo; a tool commonly used in qualitative research for qualitative data analysis. Similar statements were then grouped together to create emergent participant experiential themes (Smith, Flowers, and Larkin 2022). This process was repeated chronologically for each participant.

The final stage involved grouping participant themes together to identify shared features or commonalities between them. Smith, Flowers, and Larkin (2022) describe these as group experiential themes; however, this language does not offer an accurate reflection of the themes identified in this particular study in which 'collections of individual experiences' were the focus. Two main types of themes were evident – in the form of what we describe as superordinate themes, and themes within these which we term sub-ordinate themes.

Findings

Grief and loss

Three super-ordinate themes were derived from participant interviews, together with ten sub-ordinate themes, all under the overarching theme of grief and loss.

Super-ordinate theme 1: the great un-spoken, grief disenfranchised

All participants reported being unable to find a voice in relation to their circumcision. Their sense of loss could not be discussed with family members or peer groups; their grief was not legitimised. The sub-ordinate themes that follow can be seen as being linked to this.

Sub-ordinate theme 1: silenced; not acknowledged

Four out of five of participants felt they could not talk to their parents about their experience, causing them to feel they had to remain silent and not talk about it anywhere. Their voices were not acknowledged by the people who were supposed to offer shelter, protection, and teaching.

> **Fred:** He [my father] frowns at me and says I should keep that [negative feelings towards his circumcision] to yourself (lines 375-377).

In the above excerpt, Fred was silenced by his father when wanting to talk about circumcision, and not being able to talk to a parent led to feelings the subject could not be discussed anywhere. It was not only at home that participants did not have a voice. Another participant, John, illustrated when talking about how the media treats penile circumcision as a subject that should not be taken seriously.

> **John:** if you're watching a TV show or a movie and you hear that word [circumcision], or that topic comes up (…) and it it's often very flippant (lines 472-473).

Fred highlighted the devastating consequences that circumcision, being a great unspoken, can have on an individual.

> **Fred:** circumcision is a great unspoken (…) there have been cases of circumcision driving people to suicide (lines 164-165).

Sub-ordinate theme 2: no communication, not validated

In the absence of an explanation, participants did not feel validated in the way that they felt but continued to seek an explanation for why their childhood circumcision had been carried out. For John, questions unanswered and a lack of validation promoted the belief that this [male circumcision] must be too intimate a subject to talk about.

> **John:** the logical thing to do is to (…) have a conversation now and ask (…) for the details. (…) it's not something I've ever really felt comfortable talking about (lines 176-178).

Four out of five participants expressed similar feelings. Not understanding why circumcision had taken place without a medical need, had led to confusion and anger towards those who had perpetuated it.

> **Albert:** So the conversation was what was [so] wrong with my foreskin that it couldn't be saved. Why did it have to be amputated? (lines 206-207).

The language used, and the tone of voice, denoted the abhorrence Albert felt about the procedure being carried out without an explanation. Equally damaging were the vague general explanations used to explain circumcision. This made the procedure seem more confusing and feelings of loss and grief even less validated.

> **Albert:** They just think it's like cutting your fingernails (…) it's… [the foreskin is] something you just cut off and (…) it doesn't serve any purpose (lines 346-348).

In the absence of an adequate explanation for penile surgery, participants felt emotionally confused and upset. Acceptance was hard to achieve, and men had a sense of being stuck, searching for an explanation that they may never find. This lack of validation and barriers to communication added to the feeling that penile circumcision was a taboo subject.

Sub-ordinate theme 3: the taboo, not publicly mourned

Feelings of loss with respect to non-voluntary penile circumcision are not aligned to society's usual views about grief. Because participants viewed penile circumcision as a taboo subject, there were limited ways in which it could be discussed. Fred explained his hesitancy to discuss circumcision due to the prevailing (mis)belief in its health benefits, when he stated:

> **Fred:** I've been told, there are massive health benefits in cutting it off and (…) anyone who doesn't have it cut off is doing their sexual partners a disfavour. They' reputting them at risk of cervical cancer (lines 261-263).

This fear of contributing to misinformation compounded feelings of isolation and disenfranchisement.

Super-ordinate theme 2: spiritual divorce and other relationships impacted

This theme illustrates the shared feelings participants have felt towards people in their lives who had been pivotal in compounding the negative impact of penile circumcision.

Sub-ordinate theme one: the mother

Three out of five participants cited feelings of betrayal by their mother. This complicated their ability to reconcile loss, as John reflected on his relationship:

> **John:** not really understanding (…) why she would have wanted it done to me. (…) I felt confused (…) I've found myself becoming more [with his life became more than the relationship with his mother] or the relationship being less, overtime (lines 68-79, 72).

