BAŞKENT UNIVERSITY

INSTITUTE OF SOCIAL SCIENCES

DEPARTMENT OF PSYCHOLOGY

MASTER'S IN CLINICAL PSYCHOLOGY

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BY

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"Başkent Üniversitesi Enstitüleri Tez Çalışması Orijinallik Raporu Alınması ve Kullanılması Usul ve Esaslarını" inceledim ve bu uygulama esaslarında belirtilen azami benzerlik oranlarına tez çalışmamın herhangi bir intihal içermediğini; aksinin tespit edileceği muhtemel durumda doğabilecek her türlü hukuki sorumluluğu kabul ettiğimi ve yukarıda vermiş olduğum bilgilerin doğru olduğunu beyan ederim.

Öğrenci İmzası:

Onay

07 / 01 / 2021

Öğrenci Danışmanı Unvan, Ad, Soyad,
Dr. Öğr. Üyesi Esra Güven

To my lovely parents and grandparents…

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ÖZET

SOĞULAR, Eliz. Sünnet Olma Yaşının Erkeklerin Cinsel Deneyimleri Üzerindeki Yordayıcı Rolü: Benlik Kavramlarının Aracı Etkisi. Başkent Üniversitesi, Sosyal Bilimler Enstitüsü, Klinik Psikoloji Yüksek Lisans Programı, 2021.

Bu çalışma sünnet olma yaşı ile cinsel tatminsizlik ve aynı zamanda da cinsel işlev bozuklukları arasında yer alan erken boşalma ve erektil disfonksiyon arasındaki ilişkileri incelemeyi amaçlamaktadır. Bu amaçla sünnet yaşının, çalışmanın bu değişkenlerini çeşitli etkileşimlerle yordadığı hipotezleri sınanmıştır. Bununla birlikte çalışmada benlikle ilgili olan kavramlardan öz saygının ve öz yeterliliğin, sünnet yaşı ile cinsel deneyimler arasındaki ilişkide aracı rolüne ilişkin oluşturulan model sınanmıştır. Oluşturulan bu model yol analizi ile incelenmiştir. Çalışmanın ikincil inceleme konusu ise sünnet yaşı gruplarının (0-3, 4-6, 7-12) çalışmanın değişkenlerine göre farklılaşma örüntülerinin incelenmesidir. Araştırmanın örneklemi 0 – 12 yaş aralığında sünnet olmuş 236 erkekten oluşmaktadır. Bilgilendirilmiş Gönüllü Onam Formunu imzalayan katılımcılara sünnet deneyimine ilişkin soruların da bulunduğu Demografik Bilgi Formu, Golombok-Rust Cinsel Doyum Ölçeği, Algılanan Stres Ölçeği ve İki Boyutlu Öz Saygı: Öz Sevgi/Öz Yeterlilik Ölçeği uygulanmıştır. Öz yeterlilik ve öz saygı değişkenleri arasındaki yüksek korelasyondan dolayı öz yeterlilik çalışmanın temel analizlerinden çıkartılmış ve sadece öz saygı değişkeni kullanılmıştır. Veri toplama aşamasında Türkiye'de ilk COVID-19 vakası görülmüştür. Pandeminin etkisini kontrol etmek amacıyla ilk vakanın görülme tarihinden önce ve sonra çalışmaya gelen katılımcılar stres skorları açısından karşılaştırılmış ve anlamlı bir farklılık bulunmamıştır. Bu bulgu doğrultusunda bütün katılımcılar diğer analizlere alınmıştır. Araştırmanın sonuçlarına göre sünnet yaşı grupları arasında çalışmanın değişkenleri (cinsel işlevler ve öz saygı) açısından anlamlı bir farklılık bulunmamıştır. Buna ek olarak, yapılan yol analizi sonuçlarına göre sünnet yaşının öz saygıyı ve öz saygının da erkeklerin cinsel deneyimlerini negatif yönde yordadığı bulunmuştur. Önerilen modeldeki dolaylı etkilerin sonuçlarına göre ise öz saygının sünnet yaşı ile erkeklerin cinsel deneyimleri arasında anlamlı bir aracı etkisi olduğu tespit edilmiştir. Sonuç olarak, sünnet

yaşındaki artış bireylerin öz saygılarında azalmaya, bu azalma da erken boşalma ve erektil disfonksiyon semptomları ile bireylerin cinsel tatminsizliğine dair skorlarında artışa sebep olmaktadır. Bu bulgular, araştırmanın benlik ile ilgili kavramların sünnet olma yaşı ve erkeklerin cinsel deyimleri arasında aracılık rolüne sahip olduğuna ilişkin hipotezini desteklemektedir. Bütün sonuçlar literatür ışığında tartışılmıştır.

Anahtar Kelimler: Sünnet yaşı, erken boşalma, erektil disfonksiyon, öz saygı, yol analizi

ABSTRACT

SOĞULAR, Eliz. The Predictive Role of Circumcision Age on Sexual Experiences of Men: The Mediator Role of Self Related Concepts. Başkent University, Institute of Social Sciences, Master's in Clinical Psychology, 2021.

The present study aims to examine the relationships between circumcision age and sexual experiences of men which are premature ejaculation, erectile dysfunction, and sexual dissatisfaction. In line with this aim, path analysis was conducted to investigate the mediational role of self-related concepts which are self-esteem and self-efficacy in the relation with circumcision age and sexual dysfunctions. Also, the differences between circumcision age groups (0-3, 4-6, 7-12) on measures of the study were tested as a secondary aim of the study. The sample of the research consists of 236 circumcised men who were circumcised between the ages of 0 to 12. The participants who sign the informed consent form completed the Demographic Information Form which consists of questions regarding circumcision experience, The Golombok-Rust Inventory of Sexual Satisfaction (GRISS), The Perceived Stress Scale (PSS), and Two-Dimensional Self-Esteem: The Self-Liking/Self-Competence Scale (SLCS). Self-efficacy was removed from the main analysis of the study and only self-esteem was used as a self-related concept because of the high correlation between self-esteem and self-efficacy. Also, COVID-19 pandemic was appeared in Turkey during data collection process. Therefore, stress scores of participants, who were enrolled in the study before and after the first COVID-19 cases, were compared with each other. The results showed that there is no significant difference between groups. Therefore, all participants were included in other analyses. According to the results, there is no significant difference between circumcision age groups in terms of measures of the study (sexual experiences and self-esteem). On the other hand, the path analysis results show that circumcision age negatively predicts self-esteem. Also, self-esteem predicts sexual dysfunctions and sexual dissatisfaction in a negative way. The results of path analysis revealed the significant mediational role of self-esteem in the relationship between circumcision age and sexual dysfunction. Finally, it can be concluded that as the circumcision

age increases, a decrease is observed in individuals' self-esteem and this diminishment causes an increase in premature ejaculation and erectile dysfunction symptoms, and sexual dissatisfaction scores in men. These findings support the hypothesis of this research regarding the mediating role of self-related concepts. The results are discussed under the light of the literature.

Keywords: Circumcision age, premature ejaculation, erectile dysfunction, self-esteem, path analysis

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CHAPTER I

INTRODUCTION

Sexuality and sexual functioning are some of the most important concepts in human beings' life. Sexuality is defined as "a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, and social well-being that relates to one's sexuality". Also, it is related with physical, emotional, and social well-being of a person (World Health Organization, 2002). Sexuality can be experienced and expressed differently due to effects of social, cultural, psychological, religious, and biologic factors (Southard & Keller, 2009). Men and women are negatively affected by not having a functional sex life in terms of interpersonal functioning and quality of life (Rosen, 2000). Sexual dysfunctions are categorized under eight topics in Diagnostic and Statistical Manual of Mental Disorders – 5 (DSM V). Four of them belong to men and these are delayed ejaculation, erectile dysfunction, male hypoactive sexual desire disorder and premature ejaculation. Premature ejaculation and erectile dysfunction are the most common sexual dysfunctions among men. There is no universal definition for premature ejaculation, however, it can be defined as "in almost all or all (75 - 100%) sexual activity, the experience of a pattern of ejaculation occurring during partnered sexual activity within 1 minute after vaginal penetration" (Althof, 2006; American Psychiatric Association, 2013). It is one of the most common sexual dysfunctions among men. However, actual prevalence of premature ejaculation is still uncertain in the literature (Althof et al., 2014). There are studies which try to show estimated prevalence of the premature ejaculation. According to the studies on this area, general prevalence of the premature ejaculation shows changes between 20% and 25%. Also, these results show variations due to cultural differences (Porst et al, 2007). For instance, according to a current research, prevalence of premature ejaculation was found 9.2% among Turkish sample (Karabakan et al., 2016). However, in the US population prevalence of it was found 32.5% (Rowland et al., 2004). In addition to premature ejaculation, erectile dysfunction is another most common sexual dysfunction among men. It is defined "in almost all or all (75-100%) sexual activity, as inability to achieve or maintain an adequate erection during partnered sexual activities" (American

Psychiatric Association, 2013). Like premature ejaculation, it is hard to say exact prevalence of erectile dysfunction and it shows difference according to regions. For instance, according to a study, the overall prevalence of erectile dysfunction in Turkey was determined as 69.2% and it increases with age. In terms of moderate and severe erectile dysfunction cases, the prevalence is 36% in this study (Akkus et al., 2002). On the other hand, prevalence rate of erectile dysfunction in the US was determined as 18.4% for men and it is estimated that 18 million men affected by erectile dysfunction (Selvin et al., 2007). As mentioned before, sexual dysfunctions affect whole life of a person. Also, the relationship with partner is affected by stress which is associated with premature ejaculation. A man who has premature ejaculation symptoms can avoid maintaining the relationship due to embarrassment and social stigma. Additionally, a single man who has premature ejaculation may avoid forming a new relationship (Rowland et al., 2004; Symonds et al., 2003). Also, it is assumed that stress might be effective on sexual dysfunctions. On the other hand, depression and anxiety are the most common psychological comorbid disorders among men who have premature ejaculation and/or erectile dysfunction. Studies suggest that premature ejaculation and erectile dysfunction are significantly related with anxiety and depression (Bodenmann et al., 2006; Rajkumar & Kumaran, 2015; Mourikis et al., 2015). Not only premature ejaculation, but also erectile dysfunction has negative impact on male overall wellbeing. Men who experience erectile dysfunction reported serious distress in both their relationships and self-esteem. As a matter of fact, when the treatment did not work, they experience lack of self-worth (Tomlinson & Wright, 2004). Considering importance of the sexuality or sexual functioning and its adverse effect on wellbeing or relationship dynamics of a person, these concepts should be investigated in dept. Thus, a better understanding can be obtained about causes of sexual dysfunctions which makes both prevention and/or treatment of these dysfunctions easier.

When the subject is sexuality and sexual functioning of men, circumcision is one of the first things come to mind. It might be one of the most debated topics in this area. Although there are mixed results, studies generally claim that circumcision has little or no effect on sexual functioning. However, almost all studies were done with men who were voluntarily circumcised after 18 years old. Even though it is a very common process, the impact of infancy or childhood circumcision is still unknown in terms of sexuality or sexual functioning (Earp, 2015). Therefore, in this study, it is aimed to investigate relationship between sexual dysfunctions and

infancy and childhood circumcision with related psychological concepts. These variables will be mentioned in the next parts of the paper. Firstly, circumcision, especially circumcision age, will be discussed as a concept, then sexual dysfunctions and self-related concepts will be mentioned by focusing on their relationship with each other.

1.1. Circumcision Age

Almost all men in the world are born with a skin on penis which is known as foreskin. In some cases, foreskin can be removed by a surgical operation which is called circumcision (Abara, 2017). The origin of the circumcision is still unknown. It is hard to say when it was started. Yet, it is assumed that it has begun several thousand years ago. It may be accepted as the oldest procedure in human history. Also, male circumcision is one of the most applied surgical operations in the world. (Cox & Morris, 2012). Overall prevalence of male circumcision was estimated 36.7% - 38.7% of the population in the world. In Turkey, almost all men are circumcised, and it is estimated 98.6% of the male population were circumcised (Morris et al, 2016).

In terms of performing time of circumcision, it can be said it shows differences between cultures. In some cultures, such as African tribes it is performed at birth, however, in Judaic societies it is performed after 8 days from the birth. On the other hand, the time of circumcision varies in Muslim societies because there is no certain circumcision age for Muslims, however, they generally prefer performing it in late childhood or early adolescence (Sahin et al., 2003; Mahmood et al., 2015; Anwer et al., 2017). For instance, in eastern societies, it is common to apply male circumcision in late childhood (Gollaher, 2000). According to Öztürk (1973), 46% of the boys get circumcised between the ages of 3 and 6, 33% of them were circumcised between the ages of 7 and 11. Other males were circumcised before or after these ages in Tukey. However, in more current study, these ratios are slightly different. 11% of the boys get circumcised between the ages of 0 and 2, 27.1% of them get circumcised between the ages of 3 and 5, and 61.7% of them get circumcised between the ages of 6 and 12 (Aydur et al., 2007). Thus, it may indicate that most of the boys get circumcised after 6 years old in Turkey.

Like performing time of male circumcision, the reason of male circumcision can also show variations through countries. Culture and religion are the reasons of approximately half of the male circumcision in the world. Also, although rates are very low, there are medical reasons for male circumcision (Morris & Cox, 2012). Yet, fundamental reason of circumcision is nearly same for several cultures. The main reason behind male circumcision is to remind the power of church or God to men. It was accepted as a contract between God and men. In addition to the spiritual reasons of male circumcision, it is also applied to enhance sexual and reproductive performance of men in some cultures. Especially in patriarchal societies, circumcision may be the most important issue for men. Since circumcision is a rise for them, men must have it in male dominated societies (Dunsmuir & Gordon, 1999; Caldwell et al., 1997). On the other hand, in terms of medical perspective, it is recommended to eliminate the risk of some diseases or sexually transmitted diseases, such as penile cancer, HIV (human immunodeficiency virus), etc. (Larke et al., 2011; Bailey et al., 2007). Therefore, circumcision age may be crucial in some cases.

When the possible adverse effects of circumcision are examined, it is seen that it has physiological and mostly psychological effects. Pain is one of the most remarkable concepts of the circumcision. Like adults, infants and children can feel pain excessively. In fact, stress hormones are triggered by intense pain and this may lead to disadvantageous effect on brain development, sexual function, and behavior (Prescott, 1989). Also, circumcision, especially without anesthesia, can be a traumatic event in a child's life and it may have a long-lasting psychological effect. Increased aggressiveness, weakening of the ego, withdrawal, reduced functioning, and adaptation can be associated with circumcision (Lander et al, 1997; Boyle et al., 2002). Rhinehart (1999) claims that adults who were circumcised in childhood may show adverse reactions, such as terror, rage, and dissociation, especially when countering threatening situations. In addition to this, diminished sense of masculinity, low self-esteem and sense of personal powerlessness were reported by circumcised men. It may not be identified as a traumatic event; however, its long-lasting psychological effects are incontrovertibly important. Anxiety, depression, and sense of personal vulnerability are some of the adverse effects of childhood male circumcision (Hammond, 1999).

In addition to adverse effects of circumcision, in some cultures, being circumcised may has positive effects. For instance, as mentioned above, being circumcised as a child leads to the feeling incomplete, when he compares himself with other peers in some cultures; however, in other cultures where circumcision is applied commonly it can be perceived as a "normal" procedure (Bigelow, 1995, as cited in Boyle et al., 2002). In fact, being not circumcised might be interpreted as inadequate and diminished sense of masculinity in those cultures such as Turkey. Thus, like Öztürk (1973) says circumcision is an essential process in Turkey for self-respect of men. In fact, circumcision that is applied in the age of high memorability may show the importance of the circumcision in Turkey. Also, organizing special events with the specific clothes for circumcised child shows cultural and social value of the circumcision (Gülaçtı et al., 2016). According to Erikson's (1963) psychosocial development stages, the fourth stage which is called industry versus inferiority (6 - 12 ages) is a stage in which children start going to school and peer groups become the most important thing in their life. Also, competence begins to be a crucial concept in this period of life. The feeling of competence is developed by their accomplishments. Being circumcised may also be interpreted as an accomplishment among society and peers of the children. To be clearer, if a child has not circumcised yet in school ages and comparing himself with his peers in terms of circumcision status, this situation leads to experiencing lack of competence. This situation can be identified as "delayed circumcision" which may lead to have anxiety from childhood to adulthood, which is significantly related with sexual dysfunctions, especially premature ejaculation (Cüceloğlu et al., 2012). Anxiety has been an important concept since sexuality began to be studied for the first time. Sexual dysfunctions are common among the individuals who have anxiety disorders (Masters & Johnson, 1970, Bodinger et al., 2002). According to studies, early traumatic experiences lead to distorted psychological functioning, such as anxiety, and the adverse effect of distorted psychological functioning may show itself in adults' sexual experiences as sexual dysfunctions (Roesler & McKenzie, 1994; Najman et al., 2005).

1.2. Sexual Dysfunctions

The importance of sexual functioning was mentioned in the first part of the paper. It is not only crucial for an individual's psychological well-being, but also it is important for the quality of relationship with partners. In addition to this, it is believed that there is a connection

between sexuality and circumcision. Therefore, this possible relationship will be discussed in the next part of the paper. In order to do this, the most common sexual dysfunctions of men, which are premature ejaculation and erectile dysfunction, and overall sexual satisfaction will be used as dependent variables of the study.

1.2.1. Premature ejaculation

As identified before, premature ejaculation is a sexual dysfunction which is related with the ejaculation time of a male and the prevalence of premature ejaculation shows diversity among regions. The reason behind it can be cultural factors because premature ejaculation can consist of self-reported and self-rated concepts, so culture may affect evaluation of the premature ejaculation for an individual. The countries, such as Turkey, Egypt, South Africa etc. show lowest prevalence for premature ejaculation. The reason of this might be cultural or religious beliefs. For instance, in Muslim countries the meaning of premature ejaculation may be more than a basic disease. Premature ejaculation can be perceived as a threat to masculinity which may affect expressing of it. In developed countries, such as Central and South America, sexuality of women is also important. Therefore, having premature ejaculation symptoms can be more important for males and this can affect prevalence of the premature ejaculation among males (Jannini & Lenzi, 2005; Rowland et al., 2004). There are different kinds of reasons for premature ejaculation from physiological explanations to psychological explanations (Metz & Pryor, 2000; Masters & Johnson, 1970). Circumcision is one of the most debated topics in this area. Some studies indicate circumcision does not have a significant effect on premature ejaculation; it just affects masturbatory pleasure negatively (Yang et al., 2017; Kim & Pang, 2007). Other studies show that circumcision does not have adverse effect on premature ejaculation. In fact, after circumcision individuals reported improvement in their premature ejaculation severity in a positive way, which means adult male circumcision leads to control over ejaculation and sexual satisfaction (Gao et al., 2015; Alp et al., 2014). On the other hand, beyond from the effect of circumcision itself, applied age of it may be effective on premature ejaculation. A study which was done in Turkey indicates that men who were circumcised after the age 7 show more premature ejaculation symptoms at their adulthood than males who were circumcised before 7. Not being circumcised at that age may lead to anxiety or sense of

incompetence due to cultural factors, such as importance of the circumcision in this society (Cüceloğlu et al., 2012). It is known that meaning of premature ejaculation are differently expressed in different cultures or regions. Also, meaning of the circumcision may show differences between cultures, as mentioned in the first part of the paper. Therefore, while examining relationship between premature ejaculation and circumcision, other psychological and cultural concepts also should be investigated, such as, meaning and importance of the circumcision in that culture and self-related concepts. In other parts, these concepts will be mentioned in detail.

1.2.2. Erectile dysfunction

Erectile dysfunction, which have already identified above, have physiological and psychological reasons. Especially, cardiovascular disease and erectile dysfunction have high correlation in terms of symptom severity (Banks et al., 2013; Shabsigh et al., 2005). On the other hand, age is another risk factor for erectile dysfunction. Age has a linear relationship with erectile dysfunction. There is no determined age threshold for erectile dysfunction, however, being older than 40 or 50 can be a risk factor. The reason behind this can be more related with the other health issues which occur with age, such as cardiovascular disease, diabetes, urinary tract symptoms etc. (Braun et al., 2003; Bai et al., 2004). On the other hand, erectile dysfunction, which shows itself in younger age, may be related with performance anxiety, sexual inexperience, and life stressors. Also, young men can be less willing to answer questions about their sexual dysfunctions in assessment tools which measure sexual dysfunctions (Kessler et al., 2019; Lau et al., 2005). In addition to the organic reasons of erectile dysfunction, psychological reasons of it are also important. Especially men, who are younger than 40, reported psychogenic reasons for their erectile dysfunction in the study which was done in Turkey. Culture may be an explanation for this. In Turkey, there is a serious pressure on young individuals in terms of sexuality and this may lead to performance anxiety and affects sexual dysfunction in young men (Caskurlu et al., 2004). Culture plays an important role on both acquiring and sustaining sexual dysfunctions. Culture may not directly affect sexual dysfunction, but the rituals or practices which are done in a specific culture may affect the meaning of sex, personal performance evaluation, information about sex etc. (Ahmed & Bhugra, 2007). Circumcision is one of these

cultural practices. Studies which were done one circumcision and erectile dysfunction are similar with the results of the relationship between premature ejaculation and circumcision. There are mixed results in both. Some studies indicate that circumcision decreases penile sensitivity and affect erectile functions in a negative way (Fink et al., 2002). Unlike these results, other studies show that there are no significant differences between circumcised and uncircumcised men in terms of sexual function, and men reported significant improvement in sexual functions after circumcision (Kigozi et al., 2008; Senel et al., 2012). As mentioned before, adult circumcision has mixed results, however, childhood circumcision is also a very common process. Despite of this fact, there are no efficient studies to show relationship between childhood circumcision and erectile dysfunction. According to Aydur et al. (2007), childhood circumcision may affect domain of the sexual functions, such as avoidance and communication, but it does not affect overall sexual function. However, as mentioned before, psychological concepts and culture may have an effect on premature ejaculation and this is also valid for erectile dysfunction, so this topic should be investigated with other related psychological concepts which will be mentioned in other parts.

1.2.3. Sexual satisfaction (or dissatisfaction)

Sexual satisfaction is one of the important aspects of overall wellbeing and sexual health. There are diverse determinants of sexual satisfaction. Frequency of sex, marital satisfaction, sexual dysfunctions, cultural beliefs, circumcision etc. can be related with sexual satisfaction. For instance, in previous studies, it was considered as quantity of sex and sexual satisfaction are the same concepts. That means, they are related with each other. Individuals' perspective toward quality of their sex life was determined by their amount of sex (Edwards & Booth, 1976; Henderson-King & Veroff, 1994). More current studies also support this idea by looking marital satisfaction as well, it was found that there is a positive relationship between frequency of sex and sexual satisfaction (McNulty et al., 2016). Also, sexual dysfunctions such as premature ejaculation and erectile dysfunction, which are mentioned in the previous sections, are associated with sexual satisfaction. These are significant predictors of sexual satisfaction. Individuals who suffer from sexual dysfunctions also report lower level of sexual satisfaction (Rowland et al. 2004; Patrick et al., 2005; Nelson et al., 2007) In addition to all these,

circumcision is also one of the determinants of the sexual satisfaction. However, there is no consensus for this topic among researchers. Some studies show that circumcision affect sexual satisfaction in a positive way. After circumcision individuals reported that they reach orgasm easier and their penile sensitivity has increased. Moreover, male circumcision has no adverse effect on sexual satisfaction. In fact, adult circumcision has a beneficial effect on sexual satisfaction (Krieger et al., 2008; Morris & Krieger, 2013; Nordstrom et al., 2017). On the other hand, there are studies which did not find any significant relationship between male circumcision and sexual satisfaction (Hoschke et al., 2013). However, all these studies were done on male who were circumcised voluntary and after the age 18. Unfortunately, the effect of infant or childhood circumcision on sexual satisfaction is still unknown. A few studies suggest that infant circumcision may have adverse physical and psychological effects which affect sexual satisfaction. In a study, it was found that men, who were circumcised in their childhood, experience less satisfaction with their orgasms (Boyle & Bensley, 2001). It is seen that while circumcision positively affects men who were circumcised in adulthood, it negatively affects men who were circumcised in childhood in terms of sexual satisfaction. Childhood circumcision is not a voluntary processes and healthy part of the child is removed from him involuntary (Earp, 2015). This explanation may be the reason of different results regarding sexual satisfaction. As mentioned before, infancy and childhood circumcision are performed due to cultural and religious reasons in many regions. Also, circumcision is seen as an important value of the culture. Therefore, growing up with these cultural values and its effects may have an impact on sexual satisfaction as well as sexual dysfunctions. However, it is difficult to say that which age group causes this negative effect on sexual satisfaction. Thus, sexual satisfaction was included in this study which investigates relationship between circumcision age and sexual experiences of men.

Circumcision and its possible effects on sexual experiences were discussed thus far. In brief, although results are controversial, they claim that there may a relationship between circumcision and sexual experiences. The direction of the effect may be determined by circumcision age. The studies, which were done in this area, take attention to self-related concepts which may be related to circumcision and sexual experiences. Therefore, these self-related concepts will be discussed in the next part of the paper.

1.3. Self-Related Concepts: Self-Esteem and Self-Efficacy

Concepts of self are one of the most studied topics in the history of psychology. Self-esteem can be defined as an internal process which is "the association of the concept of self with a valence attribute" (Greenwald et al., 2002). Feeling good should be considered as a fundamental need of human nature. Also, it can be a subjective evaluation of self in terms of adequacy. This evaluation refers to self-esteem. For instance, when a person has high self-esteem, he or she successfully copes with a situation; however, unlike high self-esteem, low self-esteem leads to avoidance from the situations (Bednar et al., 1989). In addition to the self-esteem, self-efficacy is one of the other concepts that are related to self. Self-efficacy is defined as "people's beliefs about their capabilities to produce designated levels of performance". Feelings, thoughts, sense of motivation and behaviors are all affected and determined by self-efficacy. While high self-efficacy provides sense of accomplishment and personal well-being in many ways, low self-efficacy leads to avoidance from difficult tasks since they are perceived as personal threats and this situation may make people victim of the stress and depression (Bandura, 1994). Many aspects may affect self-esteem and self-efficacy of a person. Social relations are one of them. Approval and respect come from social relations form feeling of self-esteem. That means, evaluation of oneself can be determined by interpersonal relationships. Being accepted and valued person has a strong relationship with self-esteem (Barkow, 1980; Leary & Downs, 1995). Similar reasons are valid for self-efficacy. Social modelling has an impact on perceived self-efficacy. Being very different from a model may lead to low self-efficacy. Especially, peers play an important role on developing sense of self-efficacy. In school ages, social comparison with other students in terms of their accomplishments affects children's judgments of their own efficacy (Bandura, 1994). Also, social structures and sexual behaviors are related with each other. Therefore, the role of social attitudes and expectations on sexual performance should not be underestimated. These expectations and attitudes come from society are used while determining what they must be like. For instance, stereotypes may affect sexuality in a negative way. Sexual partner, health professionals and media messages determine an individual's perception about their own sexuality. Clashing normative scenarios with desires may lead to performance anxiety (Weeks, 2002). It is known that self-esteem and sexual dysfunctions affect each other, especially premature ejaculation. The men who have premature ejaculation symptoms have also lower self-esteem when compared with men who do not have

premature ejaculation symptoms (Rowland et al., 2007). The reason of this may be poor self-evaluation. Dysfunctional beliefs and expectations may cause performance anxiety and low self-esteem. Self-efficacy is one of the other important concepts in here because during treatment processes of erectile dysfunction, it is aimed to increase self-efficacy to get effective results from treatment (Rosen et al., 1994). This shows us not only self-esteem, but also self-efficacy plays a crucial role on developing and maintaining erectile dysfunction and premature ejaculation. In the light of all this information, this situation can be valid for circumcision and especially performing time of it. As mentioned before, in eastern societies circumcision is applied after the ages of 6 or 7 -school ages- the reason of this is to demonstrate the importance of the event. In societies such as Turkey circumcision is seen as one of the important aspects of virility and it has a cultural meaning. The messages about how a man must be and manhood may affect a person's perception about self, especially when the subject is sexuality or sexual performance. Therefore, it is important to examine self-related concepts while investigating circumcision and sexual dysfunctions. Actually, the relationship between circumcision and these concepts are tried to be investigated in the literature. For instance, a study which compares circumcised and uncircumcised men found that uncircumcised men have lower self-esteem (Kalkan et al.,2010). Yet, this study was conducted with individuals who were circumcised in childhood and who were not yet circumcised at the age of 20. This means, it is still unknown how self-esteem or self-efficacy will be affected by circumcision that is performed during infancy or childhood. In Turkey, every man is expected to be circumcised. Considering this cultural expectation, it is assumed that circumcision age may be effective on individual's evaluation regarding self. Thus, these concepts were included in this study to get better understanding about effects of the infancy and childhood circumcision on sexual dysfunctions.

1.4. Aims of the Study

Studies which were conducted on sexual dysfunctions in terms of relationship with other concepts are limited in the literature. Circumcision is one of them, especially infancy or childhood circumcision is one of the least studied topics in the literature in terms of the relationship with sexual dysfunctions. However, it is known that circumcision is one of the most applied operations in the world. Especially in Turkey, almost all men are circumcised before puberty. The decision of when circumcision will be applied belongs to parents. The decision of

parents show diversity according to their parenthood dynamics, cultural beliefs or expectation from this operation and these factors affect when it will be applied. In this present study, it is aimed to find whether there is any connection between circumcision age and sexual dysfunctions. Also, in the light of the findings of the current study, it is aimed to find most appropriate age range for circumcision in terms of sexual dysfunctions and sexual satisfaction in adulthood This information can be used by both parents and healthcare providers while deciding circumcision age for boys. In addition to these, it is assumed that it will make important contributions to the literature because as mentioned before, literature is extremely weak regarding this topic, especially in terms of psychological effects of circumcision.

In the light of the literature, this study aimed to investigate the predictive role of circumcision age on erectile dysfunction and premature ejaculation symptoms and overall sexual satisfaction by investigating the mediator role of self-esteem and self-efficacy in this prediction. It is expected that circumcision age negatively predicts both self-esteem and self-efficacy and this mediator role have an effect on male sexual experiences in terms of premature ejaculation, erectile dysfunction, and sexual satisfaction. These expected relationships are shown in figure 1.1. At the end of the research, it is expected to find that erectile dysfunction and premature ejaculation show changes according to circumcision age. Sexual dysfunction symptoms and sexual dissatisfaction increase according to age with the effects of the mediators. To be clearer, as the age increases, sexual dysfunction symptoms and sexual dissatisfaction scores also increase.