Albert who had tried to have a conversation with both of his parents, experienced a breakdown of communication with his father who denied involvement. His mother was said to have made the decision.

> **Albert:** I had to have the conversation with my parents. My mother started to cry and said I don't remember. My father laughed, walked out of the room, and said it was nothing to do with me (lines 66-68, 79-80).

Albert's account suggested an external façade of familial closeness, but with little warmth or affection beneath it, because circumcision was a taboo subject. There was something in his father's laughter which suggested he wanted to distance himself from the whole topic. The lack of memory by his mother caused what Fred described as a 'spiritual divorce', he still had occasional contact with her, but the emotional tie was damaged.

> **Fred:** It's resulted in my undergoing spiritual divorce from my mother (…) I explained to her (…) how unhappy I was about having lost my foreskin. She feigned a degree of surprise stating at one point I thought you liked it [your penis] (lines 101-102).

Spiritual divorce did not just apply to a parent, it also had an impact on how participants viewed religion.

Sub-ordinate theme 2: the father and religion

Interestingly for all five participants, the biological father was not blamed for the procedure. It was the mother who had solely made the decision. Only one participant reported having undergone childhood penile circumcision in the name of religion. However, 4 out of 5 men felt it had had a negative impact on the possibility of them adopting or endorsing religious beliefs.

> **Adam:** it made me an atheist quickly. As soon as I found out that this was part of that, that was the end of my religious experiences or religious belief (lines 101-102).

Paul saw the fact that the medical profession had conducted the procedure as an 'afront to God', since if it had been done for reasons of hygiene, this suggested that God did not make boys and men perfect.

> **Paul:** It's like saying that when God created us, he didn't make us perfect, and that's what needs to be done. And they speak about all these health benefits, and there's no health benefits to it at all (lines 87-89).

Sub-ordinate theme 3: the doctor

All the participants had had their circumcision carried out by a doctor in a medical facility, and all felt the operation could have been avoided. Three men were of the belief that their foreskin removal was strictly non-therapeutic, while the other two questioned whether there was a less invasive way of dealing with what was wrong. Given these feelings, mistrust and a fractured relationship with the medical profession prevailed.

> **Paul:** I think it's anger (…) that my parents were lied to and (…) sadness (…) I had it done; it's just barbaric, cruel and it's just not fit for this modern day (lines 49-50, 84).

Holding this belief meant Paul avoided seeing a doctor. John, who reported a similar avoidance of health professionals, recalled how generic advice, based on the assumption of having an intact foreskin during a school medical examination, had led to feelings of fear, being overwhelmed, and a greater sense of being abnormal.

> **John:** The nurse (…) I just remember her saying (…) make sure that when you're washing, you pull back your foreskin and wash underneath, and I remember freezing and it was obviously generic advice (lines 259-262).

Albert, similarly, had a deep mistrust and avoidance of doctors. He described how he had risked death rather than allow a doctor to attend to a surgical wound that had opened up, believing they might cause more damage.

> **Albert:** I almost bled to death that night. And I just went to bed, all the stitches had gone (…) I just thought I can't do this anymore. I put a plastic sheet over the bed, padded it with towels and went to bed and I thought in the morning I'll either be dead or alive. I don't care which (lines 117-119).

Sub-ordinate theme four: the lover

Four participants felt that circumcision has affected their ability to be sexually intimate with others. All cited a visual and sensory deficit caused by the circumcision scar and tissue removal, which has led to them proceeding into a sexual relationship with trepidation.

John explored how feelings of self-consciousness over his circumcised penis has impacted intimate relationships. What made this experience worse from his perspective was the fact that all of his partners had viewed the circumcision positively. This discord made it extremely difficult to talk about the horror he felt, in relation to what had been done.

> **John:** It adds to making me feel worse, because I feel like why would they think that this thing was a good thing? (lines 357-362).

Adam described how circumcision had had a deep impact on his self-confidence. He found sexual intimacy difficult to navigate.

> **Adam:** Well, (…) it rather ruined relating with the opposite sex (…) when the time came for the revelation, I just couldn't face that (…) Somebody will say (…) I think it's better (…) it's totally disastrous for me in the terms of (…) confidence. (…) you're thinking about if you don't climax, then was it because of that or was it because of something else? (lines 110-111, 164-165, 206-208, 239-241).