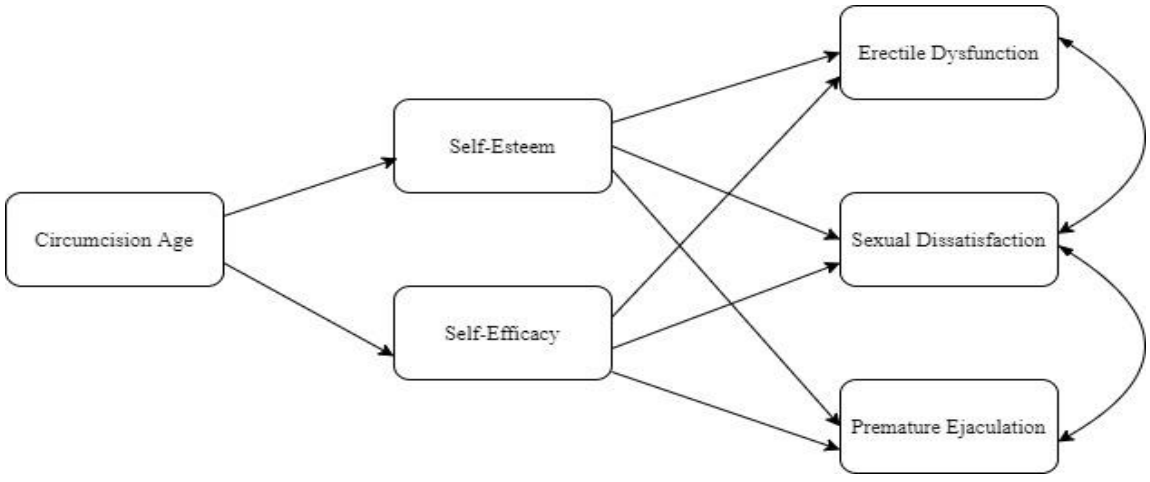


Figure 1.1. Hypothetical Model of the Study

1.5. Hypotheses of the Study

1. There is a significant difference between circumcision age groups in terms of measures of the study.
    a) There is a significant difference between circumcision age groups in terms of self-related concepts (self-esteem and self-efficacy).
    b) There is a significant difference between circumcision age groups in terms of premature ejaculation.
    c) There is a significant difference between circumcision age groups in terms of erectile dysfunction.
    d) There is a significant difference between circumcision age groups in terms of sexual dissatisfaction.
2. Suggested model, which tries to explain sexual experiences of participants in the context of circumcision age and self-related concepts, is significant. According to this model,
    a) Circumcision age predicts self-related concepts (self-esteem and self-efficacy) in a negative way.
    b) Self-related concepts predict all sexual experiences of males (premature ejaculation, erectile dysfunction, and sexual dissatisfaction) in a negative way.
    c) Circumcision age's prediction on sexual experiences is mediated by self-related concepts (self-esteem and self-efficacy).

CHAPTHER II

METHOD

2.1. Participants

Prior to analysis, participants who have cardiovascular disease and psychological disorder and participants who use psychiatric medication were eliminated from the study. Remaining two-hundred-thirty-six (236) circumcised men were involved in this study. Considering their sexual orientation, 92.8% heterosexual, 3.4% homosexual, 2.5% bisexual men participated in the study and 1.3% of the participants identified their sexual orientation other from these three orientations. Having an active sexual life up to three months ago was the first criterion to participate in the study. 83.9% of the participants reported that they have an active sexual life currently, and 8.1% of the participants reported that have not an active sexual life for the last one month, 3.4 % for the last two months and 4.7% for the last three months. The ages of participants ranged from 19 to 48 and mean age was (M = 26.45, SD = 4.74). In terms of relationship status, 66.9% of the participants had a romantic relationship, 21.2% did not have a romantic relationship and 8.5% were married, and also 3.4% of the participants chose other than these three options while identifying their relationship status. Furthermore, most of the participants had a university or higher degree in this study (literate 1.7%, high school 22.3%, university 51.3%, master and higher 24.8%). Also, income level of participants ranged from low to high (21.2% low, 59.7% middle and 19.1% high). 48.7% of the participants were students. Also, while 46.6 % of the participants had an occupation, 4.7% did not have an occupation. Lastly, 50.4% of the participants reported that they grew up in big cities, 39.8% in cities, 7.6% in towns and 2.1% in villages (see detailed information in Table 2.1.).

Table 2.1. Demographic characteristics of the participants

Variables	N (236 participants)	%	M	SD
Sexual Orientation				
Heterosexual	219	92.8		
Homosexual	8	3.4		
Bisexual	6	2.5		
Other	3	1.3		
Sexual Life				
Active sex life	198	83.9		
At least 1 month ago	19	8.1		
At least 2 months ago	8	3.4		
At least 3 months ago	11	4.7		
Age			26.45	4.74
Relationship Status				
In a relationship	158	66.9		
Single	50	21.2		
Married	20	8.5		
Other	8	3.4		
Education Level				
Literate	4	1.7		
High school	53	22.3		
University	122	51.3		
Master and higher	59	24.8		
Income Level				
Low	50	21.2		
Middle	141	59.7		
High	45	19.1		
Occupation Status				
Student	115	48.7		
Not working	11	4.7		
Have an occupation	110	46.6		
Hometown				
Village	5	2.1		
Town	18	7.6		
City	94	39.8		
Big City	119	50.4		

2.2. Instruments

Instruments, which are Demographic information form, The Golombok-Rust Inventory of Sexual Satisfaction (GRISS), The Perceived Stress Scale (PSS), and Two-Dimensional Self-Esteem: The Self-Liking/Self-Competence Scale (SLCS), were used in this study. Details regarding instruments of the study are given next parts of the paper.

2.2.1. Demographic Information Form

This is a self-report form (see Appendix 1) which was developed by the researcher and includes some demographic questions about participants. Information about age, occupation status, education and income level of the participants were obtained via this form. Also, questions regarding using any kind of drug consistently, having a psychiatric diagnosis were asked to participants. These questions were used as a hallmark to eliminate participants. Lastly, questions regarding circumcision experiences of the participants were asked. These questions were designed to get information about when participants were circumcised, how was the process, whether they have any kind of memory about the process and what is the meaning of the being circumcised for them.

2.2.2. The Golombok-Rust Inventory of Sexual Satisfaction (GRISS)

This scale (see Appendix 2) was designed by Rust and Golombok in 1986 to assess the existence and severity of the sexual problems. The scale was designed for heterosexual couples or individuals. It is a 5-point likert scale in which 0 refers to “never” and 4 refers to “all time”. There are two forms of this scale and each form includes 28 items. These forms are specified in seven subscales which are frequency of sexual contact, sexual noncommunication, dissatisfaction, non-sensuality, and avoidance of sex. These 5 subscales are common in man and woman scale, but sexual dysfunctions parts of the scale are different with each other. Whereas woman form of this scale includes anorgasmia and vaginismus, man form of the scale includes impotence and premature ejaculation. Getting 5 or more points from a subscale refer distorted function in the variable measured by the subscale. In male form, 14 items, which are 1, 2, 3, 4, 8, 9, 12, 13, 15, 16, 19, 20, 21 and 25 are summed reversely. Questions 3, 10, 16 and 23 (e.g.

“Do you become easily sexually aroused?”) measure impotence, 4, 13,24 and 27 (e.g. “Are you able to delay ejaculation during intercourse if you think you may be "coming" too quickly?”) measure premature ejaculation, 6, 12, 20 and 25 (e.g. Do you dislike stroking and caressing your partner's genitals?”) measure non-sensuality, 7, 14, 22 and 28 (e.g. “Do you become tense and anxious when your partner wants to have sex?”) measure avoidance, 5, 11, 15 and 21 (e.g. “Are you dissatisfied with the amount of variety in your sex life with your partner?”) measure dissatisfaction, 1 and 17 (e.g. “Do you have sexual intercourse more than twice a week?”) measure frequency and lastly, questions 2 and 9 (e.g. “Do you find it hard to tell your partner what you like and dislike about your sexual relationship?”) measure communication. The split-half reliabilities of female and male scales were found high, .94 and .87. The test-retest reliabilities of subscales are .79 for impotence, .84 for premature ejaculation, .57 for non-sensuality, .64 for avoidance, .61 for dissatisfaction, .66 for frequency and .52 for communication. Also, it was found that it is an appropriate scale to discriminate clinical and nonclinical groups from each other. With all these psychometric properties of this scale was found reliable and valid for heterosexual couples and individuals (Rust and Golombok, 1985; Rust & Golombok, 1986). This scale was applied to Turkish sample by Tuğrul, Öztan and Kabakçı in 1993 with the name of “Golombok-Rust Cinsel Doyum Ölçeği (GRCDÖ)”. Like in the original form, the split- half reliabilities of female and male scales were found high, .91 and .90. Values of Cronbach’s alpha of male version’s subscales are .84 for impotence, .91 for premature ejaculation, .68 for non-sensuality, .72 for avoidance, .73 for dissatisfaction, .63 for frequency and .74 for communication. Also, this version of the scale was found favorable for differentiating clinical and nonclinical groups from each other. To sum up, this version of the scale also indicates that it is a suitable psychometric instrument for Turkish sample (Tuğrul et al., 1993). Additionally, in this study, Cronbach’s alpha values of this scales was found .79. Also, three subscales were used in this study, values of Cronbach’s alpha of these subscales are .62 for impotence, .70 for premature ejaculation, and .62 for dissatisfaction.

2.2.3. The Perceived Stress Scale (PSS)

This scale (see Appendix 3) was designed by Cohen, Kamarck and Mermelstein in 1983. It consists of 14 items in order to measure how a person perceives events in terms of stress. In

addition to PSS with 14 items, there are two extra form which have 10 and 4 items. In this research PSS-14 was used. It is a 5-point Likert scale in which 0 refers to "never" and 4 refers to "often". 7 items, which are 4, 5, 6, 7, 9, 10, and 13, are the positive statements and scored in reverse direction. Total score can be 56 for this scale and higher scores show higher perceived stress for individuals. In terms of reliability of this scale, test-retest reliability was found .85 and Cronbach's alpha was found .84, .85, and .86 for three different sample (Cohen et al., 1983). Turkish adaptation of this scale was done by Eskin, Harlak, Demirkıran and Dereboy in 2013 with the name of "Algılanan Stres Ölçeği". Applied statistics show that there are two dimensions in this scale and each one of them consists seven items. One of them is insufficient self-efficacy with $\alpha = 0.81$ (e.g., "In the last month, how often have you dealt successfully with irritating life hassles?") and other one is stress/perceived discomfort with $\alpha = 0.76$ (e.g., "In the last month, how often have you felt nervous and stressed?"). Cronbach's alpha score of the reliability was found .84 for PSS-14. This result indicates that Turkish adaptation of this scale is a reliable test and can be used for Turkish sample (Eskin et al., 2013). Also, Cronbach's alpha value of this scale was found .83 in this study.

2.2.4. Two-Dimensional Self-Esteem: The Self-Liking/Self-Competence Scale (SLCS)

This scale (see Appendix 4) was developed by Tafarodi and Swan in 2001 in order to determine self-esteem scores of individuals by measuring both their self-liking and self-competence evaluations. There are 16 items in this scale, and it is a 5-point Likert scale in which 1 refers to "strongly disagree" and 5 refers to "strongly agree". As mentioned above, there are two subscales in this measurement tool and these are "self-liking" (e.g., "I feel great about who I am") with .90 Cronbach's alpha value for males, and other one is "self-competence" (e.g., "I am highly effective at the things I do") with .82 Cronbach's alpha value for males. Test-retest reliability coefficients were determined as .75 for "self-liking" and .78 for "self-competence". Also, 1, 6, 7, 8, 10, 13, 15 and 16 items are reversely coded and higher scores indicate higher self-esteem (Tafarodi & Swann, 2001). The Turkish adaptation of this scale was done by Doğan in 2011 with the name of "İki Boyutlu Öz Saygı: Öz Sevgi/Öz Yeterlilik Ölçeği". According to the results, Cronbach's alpha value of "self-liking" subscale was found as .83 and also

Cronbach's alpha value of "self-competence" subscale was found .74. Moreover, test-retest reliability of both subscales was found .72. The results indicate that the Turkish version of this scale is a reliable measurement tool for Turkish sample (Doğan, 2011). Also, Cronbach's alpha value of this scale was found .90 in this study. In terms of subscales, it was found .85 for self-liking and .82 for self-competence.

2.3. Procedure

The data of this study were obtained from men who were circumcised before the age 12. Before collecting data, the required ethical approval was received from the ethical committee of Başkent University (see Appendix 5). This research was announced in social media and all data were obtained from participants via Qualtrics. Participation to this study was on voluntary basis and attention was paid to the principle of confidentiality in the study. Therefore, informed consent form (see Appendix 6) which explains aim and duration of the study, and principle of confidentiality, was provided to all participants. After participants approved informed consent, demographic information form, The Perceived Stress Scale (PSS), The Golombok-Rust Inventory of Sexual Satisfaction (GRISS) and Two-Dimensional Self-Esteem: The Self-Liking/Self-Competence Scale (SLCS) were respectively distributed to participants. It took approximately 15-20 minutes to answer all scales.

2.4. Analysis of Data

Firstly, circumcision age defined as independent variable (IV) and self-esteem, self-efficacy, premature ejaculation, erectile dysfunction, and sexual dissatisfaction were defined as dependent variables (DV) of this study. In addition to these main variables, stress was taken as control variable in this study. In order to analyze data, which was collected from instruments, SPSS (Statistical Package for Social Sciences) and AMOS 22 version were used. Firstly, descriptive analyses (mean, standard deviation, percentile, skewness and kurtosis values, minimum and maximum scores) were done to analyze demographic characteristics of participants and descriptive features of the measures. Also, the following analyses were conducted:

- Two separate independent sample t-test analyses were done to determine whether COVID-19 pandemic (both first case and first death case) affect participants stress scores.
- A single linear regression was conducted to see whether premature ejaculation, erectile dysfunction, and sexual dissatisfaction are predicted by stress.
- Kendall's tau-b analysis was used to measure correlation between variables of the study.
- Analysis of variance (ANOVA) was used in order to determine whether circumcision age differs accordingly hometown. In order to test one of the hypotheses of the study, multivariate analyses of covariance (MANCOVA) was conducted to examine the differences on erectile dysfunction, premature ejaculation, sexual dissatisfaction, self-efficacy, and self-esteem according to the circumcision age groups.
- Crosstabs analyses were used for obtaining frequencies regarding circumcision experiences of participants based on their circumcision age and current age.
- Path analysis of Structural Equation Model (SEM) was used in order to determine mediation effect of self-related concepts between circumcision age and sexual experiences, which is the main hypothesis of the study.

CHAPTER III

RESULTS

3.1. Descriptive Analyses of the Measures of the Study

In this part of the paper, means, standard deviations, minimum scores, maximum scores, skewness, kurtosis, and internal consistency coefficients (Cronbach's alpha) values were calculated for subscales of The Golombok-Rust Inventory of Sexual Satisfaction (GRISS) (i.e., impotence, premature ejaculation and dissatisfaction), The Perceived Stress Scale (PSS), and Two-Dimensional Self-Esteem: The Self-Liking/Self-Competence Scale (SLCS) and its subscales (i.e., self-liking and self-competence). For GRISS, although this scale consists of 7 subscales, only three of them were used for this study to analyze participants' impotence, premature ejaculation and sexual dissatisfaction scores which are the main variables of the study. Therefore, only these three subscales involved in this analysis. The results regarding skewness and kurtosis values of the scales and subscales show that scores of all variables and their subscales have a normal distribution as the skewness and kurtosis values are between +1 and -1 (Hair et al., 2013; George & Mallery, 2010) (see detailed information in Table 3.1).

Table 3.1. Descriptive features of measures

Measures	N	M	SD	Min.	Max.	Skew.	Kurt.	Cronbach's Alpha
GRISS	236	22.37	8.60	2	50	.445	.178	.79
Impotence	236	3.36	2.09	0	9	.387	-.221	.62
Premature Ejaculation	236	3.14	2.08	0	11	.720	.528	.70
Dissatisfaction	236	3.92	2.37	0	11	.424	.023	.62
PSS	236	25.45	7.48	6	46	-.069	-.251	.83
SLCS	236	59.59	9.31	37	80	-.147	-.439	.90
Self-liking	236	31.07	5.28	16	40	-.373	-.417	.85
Self-competence	236	28.52	4.86	17	40	.001	-.374	.82

GRISS = The Golombok-Rust Inventory of Sexual Satisfaction
PSS = The Perceived Stress Scale
SLCS = Two-Dimensional Self-Esteem: The Self-Liking/Self-Competence Scale

3.2. Comparison of Perceived Stress Scores Depends on the COVID-19 Pandemic

Data collection of this study was started before the announcement of the first coronavirus disease (COVID-19) pandemic in Turkey. 78 participants were collected before 11 March 2020 that is when the first COVID-19 case had seen in Turkey. Other 158 participants were collected during COVID-19 pandemic. Therefore, independent sample t-test was conducted to compare perceived stress scores of participants for the before and after the first case. Before this analysis, in addition to the first 78 participants, other 78 participants were randomly selected among 158 participants who participated in the study after the first COVID-19 case. Results of the analysis show that there was not a significant difference between perceived stress scores of participants in terms of before (M = 26,10, SD = 7,38) and after (M = 25,28, SD = 7,97) the first case (t (154) = .667, p = .506). On the other hand, other independent sample t-test analysis was done in order to see whether there was a change in perceived stress scores of the participants after the first death case in Turkey, and that date was 15 March 2020. 143 participants were collected before this date and 93 participants were collected after this date. Therefore, 93 participants were randomly selected among first 143 participants and analyzed by using independent sample t-test. According to the results, there was not a significant difference between perceived stress scores of participants in terms of before (M = 25.92, SD = 7,58) and after (M = 24,68, SD = 7,95) the first death case (t (184) = 1.096, p = .275). These results show that perceived stress scores of participants, who enrolled this study, were not affected by COVID-19 pandemic, so that all participants could be included in other statistical analyses (for details see Table 3.2)

Table 3.2. Independent t-test results regarding scores of stress measure and the announcement of the first cases of COVID-19 pandemic

Measures	N	M	SD	df	t	p
Stress				154	.667	.506
Group 1 (before the first case of COVID-19 pandemic)	78	26.10	7.38			
Group 2 (after the first case of COVID-19 pandemic)	78	25.28	7.97			

Table 3.2. Continued Independent t-test results regarding scores of stress measure and the announcement of the first cases of COVID-19 pandemic

Measures	N	M	SD	df	t	p
Stress				184	1.096	.275
Group 1 (before the first death case of COVID-19 pandemic)	93	25.92	7.58			
Group 2 (after the first death case of COVID-19 pandemic)	93	24.68	7.95			

3.3. Correlations between Study Variables

The assumptions of normality were not be met for correlation analysis. Therefore, in order to measure relationship between variables of the study, Kendall's tau-b was conducted, which is the non-parametric version of Pearson's correlation (Allen et al., 2014). The results regarding the correlation coefficients between variables are given in Table 3.3.

According to the results, when the relationship between circumcision age and self-related concepts are examined, it was found that while circumcision age was negatively and significantly correlated with self-esteem (r = -.11, p < .05) and self-efficacy (r = -.13, p < .01), there is no correlation between circumcision age and self-liking (p = .10), which is the subscale of Two-Dimensional Self-Esteem: The Self-Liking/Self-Competence Scale (SLCS). In other words, increasing in circumcision age leads to a decrease in self-esteem and self-efficacy scores of individuals.

In addition to this, when the relationship between circumcision age and sexual experiences are examined, it was found that there is no correlation between circumcision age and sexual experiences of men (premature ejaculation (p = .18), erectile dysfunction (p = .84) and dissatisfaction (p = .75)). On the other hand, while premature ejaculation was positively and significantly correlated with dissatisfaction (r = .12, p < .05), it was not correlated with erectile disorder (p = .30). Also, it was found that there is a significant and positive correlation between erectile dysfunction and sexual dissatisfaction (r = .17, p < .01). In other words, when

premature ejaculation and erectile dysfunction symptoms increase, dissatisfaction scores regarding sexual life of individuals also increases.

Moreover, when the relationship between self-related concepts and sexual experiences was examined, it was found that self-esteem was negatively and significantly correlated with all sexual experiences of men (premature ejaculation (r = -.25, p < .01), erectile dysfunction (r = -.22, p < .01), and dissatisfaction (r = -.22, p < .01)). Also, self-efficacy was negatively and significantly correlated with all sexual experiences (premature ejaculation (r = -.24, p < .01), erectile dysfunction (r = -.22, p < .01), and dissatisfaction (r = -.19, p < .01)). Moreover, self-liking was significantly and negatively correlated with all sexual experiences (premature ejaculation (r = -.22, p < .01), erectile dysfunction (r = -.19, p < .01), and dissatisfaction (r = -.22, p < .01)). It can be concluded that increasing in self-related concepts leads to a decrease premature ejaculation and erectile dysfunction symptoms and scores of sexual dissatisfactions of individuals.

When the relationship between self-related concepts was examined, it was found that self-esteem scale and its subscales (self-efficacy (r = .77, p < .01) and self-liking (r = .80, p < .01)) were positively and significantly correlated with each other. Also, these subscales have positive and significant correlation (r = .54, p < .01). Increasing of self-esteem scores provide increasing in self-efficacy and self-liking. Moreover, increasing of self-efficacy scores leads to a increase in self-liking scores of individuals.

Lastly, when the relationship between stress and other variables of the study was examined, it was found that stress was significantly correlated with all variables of the study. While circumcision age (r = .12, p < .05), premature ejaculation (r = .22, p < .01), erectile dysfunction (r = .11, p < .05) and sexual dissatisfaction (r = .16, p < .01) were positively correlated, self-esteem (r = -.46, p < .01), self-efficacy (r = -.41, p < .01) and self-liking (r = -.43, p < .01) were negatively correlated with stress. In other words, the increase in stress scores is also observed in circumcision age, premature ejaculation and erectile dysfunction symptoms, and sexual dissatisfaction scores. On the other hand, increasing in stress scores leads to a decrease self-esteem, self-efficacy, and self-liking scores of individuals.

Table 3.3. Correlations between study variables

Variables	1	2	3	4	5	6	7	8
1. Circumcision Age	-							
2. Premature Ejaculation	-.07	-						
3. Erectile Dysfunction	-.01	.05	-					
4. Dissatisfaction	-.02	.12*	.17**	-				
5. Self-Esteem	-.11*	-.25**	-.22**	-.22**	-			
6. Self-Efficacy	-.13**	-.24**	-.22**	-.19**	.77**	-		
7. Self-Liking	-.08	-.22**	-.19**	-.22**	.80**	.54**	-	
8. Stress	.12*	.22**	.11*	.16**	-.46**	-.41**	-.43**	-

*p<.05, **p<.01

3.4. Simple Linear Regression for Stress and Sexual Experiences

A single linear regression was calculated to predict premature ejaculation, erectile dysfunction, and sexual dissatisfaction based on stress. Details are shown in Table 3.4. The results indicate that the model was significant for premature ejaculation (F (1,234) = 21.566, p < .001), with R^2 of .084. It was found that stress significantly predicts premature ejaculation (B = .081, p < .001). According to regression result, participants predicted premature ejaculation is equal to 1.081 + .081*stress. Premature ejaculation symptom scores of participants increase by .081 unit for each unit of stress score. For erectile dysfunction, a significant regression equation was found (F (1,234) = 7.323, p < .05), with R^2 of .030. It was found that stress significantly predicts erectile dysfunction (B = .049, p <. 05). The equation, which obtained results of regression analysis for erectile dysfunction is 2.12 + .049*stress. Erectile dysfunction symptom scores of participants increase by .049 unit for each unit of stress score. The last regression analysis was conducted for sexual satisfaction and results show that there is a significant regression equation (F (1,234) = 13.961, p <. 001), with R^2 of .056. It was found that stress significantly predicted dissatisfaction (B = .075, p < .001). According to the regression result, the equation of the predicted sexual dissatisfaction is 2.01 + .075*stress. Sexual dissatisfaction scores of participants increase by .075 unit for each unit of stress score. Since stress is a significant predictor of sexual experiences, it was decided to add it to the analysis of proposed model as a control variable.

Table 3.4. Simple linear regression results regarding stress and premature ejaculation, erectile dysfunction and sexual dissatisfaction

Variables	R^2	B	β	t	p
Premature Ejaculation	.084	.081	.290	4.64	.000
Erectile Dysfunction	.030	.049	.174	2.71	.007
Sexual Dissatisfaction	.056	.075	.237	3.74	.000

3.5. Characteristics of Circumcision Experience

All participants (*N* = 236) were circumcised in this study. The circumcision age ranged from 0 to 12 (*M* = 6.42, *SD* = 3.02). The most preferred age for circumcision was 7 (14.4%), and the least preferred age was 12 (1.7 %). While more than half of the participants stated that they would like to be circumcised (60.6%), others stated the opposite option (39.4%). Considering circumcision process, 52.5% of the participants were circumcised in the hospital, 26.7% at the home, 19.9% in a special place and only .8% of them were circumcised at somewhere other than these places. After circumcision processes 71.6% of the participants celebrated it with a special event, however, a special event was not organized for 28.4% of the participants. In terms of type of the celebration, 20.3% of the participants reported that it was just a dinner with family, for 50.8% it was a circumcision wedding with the special clothes and only .4% of the participants celebrated circumcision with the different kind of event. Regarding the meaning of circumcision, 8.5% of the participants think that it is a requirement of the religion, for 35.6% it is important for health, for 3.0% it is the first step of the virility, for 28.8% it is an unnecessary ritual, for 21.2% it is not meaningful processes for them and 3.0% of the participants stated other explanations for meaning of the circumcision (see detailed information in Table 3.5).

Table 3.5. Demographic characteristics of the participants regarding circumcision experiences

Variables	N (236 Participants)	%	M	SD
Circumcision Age			6.42	3.02
Desire to be Circumcised				
Yes	143	60.6		
No	93	39.4		
Place of the Circumcision				
Hospital	124	52.5		
Home	63	26.7		
Special place	47	19.9		
Other	2	.8		
Celebration for the Circumcision				
Yes	169	71.6		
No	67	28.4		
Type of the Celebration				
Dinner with family	48	20.3		
Wedding with special clothes	120	50.8		
Other	1	.4		
Meaning of the Circumcision				
Religion	20	8.5		
Health	84	35.6		
Virility	7	3.0		
Unnecessary	68	28.8		
Meaningless	50	21.2		
Other	7	3.0		

3.5.1. The effects of hometown on circumcision age

In order to investigate whether circumcision age differs according to hometown (village and town, city, and big city) of participants, one-way between subjects ANOVA was performed. Before analysis, 23 participants from all three group were randomly selected in order to provide equivalence in all groups. According to the results, there was not found a significant effect of hometown on at the $p < .05$ level for the circumcision age F (2,66) = .611, p = .55. Mean circumcision age of participants was found 6 (SD = 3.00) for village and town, 6.93 (SD = 3.28) for city and 6.83 (SD = 3.13) for big city (for details see Table 3.6 and Table 3.7). These results show that the place where participants grow up does not have a significant effect on circumcision age.

Table 3.6. ANOVA results regarding circumcision age and hometown

Source	df	SS	MS	F	p
Between Groups	2	12.02	6.01	.611	.55
Within Groups	66	649.457	9.84		
Total	68	661.478			

SS = Sum of Squares
MS = Mean Squares

Table 3.7. Means regarding circumcision age of the participants grouped by hometown

Hometown	N	M	SD
Village and Town	23	6.00	3.00
City	23	6.93	3.28
Big City	23	6.83	3.13
Total	69	6.59	3.12

3.5.2. Emotions regarding circumcision experience

A 5-likert type questions were asked to participants in order to analyze what kind of emotions they experienced during their circumcision experiences. There was also an option for

those who did not remember their own circumcision. Both negative and positive emotions were directed to participants and the participants were asked to rate them by thinking their circumcision experiences. These emotions were pain, anxiety, rejoicing, fear, pride, sadness, anger, power, and shame. According to the results, most experienced emotion was anxiety (*M* = 3.42, *SD* = 1.31) and least experienced emotion was power (*M* = 1.91, *SD* = 1.38). It can be concluded that while unpleasant emotions, such as pain (*M* = 2.92, *SD* = 1.47), fear (*M* = 3.38, *SD* = 1.35), and anxiety were experienced more, pleasant emotions, such as rejoicing (*M* = 2.04, *SD* = 1.29), pride (*M* = 1.99, *SD* = 1.30), and power were experienced less by participants who remember their circumcision (for details see Table 3.8).

Table 3.8. Experienced emotions of participants toward circumcision

Emotions	N	M	SD
Pain	169	2.92	1.47
Anxiety	173	3.42	1.31
Rejoicing	124	2.04	1.29
Fear	189	3.38	1.35
Pride	118	1.99	1.30
Sadness	129	2.19	1.38
Anger	131	2.21	1.43
Power	114	1.91	1.38
Shame	140	2.29	1.33

3.6. Frequencies of Circumcision Variables According to Circumcision Age of the Participants

Frequencies of groups which were done according to circumcision age were compared by using crosstabs analysis in order to see whether desire to be circumcised, place of the circumcision, celebration for the circumcision, type of the celebration and meaning of the circumcision change according to circumcision age. 236 participants were divided into three group. This grouping was done based on Erikson's stages of psychosocial development and

previous studies about this topic. First group, in which circumcision age range was from 0 to 3, included 40 participants. Second group included 69 participants with the circumcision age range was from 4 to 6 and the last group, in which circumcision age range was from 7 to 12, included 127 participants. All crosstabs analysis is shown in Table 3.9.

3.6.1. Desire to be circumcised

In total 143 participants answered as yes, and 93 participants answered as no to the question of "Would you still like to be circumcised when you ignore the spiritual value of circumcision?". While 65% of the participants said yes, 35% said no in the first group. In the second group, 50.7% of the participants answered the question as yes and 49.3% as no. 64.6% of the participants said yes and 35.4% said no in the third group.

The yes answer given to that question is the majority regardless of the circumcision age. The circumcision age group with the lowest yes answer is the second group with the participants who were circumcised between the ages of 4 and 6.

3.6.2. Place of the circumcision

In terms of place of the circumcision there were four options including "other" option. In detail, in the first group, 70% of the participants were circumcised in the hospital, 15% at the home, 12.5% at the special place and 2.5% of the participants chose the other option. 50.7% of the participants were circumcised in the hospital, 27.5% at the home and 21.7% at the special place in the second group. In the third group, 48% of the participants were circumcised in the hospital, 29.9% at the home, 21.3% at the special place and 0.8% of the participants chose the other option.

The majority of the participants were circumcised in the hospital regardless of the circumcision age. However, the group with the highest rate of circumcision in the hospital and the lowest rate of circumcision at home is the first group with the participants who were circumcised between the ages of 0 and 3. On the other hand, it is observed that most of the individuals, who were circumcised between the ages of 7 – 12, were circumcised at home.

3.6.3. Celebration for the circumcision and type of celebration

While 67 participants indicated that there was no special event for their circumcision, 169 participants indicated that there was a special event for it. In the first group, 37.5% of the participants answered the question as yes and 62.5% as no. 71% of the participants said yes and 29% said no in the second group. Also, in the third group, 82.7% of the participants stated that they had a special event for their circumcision, however, 17.3% of them did not.

The special event for circumcision was organized for participants who were circumcised after 4 years old. In terms of having celebration, 7 -12 age group has the highest rate.

In terms of type of celebration, 40 out of 169 participants stated it was a dinner with family, 81 of them said it was a circumcision wedding with the special clothes, and only one of them gave another answer which included both answers. In the first group, 46.7% of the participants answered this question as dinner with family and 53.3% as circumcision wedding with special clothes. In the second group, 36.7% of the participants answered this question as dinner with family and 63.3% as circumcision wedding with special clothes. In the third group, 21.9% of the participants answered this question as dinner with family, 77.1% as circumcision wedding with special clothes and only 1% of them in the third group stated it was a dinner with family dressed in special clothes.

The majority of the participants have circumcision wedding with special clothes regardless of the circumcision age. The highest rate belongs to the 7 -12 age group. Also, the ratio of dinner with the family is the highest in the 0 - 3 age group.