For Adam, sex was always marred by the belief there might be a problem; there was always something else 'present in the room' in the form of penile circumcision. Paul had navigated this dilemma by the complete avoidance of being intimate with a partner. He cited lack of trust, which he traced back to his circumcision, as a contributory factor.

> **Paul:** I can't trust someone as such. Yeah, I'd probably say that's the reason why I've not (…) been in a relationship with anyone: trust, and that is down to the circumcision (lines 34-36).

Similarly, Fred described a reluctance to be intimate with partners, as he worried they might think there was something wrong. He cited not having the 'compulsory item of uniform' (line 368) as the cause of this

> **Fred:** I was ashamed in my body at that point. I just, I did not like my penis the way it was. I didn't want anyone seeing it (lines 88-89).

Super-ordinate theme 3: navigating a change in world view

Undergoing penile circumcision was traumatic; it had left all the participants in this study with a sense of inferiority or of belonging to an out-group at some point in their lives. For men interviewed, this was compounded by experiences at secondary school. When bodily differences were realised in the changing rooms and communal showers, the world changed forever. The sight of an intact penis, with theirs being the only one with an exposed glans or head, led to feelings of not measuring up and low self-worth, further reinforced by the unkindness received at the hands of peers.

Sub-ordinate theme 1: navigating school - the lack of a compulsory item of uniform

Fred described how damaging his experience was at school. He had endured things at the hands of peers that he would never forget,

> **Fred:** And believe you me, I soon cottoned onto the idea that a foreskin was a compulsory item of uniform at that school (…). There were things that went on in the toilets and the showers at my school that no one could ever unsee. That wouldn't have happened if I had my foreskin (lines 59-60 110-111).

Adam had a similar experience: he would find himself hiding after games, so he did not have to shower in front of others.

> **Adam:** It became a badge of shame (…), I was 'penis shamed' in front of the whole class in the shower area. I'd (…) walk the plank of going from the changing room to the showers (lines 66, 70-73).

Being made to feel ashamed about their penis was experienced by all participants. Already silenced, and a taboo subject, and now with differences being highlighted at school, each had to carry the burden of their wound around on their own, leading to growing isolation. Albert described the situation as follows:

> **Albert:** I started to notice at school that I was different from all the other boys in the (…) changing rooms (…) I just assumed I'd been born deformed (lines 3-4).

These school experiences gave all participants life-long membership of an out-group and the associated feelings of distress this caused.

Sub-ordinate theme 2: circum-trauma, navigating life in an out-group

All participants described trauma around their circumcision that continued to have an impact on their lives.

> **Albert:** I [thought] I've been born deformed. [There] was a friend of mine and he said, no, you haven't. You've had that cut off. And it was just like being hit with a sledgehammer (lines 6-7).

For Albert, the trauma of circumcision caused a physical collapse whilst out in public, he described having had a panic attack where in which his mind shut down to protect himself.

> **Albert:** I suddenly collapsed (…) I don't remember any of this (…). They thought that it was probably something that had been brought on by a trauma (lines 41-42, 49).

Albert was dismissed by the medical profession when he described the trauma of his circumcision as being responsible for this. In support, Adam described how he is constantly 'triggered'; he cannot put what happened to one side.

> **Adam:** You have a constant physical reminder, a sensory reminder, and then you have the visual reminder (…). There's X amount of minutes at least in the day when (…) I'm devoting it to that (lines 257-258, 288-289).

John was triggered by the mere act of moving; the discomfort of his underwear rubbing against his exposed genitalia served as a constant reminder. The visible scar of the operation provided stark visual evidence of what had been taken from him.

> **John:** the scar (…) brings back the memory, I can't forget because of that sort of physical reminder (lines 167-171).

It was the physical pain caused by circumcision that triggered Paul. It affected his concentration whilst trying to complete daily tasks.

> **Paul:** it affects your concentration (…) suddenly, it's like somebody had jammed a knife and was twisting it inside your genitals as such (lines 155-156).

However, it was not just the physical and visual triggers that participants felt traumatised by. John, who had been circumcised in his teenage years, felt haunted by the memory of what happened.

> **John:** It was very, it was a traumatic experience. So, it was done under a local anaesthetic, so I was awake obviously for it, but I didn't really understand what was happening and what was being done (lines 109-110).

To this day, John was still no further forward in gaining clarity about why his circumcision was conducted. This had led to this question being stuck on loop in his brain. A similar outcome was described by Fred, who was plagued by a recurrent nightmare in which his circumcision manifested as castration anxiety.

Fred: One thing I do have is a recurrent nightmare where my penis has come off my body it's in my hand, and I'm looking at how to put it back on again. I've been having that for years. I'll probably have it till I die (lines 336-337).