3.6.4. Meaning of the circumcision

In terms of meaning of the circumcision, there were six options including “other” option. In total, 20 participants have seen circumcision as a requirement of the religion, 84 as a requirement for health, 7 for the first step of the virility, 68 as an unnecessary ritual and lastly 50 participants reported that circumcision is not a meaningful ritual for them. In addition to this, only 7 participants chose other option. In the first group, 5% of the participants regard circumcision as a religious necessity, 47.5% as necessary for health, 5% as first step of the

virility, 17.5% as an unnecessary ritual, 20% as meaningless and 5% of the participants chose other option. In the second group, 5.8% of the participants regard circumcision as religious necessity, 34.8% as necessary for health, 1.4% as first step of the virility, 37.7% as an unnecessary ritual, 18.8% as meaningless and 1.4% of the participants chose other option in the second group. In the third and last group, 11% of the participants regard circumcision as religious necessity, 32.3% as necessary for health, 3% as first step of the virility, 27.6% as an unnecessary ritual, 22.8% as meaningless and 3.1% of the participants chose other option.

While the majority of the 7 - 12 age group see circumcision as a religious requirement, most of the 0 - 3 age group see circumcision as necessary for health. The rate of those who see circumcision as unnecessary ritual is the highest in the 4 – 6 age group.

Table 3.9. Frequencies of circumcision variables according to circumcision age of the participants

Circumcision Age	0-3 (1st Group)		4-6 (2nd Group)		7-12 (3rd Group)	
Variables	N	%	N	%	N	%
Desire to be Circumcised						
Yes	26	65	35	50.7	82	64.6
No	14	35	34	49.3	45	35.4
Place of the Circumcision						
Hospital	28	70	35	50.7	61	48
Home	6	15	19	27.5	38	29.9
Special place	5	12.5	15	21.7	27	21.3
Other	1	2.5	0	0	1	0.8
Celebration for the Circumcision						
Yes	15	37.5	49	71	105	82.7
No	25	62.5	20	29	22	17.3
Type of the Celebration						
Dinner with family	7	46.7	18	36.7	23	21.9
Wedding with special clothes	8	53.3	31	63.3	81	77.1
Other	0	0	0	0	1	1

Table 3.9. Continued Frequencies of circumcision variables according to circumcision age of the participants

Circumcision Age	0-3 (1st Group)		4-6 (2nd Group)		7-12 (3rd Group)	
Variables	N	%	N	%	N	%
Meaning of the Circumcision						
Religion	2	5	4	5.8	14	11
Health	19	47.5	24	34.8	41	32.3
Virility	2	5	1	1.4	4	3
Unnecessary	7	17.5	26	37.7	35	27.6
Meaningless	8	20	13	18.8	29	22.8
Other	2	5	1	1.4	4	3.1

3.7. Frequencies of Circumcision Variables According to Age of the Participants

Frequencies of groups which were done according to participants' current age were compared by using crosstabs analysis in order to see whether desire to be circumcised, place of the circumcision, celebration for the circumcision, type of the celebration and meaning of the circumcision change according to age. Two groups were obtained from 236 participants. In order to divide groups, median split was used. According to this process, median was found 26 for age. Therefore, age of the first group ranged from 19 to 26 (N = 127) and age of the second group ranged from 27 to 48 (N = 109). All crosstabs analysis is shown in Table 3.10.

3.7.1. Desire to be circumcised

For the first question which is "Would you still like to be circumcised when you ignore the spiritual value of circumcision?". 62.2% of the participants said yes and 37.8% of the participants said no in the first group. On the other hand, while 58.7% of the participants said yes, 41.3% of the participants said no in the second group.

The yes answer given that question is the majority regardless of the age. The age group with the highest yes answer is the first group with the participants who are between the ages of 19 and 26.

3.7.2. Place of the circumcision

Another question was about place of the circumcision. There were four options for this question. These are hospital, home, special place and other. In detail, in the first group, 61.4% of the participants were circumcised in the hospital, 21.3% at the home, 17.3% of the participants were circumcised at the special place. In the second group, 42.2% of the participants were circumcised in the hospital, 33% at the home and 22.9% at the special place and lastly, 2 people which means 1.8% of the participants of the second group indicated that they were circumcised another place apart from these three options.

While the new generation (first group) has the highest rate of being circumcised in the hospital, the rate of being circumcised at the home or in a private place is lowest for this group.

3.7.3. Celebration for the circumcision and type of celebration

The question “has there been a special event for your circumcision?" was asked to participants. While 67 participants indicated that there was no special event for their circumcision, 169 participants indicated that there was a special event. In the first group, 69.3% of the participants answered the question as yes and 30.7% of the participants answered the question as no. In the second group, 74.3% of the participants said yes and 25.7% of them said no.

The yes answer given that question is the majority regardless of the age. The age group with the highest yes answer, with a small difference, is the second group with the participants who are between the ages of 27 and 48.

In terms of type of celebration, 48 out of 169 participants stated it was a dinner with family, 120 of them said it was a circumcision wedding with the special clothes, and only one of them gave another answer which included both answers. In the first group, 26.1% of the participants answered this question as dinner with family and 72.1% as circumcision wedding with special clothes and 1.1% of them in the first group stated it was a dinner with family dressed in special clothes. In the second group, 30.9% of the participants answered this question as dinner with family and 69.1% of them answered this question as circumcision wedding with special clothes.

The majority of the participants have circumcision wedding with special clothes regardless of the circumcision age. The ratio of dinner with the family, with a small difference, is the lowest in the 19 - 26 age group.

3.7.4. Meaning of the circumcision

In terms of meaning of the circumcision, there were there were six options including "other" option. In total 20 participants have seen circumcision as a requirement of the religion, 84 for the health, 7 for the first step of the virility, 68 for the unnecessary ritual and lastly 50 participants found circumcision as meaningless. Also, 7 participants chose other option. In the first group, 7.9% of the participants regard circumcision as religious necessity, 33.1% as necessary for health, 3.9% as the first step of the virility, 29.1% as an unnecessary ritual, 23.6% as meaningless and 2.4% of them chose other option. In the second group, 9.2% of the participants regard circumcision as religious necessity, 38.5% as necessary for health, 1.8% as the first step of the virility, 28.4% as an unnecessary ritual, 18.3% as meaningless and 3.7% of the participants chose other option.

The majority of the participants see circumcision as necessary for health regardless of the age. The highest ratio belongs to 27 – 48 age group with a small difference. In addition to this, first group has slightly more ratio than the second group in terms of seeing circumcision as meaningless.

Table 3.10. Frequencies of circumcision variables according to age of the participants

Age	19-26 (1st Group)		27-48 (2nd Group)	
Variables	N	%	N	%
Desire to be Circumcised				
Yes	79	62.2	64	58.7
No	48	37.8	45	41.3
Place of the Circumcision				
Hospital	78	61.4	46	42.2
Home	27	21.3	36	33
Special place	22	17.3	25	22.9
Other	0	0	2	1.8

Table 3.10. Continued Frequencies of circumcision variables according to age of the participants

Age	19-26 (1st Group)		27-48 (2nd Group)	
Variables	N	%	N	%
Celebration for the Circumcision				
Yes	88	69.3	81	74.3
No	39	30.7	28	25.7
Type of the Celebration				
Dinner with family	23	26.1	25	30.9
Wedding with special clothes	64	72.1	56	69.1
Other	1	1.1	0	0
Meaning of the Circumcision				
Religion	10	7.9	10	9.2
Health	42	33.1	42	38.5
Virility	5	3.9	2	1.8
Unnecessary	37	29.1	31	28.4
Meaningless	30	23.6	20	18.3
Other	3	2.4	4	3.7

3.8. Differences of The Circumcision Age Groups Regarding Measures of the Study

In this section of the paper, one-way multivariate analyses of covariance (MANCOVA) was conducted in order to test one of the hypotheses of the study, which is there is a significant difference among circumcision age groups in terms of measures of the study (erectile dysfunction, premature ejaculation, sexual dissatisfaction, self-esteem and self-efficacy). In order to do that stress was taken as covariate since stress was found as a significant predictor for sexual experiences. Also, circumcision age groups were divided into three (1:0-3, 2:4-6, 3:7-12) based on Erikson's stages of psychosocial development. The results are shown in Table 3.11.

While analyzing assumptions of MANCOVA, multicollinearity between self-esteem and self-effacing (r = .91) was detected. Therefore, self-efficacy was removed from the analysis and only self-esteem was used, which is the main scale to measure self-related concepts. In addition to this, in order to provide assumption of normality for MANCOVA all groups were

equalized based on the first group, in which there is the fewest participants (N = 40). In order to do that, 40 participants from each group were randomly selected (Allen et al., 2014).

According to the results, there was not a statistically significant difference in measures of the study (erectile dysfunction, premature ejaculation, sexual dissatisfaction, and self-esteem) based on circumcision age groups (1:0-3, 2:4-6, 3:7-12) after controlling stress, F (8, 226) = 1.34, p = .23; Wilk's Λ = .912, partial η^2 = .05. Therefore, further tests were not performed.

Table 3.11. MANCOVA results regarding circumcision age groups and measures of the study

Variables	N (120)	M	SD	F	p	Wilk's Λ	df
Circumcision Age				1.34	.23	.912	8,226
ED							
Group 1 (0-3)	40	3.73	2.59				
Group 2 (4-6)	40	3.35	1.97				
Group 3 (7-12)	40	3.32	2.31				
PE							
Group 1 (0-3)	40	3.65	2.21				
Group 2 (4-6)	40	3.70	2.13				
Group 3 (7-12)	40	2.65	1.89				
SD							
Group 1 (0-3)	40	4.08	2.49				
Group 2 (4-6)	40	4.08	2.13				
Group 3 (7-12)	40	3.85	2.83				
Self-esteem							
Group 1 (0-3)	40	62.13	8.56				
Group 2 (4-6)	40	58.48	9.11				
Group 3 (7-12)	40	62.27	10.57				

ED = Erectile Dysfunction
PE = Premature Ejaculation
SD = Sexual Dissatisfaction

3.9. Structural Equation Model: Path Analysis

The mediator role of self-related concepts (self-efficacy and self-esteem) between circumcision age and sexual experiences (premature ejaculation, erectile dysfunction, and sexual dissatisfaction) was investigated in this part of the paper. Therefore, path analysis was done using Structural Equation Modeling (SEM) for the hypothesis tests of the study.

In order to test hypothesis of the study, two main scale were used. One of them was The Golombok-Rust Inventory of Sexual Satisfaction (GRISS). Only three subscales of GRISS, which measure premature ejaculation, impotence, and dissatisfaction, were involved and others did not. On the other hand, total score of Two-Dimensional Self-Esteem: The Self-Liking/Self-Competence Scale (SLCS) was used so that self-esteem score could obtained and one of the subscales of SLCS was used to get self-efficacy scores of the participants because only one subscale, which is "self-competence", is used in order to measure the self-efficacy. Furthermore, in order to eliminate cofounding effect of stress, The Perceived Stress Scale (PSS) scores were used as covariate in the analysis of the model since stress is a significant predictor of sexual experiences which is shown in Table 3.4.

Firstly, model fit indexes were investigated in order to test model and hypothesis of the research. Fit indexes show the harmony of the hypothetical model and the data used in the research (Sümer, 2000). The acceptable value ranges of model fit indexes are shown in the Table 3.12.

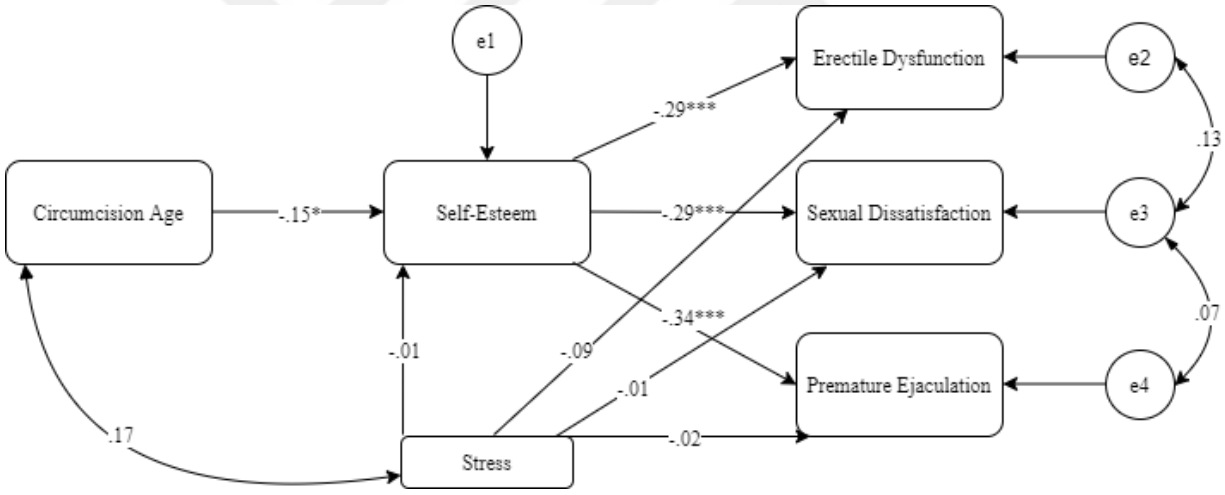
Table 3.12. Model fit indexes and acceptable values

Fit Indexes	Perfect Fit Indexes	Acceptable Fit Indexes
X^2/sd	≤ 3	≤ 5
AGFI	≥.95	≥.90
GFI	≥.95	≥.90
CFI	≥.95	≥.90
NFI	≥.95	≥.90
RMSEA	≤.05	≤.08

X^2 = Chi-square
AGFI = Adjusted goodness-of-fit index
GFI = Goodness-of-fit index
CFI = Comparative fit index
NFI = Normed fit index
RMSEA = Root mean square error of approximation

3.9.1. Evaluation of direct effects

A few model fit indexes in the hypothetical model, which is shown in figure 1.1 (page 12), did not meet the desired level. The reason of this, mediating variables which are self-esteem and self-efficacy have high correlation which is shown in Table 3.3 (page 25). Thus, the model was modified (see figure 3.1) in the light of the modification indices. In modified version of the hypothetical model, self-efficacy was eliminated and only the mediating effect of self-esteem was examined. The analysis was repeated after this revision. Model fit indexes were obtained by repeating the analysis, χ^2/sd= 2.280; AGFI = .936; GFI = .988; CFI = .937; NFI = .906; RMSEA =.074. When the model fit values regarding the model are examined, it can be said that the model fits well with the data.



*p<.05, ***p<.001

Figure 3.1. Modified Model of the Study

After determining model fit values, the significance of all parameters in the model was examined. When the table is examined, it is seen that some path coefficients are not significant. All unsignificant path coefficients is related with stress scores of participants which is the covariate of the model. That is mean stress does not cofound the relationships which was specified in this model. Modified model and path coefficients are shown in figure 3.1. With these results, one of the hypotheses, which is the circumcision age negatively predicts self-

esteem (β = -.15, $p < .05$), was accepted since self-esteem were predicted by circumcision age in a negative way. It was also expected that self-esteem predicts sexual experiences in a negative way. All sexual experiences (erectile dysfunction (β = -.29, $p < .001$), sexual dissatisfaction (β = -.29-., $p < .001$), and premature ejaculation (β = -.34, $p < .001$)) were predicted significantly and negatively by self-esteem.

Results were interpreted with non-standardized regression values (B) and according to the results, circumcision age negatively predicts self-esteem. In other words when circumcision age increases, self-esteem (B = -.47) decreases. In addition to this, self-esteem predicts erectile dysfunction, premature ejaculation, and sexual dissatisfaction in a negative way. In other words, increasing on self-esteem scores lead to a decrease on erectile dysfunction (B = -.06) and premature ejaculation (B = -.08) symptoms. Also, increasing in self-esteem scores leads to a decrease in sexual dissatisfaction (B = -.07) scores of the participants (for details see Table 3.13).

Table 3.13. Path analysis results regarding direct effects of variables of the study

			B	SE	β	p
Self-Esteem	←	Circumcision Age	-.47	.20	-.15	.024
ED	←	Self-Esteem	-,06	.01	-.29	.000
SD	←	Self-Esteem	-.07	,02	-.29	.000
PE	←	Self-Esteem	-.08	.01	-.34	.000
Self-Esteem	←	Stress	-.01	,08	-.01	.901
PE	←	Stress	-.12	.02	-.02	.759
SD	←	Stress	-.02	.02	-.01	.823
ED	←	Stress	-.06	.02	-.09	.171

ED: Erectile Dysfunction
PE: Premature Ejaculation
SS: Sexual Dissatisfaction
B: Unstandardized Regression Weight
β: Standardized Regression Weight
SE: Standard Error

3.9.2. Evaluation of indirect effects (mediations)

The main purpose of this study was to test whether circumcision age predicts sexual experiences of men with the mediation of self-related concepts. In order to evaluate significance level of indirect effects, "Bootstrap" method was used which is recommended by Shrout and Bolger (2002). "The bootstrap method is a resampling technique used to estimate statistics on a population by sampling a dataset with replacement". 1000 bootstrap sample that was created from original data set by using the program and the mediated structural model was repeated with each bootstrap method to obtain 1000 estimates of each path rotation.

The modified model, which is shown in figure 3.1, was used so that the mediating effect of self-related concepts between circumcision age and sexual dysfunction symptoms could be examined. As mentioned before, since there is a high correlation between self-esteem and self-efficacy, only self-esteem was used as mediator for self-related concepts. The analyses for the mediation effect are given in Table 3.14.

Table 3.14. Mediator role of self-related concepts between circumcision age and sexual experiences

						95% Confidence Level		
Independent Variable		Mediator		Dependent Variable	β	SE	Lower Bounds	Upper Bounds	p
Circumcision Age	→	Self-Related Concepts	→	Premature Ejaculation	.05	.02	.008	.100	.027
Circumcision Age	→	Self-Related Concepts	→	Sexual Dissatisfaction	.04	.02	.008	.087	.024
Circumcision Age	→	Self-Related Concepts	→	Erectile Dysfunction	.04	.02	.007	.089	.028

β: Standardized Indirect Effect
SE: Standard Error

In order to determine whether indirect effect is significant, lower and upper bounds were investigated. The absence of 0 (zero) in these ranges and the significance values being less than .05 indicates that the indirect effects are significant. To sum up, self-related concepts (self-esteem) play a mediating role between circumcision age and sexual experiences for the 95% confidence interval. According to the standardized indirect effect results, when circumcision age goes up by 1 standard deviation, premature ejaculation symptoms go up by .05, sexual dissatisfaction scores go up by .04, and erectile dysfunction symptoms go up by .04 standard deviations.

Finally, these results indicate that self-related concepts (self-esteem) have a significant mediating effect between circumcision age and sexual experiences.

3.10. Summary of the Results

In this part of the paper, all results will be summarized, and rejected and accepted hypothesis will be given. Firstly, it was expected to find significant differences between circumcision age groups in terms of measures of the study (self-esteem, self-efficacy, premature ejaculation, erectile dysfunction, and sexual dissatisfaction). Self-efficacy was removed from the analysis due to multicollinearity with self-esteem and only self-esteem scores was used. According to the results of the analysis,

H1 was rejected: There is a significant difference between circumcision age groups in terms of self-related concepts (self-esteem).

H2 was rejected: There is a significant difference between circumcision age groups in terms of premature ejaculation.

H3 was rejected: There is a significant difference between circumcision age groups in terms of erectile dysfunction.

H4 was rejected: There is a significant difference between circumcision age groups in terms of sexual dissatisfaction.

Secondly, in the light of the suggested model, it was expected to find significant mediator roles of self-related concepts (self-esteem and self-efficacy) between circumcision age

and sexual experiences (premature ejaculation, erectile dysfunction, and sexual dissatisfaction) of participants. Self-efficacy was removed from the model due to multicollinearity between self-esteem and path analysis was done based on the modified model. According to the results of the analysis,

H5 was accepted with modification: Circumcision age predicts self-related concepts (self-esteem) in a negative way.

H6 was accepted with modification: Self-related concepts (self-esteem) predict all sexual experiences of males in a negative way.

H7 was accepted with modification: Circumcision age's prediction on sexual experiences is mediated by self-related concepts (self-esteem).

Other descriptive findings related circumcision experience are;

- The mean age of circumcision was found 6.42 and it did not differ significantly according to the places where the participants grew up.
- Approximately 61% of the participants indicated that they would like to be circumcised.
- More than half of the participants, especially younger individuals, were circumcised in the hospital.
- Approximately 72% of the participants indicated that a special event (celebration) was organized for their circumcision and half of this is a circumcision wedding with special clothes. A special event was organized, especially for those who were circumcised after the age of 4. Also, the most common ages for circumcision wedding were found 7 and older.
- Participants generally see circumcision as a necessary procedure for health.
- The most associated emotion with circumcision is anxiety and least associated emotion is power.

CHAPTER IV

DISCUSSION

In this part of the paper, the results of the study, which is shown in previous section, will be evaluated, and discussed in the light of the literature. Also, limitations of the study will be mentioned, and recommendation for further studies will be discussed.

4.1. Evaluation of the Results

The fundamental aim of the present study was to investigate whether circumcision age predicts sexual experiences (erectile dysfunction and premature ejaculation symptoms, and sexual satisfaction) of men on self-related concepts. In order to do this, a hypothesized model was designed and self-related concepts which are self-esteem and self-efficacy were included to the model as mediators. This hypothesized model that is shown in figure 1.1 was modified and the model which is shown in figure 3.1 was tested by using path analysis. Another aim of the present study was to investigate whether there is a significant difference between circumcision age groups in terms of the measures of the study which are self-esteem, self-efficacy, erectile dysfunction, premature ejaculation, and sexual satisfaction. Before all these main analyses, a few analyses were done in order to get better understanding the participants' attitudes towards circumcision. 236 circumcised men, who were circumcised between the ages of 0 and 12, were involved this study and all analyses were done on these participants. All results were presented in the previous section. In this part of the paper, these results will be discussed in the light of the literature.

4.1.1. The effect of the COVID-19 pandemic on perceived stress scores of the participants

The first COVID-19 pandemic case was announced in Turkey during data collection of this study. Therefore, the perceived stress scores of participants were compared in order to examine whether participants of this study were affected COVID-19 pandemic, or not. This

comparison was done based on the dates when the first patient and the first death cases were announced. The reason for the comparison on perceived stress scores is that stress is correlated with main variables of the study. Details regarding the correlation between stress and other variables (sexual dysfunctions and self-esteem) will be explained in other sections of the paper. According to the results, it was not found a significant difference between groups in terms of stress scores. Therefore, all participants were included in all other statistical analyses. The studies which were done on psychological impacts of COVID-19 pandemic show that it leads to anxiety, depression, and stress. In a few studies, it was found that there are gender differences in terms of COVID-19 related stress. The COVID-19 pandemic related stress in men was found less than in women (Tee et al., 2020; Alkhamees et al., 2020). Regardless of the COVID-19 pandemic, it is also assumed that there are gender differences in terms of perceived stress, and men report lower levels of stress than women (Anbumalar et al., 2017). Even they experienced same number of life events, women tend to rate life events as more negative and less controllable than men (Matud, 2004). Social expectations and gender roles might be the explanation for this. Women are more likely to share their stressful life events, and they can seek and receive more social support from others than men (Misigo, 2015; Day & Livingstone, 2003). All participants in this study were men and there was a short duration between participants who completed the study before and after the first COVID-19 cases. Therefore, it is understandable that there is no significant difference between participants in terms of stress scores.

4.1.2. Attitudes toward circumcision

Preferred age: When the circumcision age was compared in terms of the place where people were born and raised, a significant difference was not found in this study. According to an earlier study on this subject, there is also no significant difference between individuals who live in rural areas and who live in urban areas in terms of circumcision age (Öztürk, 1973). Also, mean of the circumcision age was found 6.42 in this study. This result is consistent with other studies which were done in Turkey. Previous studies also showed that the most preferred circumcision age range is 6 and 7. In addition to this, parents who planned to circumcise their children, who were not circumcised yet, also reported they prefer age 6 for circumcision (Sahin et al., 2003; Yıldırım et al., 2003).

Purposes: In many cultures, circumcision is practiced for religious or medical purposes. In addition to these reasons, there is another important purpose, which is improving masculine virility (Siweya et al., 2018). In the light of this information, the reason why there both the desired and preferred age are so similar in many years and in all places where men grow up might be explained by culture. Religion can be seen as the main factor of circumcision in Turkey, however, performing circumcision at an age that the child can remember and in the preschool period, and then organizing event with special clothes, which support strong male image, may show that there is a highly strong link between circumcision and "being a man" in Turkey. According to the results of this study, circumcision wedding was performed more for individuals who were circumcised after the age of 6 supports this view. More than half of the men who were circumcised at 0 and 3 age range stated that there was no celebration for their circumcision. Unlike this, the celebration for circumcision was organized for 82.7% of men who were circumcised between the ages of 7 and 12 and the type of this celebration was a circumcision wedding with special clothes for 77.1% of this group.

Motivation: However, participants from all circumcision age groups tended to view circumcision as an essential operation for health rather than the first step towards masculinity. According to Öztürk (1973), although circumcision has been associated with negative emotions, men see circumcision as a part of social acceptance, and it is related with their own self-concepts. Therefore, being circumcised is important for men in Turkey. In fact, this shows partial consistency with the results of the current study. Circumcision is associated with negative and unpleasant emotions, such as anxiety and fear, by participants who remember their circumcision. In addition to this, although half of the participants see circumcision as an unnecessary and meaningless ritual, approximately 61% of the participants said they would like to be circumcised. Yet, according to the results of the study, the different point is that the main motivation is health, not religion or virility. The change in this motivation may be related with the generation differences or the studies on circumcision showing it is a protective factor against infectious disease, such as HPV (human papilloma virus), HSV (herpes simplex virus) and especially HIV (Dave et al., 2018; Szabo & Short, 2000). Furthermore, seeing circumcision as an unnecessary and meaningless ritual may also indicate that individuals' perspective toward circumcision has changed over the years. Also, the present study shows that most of the participants, mostly younger individuals, were circumcised in the hospital. However, previous

studies indicated that places rather than hospital were preferred for circumcision, such as home, mass circumcision etc. (Yıldırım et al., 2003; Corduk et al., 2013) This situation may also be an indication that the attitude towards circumcision differs between generations. Also, in previous studies, it was found that the economic level and status of families have an impact on the meaning given to circumcision and purposes of it. The results indicate that while parents who have higher education level consider circumcision necessary for health, parents who have lower education level consider circumcision necessary for religion. In addition to this, it was found that parents who have higher socioeconomic status prefer hospital or policlinics for circumcision when compared those who have lower socioeconomic status (Sivaslı et al., 2003; Koc et al., 2013). Also, the results of the current study show consistency with a study, which has a similar sample in terms of demographic characteristics of participants, tried to understand attitudes toward circumcision of university students in Turkey. The results of this study indicate that circumcision is not considered as a symbol of masculinity and the importance of social relations in being circumcised is emphasized rather than the personal importance of the circumcision experience (Gülaçtı et al., 2016). Thus, education level and socioeconomic status can be evaluated as some of the determinants of attitudes toward circumcision. Similarly, in this study, most of the participants have higher education level and socioeconomic status. Therefore, this difference in individuals' motivation towards circumcision may be explained by the education level and socioeconomic status of the participants.

4.1.3. Relationship between stress and measures of the study

Self-esteem, self-efficacy, premature ejaculation, erectile dysfunction, and sexual satisfaction were dependent variables of this study. In the literature, it is assumed that there may be a relationship between stress and these variables. Therefore, stress scores were also obtained from participants and this assumption was tested to determine whether it is also valid for the sample of this study. The results indicate that there is a significant relationship between stress and dependent variables of the study.

Although there are a few studies which are conducted on the relationship between stress and sexual dysfunctions, many theorists and sex therapists assumed that stress is

associated with sexual dysfunctions and sexual activities. Subjective stress leads to lower sexual activity and satisfaction. In a study, more sexual activities were reported on weekends when people have more time for each other and there is a lower work stress. In addition to this, especially internal daily stress and in some cases critical life events related to sexual problems, specifically premature ejaculation in men, and stress is also significantly associated with erectile dysfunction (Bodenmann et al., 2010; Bodenmann et al., 2006; Ponholzer et al., 2005). It is assumed that life stressors may lead to produce psychogenic erectile dysfunction, especially for younger men, because more severe psychosocial difficulties associated with erectile dysfunction may be more experienced by younger men (Moore et al., 2003). Moreover, there is a significant relationship between stress and self-esteem. It is known that stressful life events have a negative impact on self-esteem. Self-esteem usually plays an important role between life stressors and depression. It is reported that negative moods, including stress, was associated with lower self-esteem (Lee et al., 2013; Edwards et al., 2010; Pritchard et al., 2007). In a study, which was conducted to examine relationship among stress, self-esteem, and sexual satisfaction, it was found that sexual satisfaction was higher in individuals who have higher self-esteem and lower stress scores (Jamali et al., 2018). The results of this study are consistent with the literature which was done on stress, self-esteem, and sexual dysfunctions relationship. In this study, it was found that there is a significant correlation between self-esteem and stress in a negative way. Also, it was found that stress is a significant predictor of premature ejaculation, erectile dysfunction, and sexual satisfaction. Increasing in perceived stress scores leads to an increase in individuals' premature ejaculation and erectile dysfunction symptoms, and sexual dissatisfaction scores. Considering both these results and the mean age of the participants in this study, stress was taken as a covariate in main analyses of the study which will be discussed next parts of the paper.

4.1.4. Differences of the circumcision age groups regarding measures of the study

One of the hypotheses of the study was expected to find significant differences for all measures of the study according to circumcision age groups. However, this hypothesis was not supported, and the results indicate that there is not a significant difference between circumcision

age groups in terms of erectile dysfunction, premature ejaculation, sexual satisfaction, and self-esteem.

Studies which were done on circumcision claim that circumcision is a traumatic event for individuals who were circumcised. Trauma is basically defined as emotional response to terrible evets and according to DSM-V, these events consist of “actual or threatened death, serious injury, or sexual violence” (American Psychiatric Association, 2013). Circumcision procedure involves forcing a person to the cutting of his part of the penis and experiencing unpleasant feelings, such as pain and fear. From this perspective, circumcision may be evaluated as a traumatic event since it is a condition that threats one’s physical integrity (Goldman, 1999). Trauma can occur at any age. Thus, children are also vulnerable to trauma. Furthermore, physical trauma may lead to long lasting effects on children at any age (Eth & Pynoos, 1985; Green, 1983). Neurological damage is one of the negative consequences of trauma. It was found that adult survivors have smaller hippocampal volume than individual who did not experience any physical or sexual trauma (Bremner et al., 1997). Therefore, “the possibility of circumcision resulting in traumatic effects on older children can be better explored because of the easier access to memory and the child's ability to talk” (Goldman, 1999). There is a quite old study on this topic which belongs to Cansever (1965). This study states that children, who were circumcised between the ages of 4 and 7, see this procedure as “an aggressive attack on his body, which damaged, mutilated and in some cases totally destroyed him”. This definition is highly associated with trauma. On the other hand, in societies where circumcision is an important part of the culture, this situation may not be perceived as a trauma. On the contrary, it can be regarded as a feeling of accomplishment such as “being a man” which mentioned in the first part of the paper. Also, according to the studies which were done on self-esteem, there is a positive correlation between masculinity and self-esteem. Individuals who have higher score on masculinity also have higher scores on well-being indicators including self-esteem (Bassoff & Glass, 1982; Whitley, 1988). In addition to self-esteem, similar results were found for self-efficacy. Masculinity is seen as one of the predictors of self-efficacy (Choi, 2004). Moreover, it is regarded as circumcision is the potent symbol of “being a full man” in this society. Ironically, while the boy loses a piece of his penis, he lays a stronger foundation for masculinity and they never see the piece they lost from their penis as a deficiency because of the strong link between circumcision and masculinity (Barutçu, 2015). In fact, not being circumcised may be considered

as a deficiency. Consistently to these, the results of this study show that increasing in circumcision age leads to a decrease in self-esteem and self-efficacy concepts These explanations may be evaluated as a reason of negative correlation between circumcision age and self-related concepts which was found in this study.