And Adam commented,

Adam: it's the most perfect operation to cause maximum effect on somebody on a day to-day basis (lines 365-366).

Assumptive World Theory (Janoff-Bulman 1992) describes the damage that is caused when our assumed world is suddenly changed. It causes a feeling of grief and loss for the life we knew before, or the life we could have had if things had not changed.

Sub-ordinate theme 3: navigating grief

Exploring how participants navigated their grief showed they felt 'locked in'. Being more loss-oriented meant having to struggle to make sense of their experience, compounded by the added sense of feeling disenfranchised, and being part of an out-group.

Adam: From that day to this, probably it's become a something you just can't get out of your head even if you want to (lines 77-79).

And Albert said,

Albert: I just need to know what I'm grieving for? (…) if you can't come to terms with it, you can't move on (lines 225 and 230).

Albert, stuck in grief, showed an inability to attend to the changes caused by his circumcision. Instead, he was forced to focus on what he had lost. Ruminating on loss, looking at what could have been, has been damaging for him. John too was equally stuck, ruminating on the grief he had experienced.

John: I suppose it has affected my mental health because it's something that I think about a lot (lines 468-469).

Fred was the only participant not to feel stuck in grief, and had been able to gain a sense of moving forwards by restoring his foreskin (Hammond et al. 2023). All the men were trying to develop a new relationship with what had happened. Trying to find a positive coping strategy along with other people with similar experience worked to alleviate some of the grief. Paul described the importance of doing this.

Paul: With this group I'm willing to help them in any way, so it doesn't happen to young boys in the future. I suppose that's the only positive that's come out of it at the moment (lines 67-68).

Discussion

Findings from this analysis show childhood penile circumcision had a profound effect on participants in this study. Men felt mutilated, silenced, abused and shamed, and their grief had been dismissed. Supporting someone who feels mentally impacted by

penile circumcision needs a well-informed mental health practitioner if further damage is to be avoided. Some suggestions as to how this might be achieved are detailed below.

Ways forward

This study highlights the psychological impact of childhood circumcision on men through three superordinate themes. Each theme offers insights into the challenges faced by participants, particularly in relation to disenfranchised grief, attachment disruption, and trauma. The findings underline the importance of an informed therapeutic approach to supporting individuals in processing these complex experiences.

The first theme 'the great unspoken', aligns with Doka's (1989) notion of disenfranchised grief (cited in Doka 2002). He defined this as loss that is not acknowledged, not validated by society, and not mourned publicly. This silencing compounded emotional distress, leaving participants unable to process or articulate their grief. The lack of societal empathy exacerbates their sense of invisibility, reinforcing the belief that their grief was illegitimate. A therapeutic relationship must ensure that the core condition of empathetic listening is at the forefront, and it is essential to validate clients' experiences explicitly. This could involve practitioners undertaking psychoeducation about disenfranchised grief so as to normalise clients' feelings, as well as proactively asking 'were you circumcised?'

A feeling of disenfranchisement led to the emergence of the second super-ordinate theme, that of spiritual divorce. Byng-Hall's (2008) concept of insecure avoidant attachment, which arises when caregivers dismiss emotional distress, is evident in these accounts and carried longer-term implications for relational trust and emotional security. Bowlby's (2005) attachment theory reinforces the importance of secure caregiving from the mother in supporting emotional resilience, highlighting how disruptions, such as those occasioned by circumcision in infancy or childhood, can lead to lasting grievances and difficulty forming intimate relationships. Seligman and Reichenberg (2014) further explain how the mother often forms the primary 'internal object' for the child, with other figures doing so later. Lack of maternal protection during trauma can disrupt attachment, affecting trust in others and psychological well-being. This, coupled with physical damage to the foreskin, may explain the effects on sexual experience, self-esteem, and mental health that men describe (Hammond et al. 2023). With their penis exposed and a loss of sensitivity, intercourse may be impaired, and intimate partnerships avoided or affected, as they were for men in this study.

From a therapeutic perspective, object relations therapy (Slap 2020) offers a valuable framework from which to address these attachment injuries. By fostering a reparative client-therapist relationship that mirrors secure attachment, therapists can help clients rebuild trust and process unresolved anger or sadness. Techniques such as journaling or letter-writing may also facilitate the expression of unvoiced emotions, enabling clients to process their feelings. Additionally, participants' difficulties with intimacy suggest a need for compassion-focused therapy (Gilbert 2009) to support self-compassion and reduce shame. Yalom's (2001) notion of therapists as 'fellow travellers' underscores the importance of mutuality and empathy in creating a space in which clients can explore relational repair without fear of judgement.