In the light of these information, it has been claimed that when a school-age child who has not yet been circumcised, it may cause a negative effect on the individual's self-evaluation, and such a hypothesis has been developed. However, results demonstrate that there is no significant difference between age groups in terms of self-esteem. As mentioned before, the meaning of the circumcision has changed over time. For most of the participants in this study, circumcision is regarded as more important for health than “being a man”. Therefore, it is understandable that there is no significant difference between circumcision age groups in terms of self-esteem because meaning of the circumcision was similar in all circumcision age groups.

The effect of circumcision on sexual dysfunctions is one of the most debated topics in the literature and also, it is difficult to study sexuality and sexual functions because it is not only related to anatomical or physiological issues, but also personal attitude towards genital image, psychology of an individual, religion, culture, or sociocultural background are some of the important aspects while evaluating sexual dynamics. On the other hand, although there are studies which show medical benefits of circumcision, as mentioned in the first parts of the paper, providing solid and scientific data about possible short- or long-term psychological effects of circumcision is difficult because of the insufficient number of the studies and mixed results regarding relationship between circumcision and sexuality. Especially, it is hard to mention a direct effect of an infant or childhood circumcision on sexual functions. It is only discussed with the findings of circumcision studies that were conducted in adulthood (Marco & Heil, 2020; Morris et al., 2012). For premature ejaculation, some of them found that uncircumcised males were less likely to have premature ejaculation than the circumcised males. From medical perspective, the reason of this thickening and keratinization of the glans penis or the nerves of glandis corona may be hyperstimulated in circumcised male during intercourse and it leads to ejaculation before it is desired (O’Hara & O’Hara, 1999; Kim & Pang, 2007). On the other hand, Waldinger et al. (2005) found that there is no significant difference between circumcised and uncircumcised males in terms of intravaginal ejaculation latency time. Similar results were also

obtained from a study which consist of 3980 participants and it was found that circumcision status does not affect premature ejaculation symptoms significantly (Son et al., 2010). Same mixed results apply to erectile dysfunction and sexual satisfaction. While Collins et al. (2002) claim there is no significant difference in scores of sexual drives, erection, ejaculation, and overall satisfaction after circumcision procedure, Fink et al., (2002) stated circumcision affect erectile function negatively. Another study which compares same males before and after circumcision found that there are no statistically significant differences in sexual drive, erection, problem assessment and overall satisfaction. Yet, only one section which is ejaculation latency time was found statistically significant and according to the results of this study, the mean ejaculatory time was longer after circumcision (Senkul et al., 2004).

As mentioned before, in addition to all these studies, it is recommended to investigate infancy and childhood circumcision since all these studies were generally conducted with volunteer participants in adulthood. However, the literature is quite weak in this regard. There are only a few studies that do research on this subject. One of them was done to understand sexual experiences of gay men. The results show that men who were circumcised after infancy are more likely to have erection difficulties and less likely to experience premature ejaculation than those who were circumcised at infancy (Mao et al., 2008). Another study, which compares men who were circumcised before puberty and men who were circumcised during adolescence and later, shows that circumcision during adolescence and later leads to less sexual pleasure at the glans of penis and pain or discomfort at the penile shaft (Bronselaer et al., 2013). However, it should be kept in mind that these studies were not conducted in countries where circumcision is frequently performed. The studies which are done in societies where circumcision is often applied such as Turkey, may show different results in terms of relationship between circumcision and sexual functions. There are a few studies which were done in Turkey on this topic. The study which belongs to Armagan et al. (2013) aimed to elucidate whether circumcision during the phallic period negatively affect psychosexual functions (erectile function, premature ejaculation, and depression scores) in adulthood. In order to do this, 302 men enrolled into the study. According to the results, circumcision during the phallic period does not have a negative effect on psychosexual functions in adulthood. Furthermore, while Aydur et al. (2007) reported that childhood circumcision did not affect overall sexual function

in men, Cuceloğlu et al. (2012) stated that men who were circumcised after the age of 7 have higher premature ejaculation symptoms than those who were circumcised before the age 7.

The insufficiency of the number of studies and mixed results cause not having a clear idea about this subject. Therefore, it was aimed to conduct similar study which consists of different psychological concepts. Similar to some of the previous studies, a significant correlation between circumcision age and sexual functions of men was not found in this study. In addition to this, it is understandable that there is no significant difference between circumcision age groups in terms of sexual dysfunctions of men and there is no correlation between these concepts in this study since circumcision is seen quite normal procedure, not a trauma, in this culture, so significant effect of circumcision age was not observed on sexual dysfunctions in adulthood. Moreover, it was also aimed to investigate predictive role of circumcision age on sexual experiences with the mediation of self-related concepts that will be discussed next part of the paper.

4.1.5. Model of the study: direct and indirect effects

The main hypothesis of this study was whether circumcision age predicts sexual experiences on self-related concepts. Also, it was expected that circumcision age negatively predicts self-related concepts, and sexual experiences of men are negatively predicted by self-related concepts. According to the results, these hypotheses were accepted.

Although the physiological and medical effects of circumcision have been investigated, much attention has not been paid to the psychological effects of it in the literature. Circumcision is an operation which experienced by almost all men who live in Turkey. Also, it is accepted as an important aspect of being a man in this culture. For instance, it is seen as a passage from childhood to adulthood. In fact, being uncircumcised caused sense of shame and being defective for most of the hemophiliac patients who cannot be circumcised because of their health conditions. Also, these evaluations are similar for their parents. Most of the parents who have boys suffer from hemophilia want circumcision for their children, and parents of circumcised patients stated that they are happy after the circumcision (Kavakli et al., 2000). Therefore, it was aimed to investigate psychological part of circumcision in this study. In this direction and in the

light of the literature most related topics with circumcision were included this study which are sexual dysfunctions. Also, considering the place of circumcision in society, a few self-related concepts were used to investigate psychological effects of circumcision. As mentioned before, circumcision is a quite normal procedure in Turkey for boys because there is a positive image of circumcision. Children are prepared for this procedure and there are many positive images related to circumcision, such as gifts, "being a man", celebrations, etc. Thus, adverse effects of circumcision may be limited by those positive images in Turkey (Yavuz et al., 2012). In fact, the child has not yet been circumcised at an age when he can perceive himself and his environment may be considered as a problematic situation in a place where circumcision is important and essential. In some sources, it is called "delayed circumcision" (Cüceloğlu et al., 2012). It is known that school ages are important for developing sense of competence. In Erikson's psychosocial development stages, it is named as industry versus inferiority. In this stage, children start going to school and they find themselves in a wider social environment. Peers get greater significance and become a major source of the child's self-esteem. They try to master culturally important skills. Gaining admiration and appreciation for what they have learned and achieved is an indispensable need in this period. The acquisition of these culturally determined and valued talents and skills results in a sense of industry and psychosocial strength of competence. If they cannot develop a specific skill which is demanded by society, they may develop a sense of inferiority which affects their adulthood period (Dunkel & Harbke, 2017; Erikson, 1950; Erikson, 1982).

In the light of this information and place of the circumcision in Turkey, it was assumed that there may be negative evaluations about self-perception in children who have reached at an age when he can understand his environment and have not yet been circumcised. In line with all this information, it was decided that self-related concepts should be included in the study while investigating relationship between circumcision age and sexual dysfunctions. A model of the study was formed based on this and tested. In addition to this, as mentioned in the first part of the paper, self-related concepts, especially self-esteem and self-efficacy, play an important role in experiencing and maintaining sexual dysfunctions. In brief, self-esteem has a significant correlation with sexual satisfaction and people who have lower self-esteem reported more sexual dysfunctions (Ramezani et al., 2012). While high self-esteem is associated with high sexual satisfaction, poor self-esteem is highly associated with premature ejaculation. Also, lower self-

esteem was reported more frequently in individuals who suffer from premature ejaculation and erectile dysfunction (Hally & Pollack, 1993; Balon, 2017; Tsai et al., 2019). Consistent with previous studies, the results of this study also indicate that there is a significant correlation between self-related concepts and sexual dysfunctions in a negative way. Moreover, results of the path analysis show that self-esteem negatively predicts all sexual experiences of men. Finally, according to the results of the path analysis, it can be concluded that as the circumcision age increases, a decrease is observed in individuals' self-esteem and this diminishment causes an increase in premature ejaculation and erectile dysfunction symptoms, and sexual dissatisfaction scores in men. The decrease in self-esteem according to the increase in circumcision age may be explained with "delayed circumcision" situation. Since children begin to understand and evaluate themselves and their environment better as they get older, if they have not been circumcised, their self-esteem might be affected in adulthood because their assessment of themselves is based on their peers and demands of the culture. As mentioned before, cultural expectations are related with self-esteem and self-efficacy. Also, masculinity and femininity related gender roles are formed by expectations from parents, peers, teachers, and media. Gender roles, which indicate how a man should behave or perform, lead to performance anxiety, and affect indirectly sexual functions of men (Mahalik et al., 1998; Santtila et al., 2009). It is known that performance anxiety plays an important role on the psychological etiology of sexual dysfunctions. It causes or maintains the most common sexual dysfunctions (McCabe, 2005; Pyke, 2020). Also, these sexual dysfunctions, which are premature ejaculation and erectile dysfunction, related with sexual satisfaction. According to the results of this study, there is a positive correlation between these sexual dysfunctions and sexual dissatisfaction. Individuals who have premature ejaculation and erectile dysfunction symptoms also have higher level of sexual dissatisfaction. Previous studies also indicate that sexual dysfunctions are significant predictors of sexual satisfaction (Patrick et al., 2005; Nelson et al., 2007). It is known that cultural beliefs and conflicts related with sexual satisfaction. In other words, social and cultural environment related variables have an impact on sexual satisfaction of individuals (del Mar Sánchez-Fuentes et al., 2014). As mentioned before, culturally determined gender roles and expectations lead to performance anxiety and this have an impact on sexual dysfunctions. This situation may indirectly influence sexual satisfaction of men.

To sum up, according to the results of this study, there is no relationship between circumcision age and sexual experiences; however, the prediction of circumcision age on sexual experiences is mediated by self-related concepts (self-esteem). This situation may show that not circumcision itself but the feeling of inadequacy, which is acquired by men in their childhood due to the timing of the circumcision, may have a negative impact on their sexual experiences in adulthood as a reflection of performance anxiety.

4.2. Clinical Implications and Importance of the Current Study

This study aimed to investigate whether there is a connection between circumcision age and sexual experiences of men in adulthood. Also, finding an appropriate circumcision age range was aimed with the findings of the study.

Almost all men are circumcised in Turkey and the decision of circumcision age generally belongs to families. At the same time, recommendations, which are provided by doctors, might be used by families while deciding when circumcision will be applied. Therefore, the findings of this study can be applied by those who are working in clinical settings, which is important in order to reduce chance of experiencing sexual dysfunctions in adulthood. According to the results of this study, increasing in circumcision age predicts premature ejaculation and erectile dysfunction symptoms, and sexual dissatisfaction in a positive way. In addition to this, it was found that there is a negative relationship between circumcision age and self-related concepts. It is important to consider this information while deciding the circumcision age so that the possibility of experiencing premature ejaculation, erectile dysfunction and sexual dissatisfaction in adulthood could be reduced.

To sum up, in line with this information, being circumcised at early ages can be recommended in order to prevent possible risks of sexual dysfunctions. Especially considering the relationship between circumcision age and self-related concepts, which are more important concepts in school-age children, circumcision of the child in preschool period may be beneficial for reducing the chance of experiencing sexual dysfunctions in adulthood. In addition to the findings of this study which aims to investigate the psychological aspects of circumcision, there is a systematic review of the literature by Morris et al. (2012), which interested in medical aspects of circumcision, recommends performing it in the early period, especially in the infancy

period when there is no need for sutures, complications are not seen frequently, recovery is rapid, cosmetic outcomes are generally perfect and there is more opportunity to use local anesthesia because of the low mobility of an infant. On the other hand, it is assumed that circumcision performed in the phallic period may have short-term psychological effects on children (Sılay, 2018). Therefore, in the light of all these studies, it can be recommended that practicing circumcision in infancy period would eliminate possible undesirable psychological and medical outcomes of circumcision.

In addition to all these, while working with sexual dysfunctions, it is aimed to enhance self-esteem or self-efficacy of a person to get better outcomes from treatment (Rosen et al., 1994). Therefore, focusing on circumcision experience while working with men, who suffer from sexual dysfunctions, will be beneficial in clinical settings because of the relationship among circumcision age, self-related concepts, and sexual dysfunctions.

4.3. Limitations and Recommendations

Although this study is thought that it makes contributions to the literature in terms of the concepts it investigated, there are some limitation. Firstly, this study was conducted with 236 men who were circumcised between the ages of 0 and 12 to investigate predictive role of circumcision age on sexual experiences. Therefore, only circumcised men were involved in this study. In addition to this, it was aimed to compare the variables of the study with the circumcision age groups. The absence of uncircumcised men as a control group is one of the limitations of the study while comparing groups.

In addition to this, only participants' self-evaluations about their own sexual performance were required in this study. Evaluations of their partners were not included in this study. Yet, as mentioned before, in societies where the concept of masculinity is more important, individuals may make incomplete or exaggerated evaluations regarding their sexual performance. This may be valid for men living in Turkey and may have affected the information they gave about their sexual dysfunction symptoms, which is another limitation of the study.

On the other hand, the scale, which was used to measure sexual dysfunctions of men, is generally used for heterosexual males. However, in this study there were 17 individuals who

identify their sexual orientation other than heterosexual. Before starting the analyses of the study, it was checked whether there is a difference between these individuals in terms of sexual dysfunctions and no significant difference was found. Therefore, all participants were included in the study. However, although there is no significant difference between sexual dysfunction scores of men in terms of sexual orientation, this situation can be considered as a limitation.

Therefore, conducting a similar study with a larger clinical sample and taking evaluations of partners regarding sexual performance of men may be recommended for further studies. In addition to this, considering limited studies on circumcision in Tukey, focusing on circumcision experience related factors in more detail can be recommended for further studies. For instance, information regarding what kind of complications developed during circumcision may be obtained from men to see how these complications affect attitudes toward circumcision and sexual dysfunctions. In addition to this, taking women's evaluations, especially mothers of boys, regarding importance of the circumcision ritual may be beneficial to get better understanding about attitudes toward circumcision. Lastly, including men and women from different age groups in further studies will be beneficial in order to see how the attitudes toward circumcision differs between generations and genders.

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APPENDICES

APPENDIX 1: DEMOGRAPHIC INFORMATION FORM

DEMOGRAFİK BİLGİ FORMU

Lütfen aşağıdaki soruları inceleyip cevaplayınız.