In the third super-ordinate theme, navigating the change, participants described circumcision as a violation of bodily autonomy, aligning with the DSM-5's (APA 2013) definition of trauma arising from personally experienced intentional violence. Van Der Kolk (2014) asserts that trauma arising from harm that is deliberately inflicted often results in more severe psychological consequences given the perceived loss of agency. In this study, participants' physical reminders of circumcision, including scars and sensory loss, served as ongoing triggers, reinforcing feelings of shame and identity disruption. Social ridicule further entrenched an external locus of evaluation (Rogers 1951, cited in Sanders 2012), leaving participants dependent on others' judgements and exacerbating feelings of inferiority and alienation.

Therapeutically, addressing these intertwined issues of trauma and identity requires the use of a multifaceted approach. Psychoeducation grounded in the DSM-5 framework and trauma can help normalise clients' responses by reducing internalised blame and fostering a sense of agency. Counterconditioning, as described by Lietar (1984, cited in Mearns, Thorne, and Mcleod 2013), can be employed to challenge negative external evaluations, allowing clients to replace them with self-affirming beliefs reinforced by the therapist's unconditional positive regard. Grounding techniques and compassion-focused therapy (Gilbert 2009) can further support clients in managing emotional triggers while cultivating a sense of safety.

Participants in this study demonstrated a preoccupation with grief, finding themselves unable to move beyond the loss-oriented phase described in Stroebe and Schut (1999) Dual Process Model. Most grieving individuals show an increase in resilience for their loss within 18 months (Galatzer-Levy and Bonanno 2012), but this was not the case for participants in this study, for them, decades had passed between their loss and present day. The form of grief they experienced was consistent with that of prolonged grief disorder (APA 2013). When encountering situations such as this, a mental health practitioner needs to facilitate the client in confronting their loss, experiencing its significance, and promoting oscillation between the grief and restoration phases to allow healing to begin. Therapists can facilitate oscillation by encouraging restorative activities that promote identity reconstruction and a learning to live with what has been lost. Tonkin's (1996) model of grief identifies the therapeutic goal of facilitating clients' ability to 'grow around' their grief, integrating the experience of loss into a broader life narrative that enables the person to focus on other positive aspects of their life.

Creating opportunities for group therapy or peer-led support can help combat isolation, fostering a sense of belonging and mutual validation. When used in such a context, the therapeutic approaches described above can enable clients to navigate their trauma, reclaim self-worth, and rebuild a more cohesive sense of identity.

Limitations

This study has several limitations that should be acknowledged. First, participants were recruited from specific advocacy and support groups, 15 Square and the Reddit 'Circumcision Grief' forum, which may have introduced a selection bias by attracting individuals with strong negative feelings about their circumcision, although homogenous selection was necessary to understand the hermeneutic of those experiencing

a negative mental health impact caused by circumcision. Furthermore, data were collected at a single point in time, which does not account for the potential evolution of participants' feelings or ways of coping over a longer period.

The population validity of the study is limited, and its findings cannot be generalised beyond the sample, particularly to those from different cultural or social contexts. However, generalisation was not the goal of this investigation; rather, the study sought to explore in-depth the lived experiences of a specific subgroup. Because of this, the ecological validity of the findings is potentially high, as it relates to the in-depth experiences of a sub-set of men who experienced childhood penile circumcision and who participated in specialist support groups in the UK.

Future research could address these limitations by including more diverse groups of participants, a longitudinal design, and by comparing psychological outcomes between circumcised and uncircumcised individuals.

Conclusion

This study aims to contribute to conversation about how to provide psychotherapeutic support to men who feel their mental health has been impacted by childhood penile circumcision. The analysis highlights the overarching theme of bereavement men experienced, with a chronic form of disenfranchised grief at its centre. In other forms of grief where disenfranchisement is common, such as the loss of a pet or a loved one through completing suicide, (Doka 2002) very few would see this as a matter for ridicule, but this is frequently the case when childhood penile circumcision is discussed (Watson and Golden 2017). The term chronic disenfranchised grief is deliberately used here to reflect the fact that participants in this study never had a voice; they feel abused by their peers, shunned by their mothers, dismissed by their fathers, mutilated and ignored by the medical profession. Voices such as those that are shared here do not deserve to be silenced when they have just started to be heard. It is imperative that further research into the mental health consequences of childhood penile circumcision is carried out by researchers adopting a psychotherapeutic lens if the phenomenon is to be understood more adequately in the future.

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