1. Yaşınız…
2. Şu anda aktif olarak cinsel birlikteliğinizin olduğu bir partner ya da partnerler var mı?
    a. Var
    b. Yok
    c. Son 1 aydır yok
    d. Son 2 aydır yok
    e. Son 3 aydır yok
    f. 3 aydan fazladır yok
3. Cinsel eğiliminizi nasıl tanımlıyorsunuz?
    a. Heteroseksüel (Sadece karşı cinse duyulan ilgi)
    b. Homoseksüel (Sadece hemcinse duyulan ilgi)
    c. Biseksüel (Her iki cinse de duyulan ilgi)
    d. Diğer…
    e. Belirtmek istemiyorum
4. Hayatınızın ilk 15 yılını geçirdiğiniz yer neresidir?
    a. Köy
    b. Kasaba
    c. Şehir
    d. Büyük Şehir
5. İlişki durumunuz
    a. İlişkisi var (Lütfen süresini ay/yıl şeklinde belirtiniz…)

b. İlişkisi yok
c. Evli (Lütfen süresini ay/yıl şeklinde belirtiniz…)
d. Diğer…

6. Eğitim durumunuz
    a. Okur-yazar değil
    b. Okur-yazar
    c. İlkokul mezunu
    d. Ortaokul mezunu
    e. Lise mezunu
    f. Lisans mezunu
    g. Lisansüstü
7. Mesleğiniz
    a. Öğrenci
    b. Çalışmıyor
    c. Diğer…
8. Aylık geliriniz nasıl tanımlarsınız?
    a. Düşük
    b. Ortalama
    c. Yüksek
9. Şu anda sizi yardım almaya yönlendiren veya profesyonel yardım aldığınız psikiyatrik bir tanınız var mı?
    a. Evet
    b. Hayır
10. Herhangi bir psikiyatrik ilaç kullanıyor musunuz?
    a. Evet
    b. Hayır
11. Bilinen bir kalp rahatsızlığınız var mı?
    a. Evet
    b. Hayır
12. Sünnetin sizin için manevi değerini göz ardı ettiğinizde yine de sünnet olmak ister miydiniz?

a. Evet sünnet olmak isterdim (Lütfen nedenini belirtiniz…)
b. Hayır sünnet olmak istemezdim (Lütfen nedenini belirtiniz…)

13. Kaç yaşında sünnet oldunuz?
14. Sünnet olma işleminiz nerede gerçekleşti?
    a. Hastanede
    b. Evde
    c. Özel bir yerde
    d. Diğer…
15. Sünnetiniz için özel bir etkinlik (kutlama, sünnet düğünü, yemek vs.) oldu mu?
    a. Evet ise nasıl bir etkinlikti?
        i. Aile arasında bir kutlama/yemek
        ii. Özel kıyafetlerin giydirildiği bir sünnet düğünü
        iii. Diğer…
    b. Hayır
16. Sünnetinize dair aklınıza gelen ilk anınız nedir? Lütfen kısaca belirtiniz. (Hatırlamıyorsanız lütfen "0" yazınız).
17. Genel olarak sünnet sizin için nasıl bir anlam ifade ediyor?
    a. Dini bir gereklilik
    b. Sağlık için gerekli bir işlem
    c. Erkekliğe atılan ilk adım
    d. Gereksiz bir ritüel
    e. Bir anlam ifade etmiyor
    f. Diğer…
18. Sünnetinizi düşündüğünüzde aşağıda belirtilmiş olan duyguları sünnetiniz sırasında ne kadar yoğun hissettiğinizi 0-5 arasında değerlendiriniz. (0= Hatırlamıyorum, 1= Hiç hissetmedim, 5=Çok hissettim)

ACI	0	1	2	3	4	5
KAYGI	0	1	2	3	4	5
SEVİNÇ	0	1	2	3	4	5
KORKU	0	1	2	3	4	5

GURUR	0	1	2	3	4	5
ÜZÜNTÜ	0	1	2	3	4	5
ÖFKE	0	1	2	3	4	5
GÜÇ	0	1	2	3	4	5
UTANÇ	0	1	2	3	4	5

19. Bu duygular dışında sizin baskın olarak hatırladığınız ve belirtmek istediğiniz herhangi bir duygu var mı?

    a. Evet…
    b. Hayır

APPENDIX 2: THE GOLOMBOK-RUST INVENTORY SEXUAL SATISFACTION SCALE (GRISS)

GOLOMBOK-RUST CİNSEL DOYUM ÖLÇEĞİ

Aşağıda cinsel yaşam ile ilgili bazı sorular yer almaktadır. Her soru için "hiçbir zaman", "nadiren", "bazen", "çoğu zaman", "her zaman" şeklinde beş cevap şıkkı yer almaktadır. Sizden istenen kendi cinsel yaşamınızı göz önünde bulundurarak soruları cevaplandırmanızdır. Soruları durumun son zamanlarda ne kadar sıklıkla ortaya çıktığını düşünürken başkalarının görüşlerini dikkate almadan sadece kendi görüşlerinizi belirtiniz. Şu anda aktif bir cinsel hayatınız yoksa lütfen soruları en son beraber olduğunuzun partner ya da partnerleri düşünerek cevaplayınız.

	Hiçbir Zaman	Nadiren	Bazen	Çoğu Zaman	Her Zaman
1.Haftada 2 defadan fazla cinsel birleşmede bulunur musunuz?					
2.Partnerinize, cinsel ilişkinizle ilgili olarak, nelerden hoşlanıp nelerden hoşlanmadığını söyleyebilir misiniz?					
3.Cinsel yönden kolay uyarılır mısınız?					
4.Cinsel ilişki sırasında boşalmak için henüz erken olduğunu düşünürseniz, boşalmayı geciktirebilir misiniz?					
5.Partnerinizle olan cinsel yaşamınızı tekdüze (monoton) buluyor musunuz?					
6.Partnerinizin cinsel organına dokunup, okşamaktan rahatsız olur musunuz?					
7.Partneriniz sizinle sevişmek istediğinde, tedirgin ve endişeli olur musunuz?					

8.Cinsel organınızın partnerinizin cinsel organına girmesinden zevk alır mısınız?					
9.Partnerinize, cinsel ilişkinizle ile ilgili olarak nelerden hoşlanıp, nelerden hoşlanmadığını sorar mısınız?					
10.İlişki sırasında cinsel organınızın sertleşmediği olur mu?					
11.Partnerinizle olan cinsel ilişkinizde sevgi ve şefkatin eksik olduğunu hisseder misiniz?					
12.Partnerinizin, cinsel organınıza dokunup okşamasından zevk alır mısınız?					
13.Cinsel birleşme sırasında erken boşalmayı engelleyebilir misiniz?					
14.Partnerinizle sevişmekten kaçınır mısınız?					
15.Partnerinizle olan cinsel ilişkinizi tatminkâr buluyor musunuz?					
16.Önsevişme (öpme, okşama gibi) sırasında cinsel organınızın sertleştiği olur mu?					
17.Bir hafta boyunca cinsel ilişkide bulunmadığınız olur mu? (Hastalık gibi nedenler dışında)					
18.Partnerinizle karşılıklı mastürbasyon yapmaktan (kendinizi tatmin etmekten) zevk alır mısınız?					
19.Partnerinizle sevişmek istediğinizde, ilişkiyi siz başlatır mısınız?					
20.Partnerinizin sizi sevip okşamasından hoşlanır mısınız?					
21.İstediğiniz kadar sık cinsel ilişkide bulunur musunuz?					
22.Partnerinizle sevişmeyi reddettiğiniz olur mu?					

23.Cinsel birleşme sırasında, cinsel organınızın sertliğini kaybettiği olur mu?					
24.Cinsel organınız, partnerinizin cinsel organına girer girmez istemeden boşaldığınız olur mu?					
25.Partnerinize sarılıp, vücudunu okşamaktan zevk alır mısınız?					
26.Cinsel yaşama karşı ilgisizlik duyar mısınız?					
27.Cinsel organınız partnerinizin cinsel organına girmek üzereyken, istemeden boşaldığınız olur mu?					
28.Sevişme sırasında yaptıklarınızdan tiksinti duyar mısınız?					

APPENDIX 3: THE PERCIEVED STRESS SCALE (PSS)

ALGILANAN STRES ÖLÇEĞİ

Aşağıda geçtiğimiz son ay içerisindeki duygu ve düşünceleriniz hakkında çeşitli sorular yer almaktadır. Sizden her bir soruda tarif edilen duygu ve düşünceyi ne kadar sıklıkla yaşadığınızı belirtmeniz istenmektedir. Bazı sorular birbirine çok benzer gözükse de aralarında birtakım farklılıklar bulunmaktadır. Bu yüzden her bir soruya ayrı ayrı düşünerek yanıt vermeniz istenmektedir. Bu amaçla her soruyu hızlı bir şekilde düşünerek yanıtlamanız uygun olacaktır. Tarif edilen duygu veya düşünceyi geçen ay boyunca kaç kere hissettiğinizi saymak yerine verilen alternatiflerden size en uygun gelen seçeneği işaretlemeniz istenmektedir.

	Hiçbir Zaman	Neredeyse Hiçbir Zaman	Bazen	Oldukça Sık	Çok Sık
1. Geçen ay, beklenmedik bir şeylerin olması nedeniyle ne sıklıkta rahatsızlık duydunuz?					
2. Geçen ay, hayatınızdaki önemli şeyleri kontrol edemediğinizi ne sıklıkta hissettiniz?					
3. Geçen ay, kendinizi ne sıklıkta sinirli ve stresli hissettiniz?					
4. Geçen ay, ne sıklıkta gündelik zorlukların üstesinden başarıyla geldiniz?					
5. Geçen ay, hayatınızda ortaya çıkan önemli değişikliklerle etkili bir şekilde başa çıktığınızı ne sıklıkta hissettiniz?					
6. Geçen ay, kişisel sorunlarınızı ele alma yeteneğinize ne sıklıkta güven duydunuz?					
7. Geçen ay, her şeyin yolunda gittiğini ne sıklıkta hissettiniz?					

8. Geçen ay, ne sıklıkta yapmanız gereken şeylerle başa çıkamadığınızı fark ettiniz?					
9.Geçen ay, hayatınızdaki zorlukları ne sıklıkta kontrol edebildiniz?					
10. Geçen ay, ne sıklıkta her şeyin üstesinden geldiğinizi hissettiniz?					
11. Geçen ay, ne sıklıkta kontrolünüz dışında gelişen olaylar yüzünden öfkelendiniz?					
12. Geçen ay, kendinizi ne sıklıkta başarmak zorunda olduğunuz şeyleri düşünürken buldunuz?					
13. Geçen ay, ne sıklıkta zamanınızı nasıl kullanacağınızı kontrol edebildiniz?					
14. Geçen ay, ne sıklıkta problemlerin üstesinden gelemeyeceğiniz kadar biriktiğini hissettiniz?					

APPENDIX 4: TWO-DIMENSIONAL SELF-ESTEEM: THE SELF-LIKING/SELF-COMPETENCE SCALE (SLCS)

İKİ BOYUTLU BENLİK SAYGISI: KENDİNİ SEVME/ÖZYETERLİLİK ÖLÇEĞİ

Aşağıda kendinizle ile ilgili genel birtakım ifadeler bulunmaktadır. Sizden her bir ifadenin size ne kadar uygun olduğunu belirtmeniz istenmektedir. Lütfen ifadeleri dikkatlice okuyup size ne kadar uygun olduğunu işaretleyiniz.

	Hiç Uygun Değil	Uygun Değil	Biraz Uygun	Uygun	Tamamen Uygun
1.Kendimi değersiz görmeye eğilimliyim.					
2.Yaptığım işlerde oldukça yeterliyim.					
3. Kendimle oldukça barışığım.					
4. Uğrunda çaba gösterdiğim hemen her işi başarabilirim.					
5. Kendi değerimden eminim.					
6. Kendimle ilgili düşünmek kimi zaman hoşuma gitmez.					
7.Kendime karşı olumsuz tutum içindeyim.					
8. Bazen benim için önemli olan şeyleri başarmakta zorlanırım.					
9.Kendimden gayet memnunum.					
10. Zorluklarla başa çıkmada bazen yetersiz kalırım.					

11.Kendi kişisel değerimden asla şüphe duymam.					
12. Birçok konuda oldukça başarılıyımdır.					
13.Hedeflerimi gerçekleştirmede bazen başarısız olurum.					
14. Çok Yetenekliyim.					
15.Kendime yeterince saygım yoktur.					
16.Keşke yaptığım işlerde daha becerikli olsam.					

APPENDIX 5: ETHICAL APPROVAL

ETİK KURUL ONAYI

Sayı : 17162298.600-321 31 OCAK 2020
Konu : Tez Çalışması

İlgili Makama

Üniversitemiz Sosyal Bilimler Enstitüsü Klinik Psikoloji Tezli Yüksek Lisans Programı öğrencisi Eliz Soğular'ın, Dr. Öğretim Üyesi Esra Güven danışmanlığında yürütmekte olduğu "The Predictive Role of Circumcision Age on Sexual Experiences of Men Who Live in Turkey" başlıklı yüksek lisans tez çalışması değerlendirilmiş ve yapılmasında bir sakınca olmadığı tespit edilmiştir.
Bilgilerinize saygılarımızla sunarız.

Başkent Üniversitesi Sosyal ve Beşeri Bilimler ve Sanat Araştırma Kurulu

Ad, Soyad	Değerlendirme	İmza
Prof. Dr. M. Abdülkadir Varoğlu	Olumlu/~~Olumsuz~~	
Prof. Dr. Kudret Güven	Olumlu/Olumsuz	
Prof. Ali Sevgi	Olumlu/~~Olumsuz~~	
Prof. Dr. Işıl Bulut	Olumlu/~~Olumsuz~~	
Prof. Dr. Sadegül Akbaba Altun	Olumlu/~~Olumsuz~~	
Prof. Dr. Can Mehmet Hersek	Olumlu/~~Olumsuz~~	
Prof. Dr. Özcan Yağcı	Olumlu/~~Olumsuz~~	

APPENDIX 6: INFORMED CONSENT FORM

BİLGİLENDİRİLMİŞ GÖNÜLLÜ ONAM FORMU

Sayın Katılımcı,

Bu araştırma Başkent Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Eliz Soğular tarafından, Dr. Öğr. Üyesi Esra Güven danışmanlığında bir tez çalışması kapsamında yürütülmektedir. Araştırmanın amacı erkeklerin cinsel yaşantılarının sünnet ve birtakım psikolojik süreçlerle ilişkisini araştırmaktır. Bu çalışmaya katılmak için sünnet olmuş ve 18 – 50 yaş aralığında olmanız aynı zamanda da şu anda ya da yakın geçmişte aktif bir cinsel hayatınızın olmuş olması gerekmektedir.

Sizlere yöneltilen soruların doğru veya yanlış cevapları yoktur. Çalışmanın amacına ulaşabilmesi için sizden ricamız verilen anketlerdeki sorulara olabildiğince eksiksiz ve içtenlikle size en uygun gelen yanıtları vermenizdir. Bu çalışmadan elde edilecek bilgiler tamamen bilimsel amaçlı kullanılacak olup kişisel bilgileriniz kesinlikle gizli tutulacaktır. Tüm soruların yanıtlanması yaklaşık olarak 10-15 dakika sürecektir. Çalışmanın güvenilirliği sebebiyle soruların tamamının yanıtlanması oldukça önemlidir.

Çalışma esnasında kimliğiniz veya kimliğinizi belirleyecek hiçbir bilgi sizden talep edilmeyecek, sadece temel demografik bilgileri doldurmanız istenecektir. Verdiğiniz cevaplar gizli tutulacaktır ve üçüncü kişilerle paylaşılmayacaktır. Bu çalışmaya katılmak tamamen gönüllülük esasına dayanmaktadır. Bu formu okuyup onay vermeniz çalışmaya katılmayı kabul ettiğiniz anlamına gelmektedir. Ancak, çalışmaya katılmama veya katıldıktan sonra rahatsızlık duyduğunuz herhangi bir noktada çalışmayı bırakma hakkına sahipsiniz. Yapılan çalışma ile ilgili soru sormak isterseniz çalışmanın yürütücüsü Eliz Soğular ile elizsogular@gmail.com adresi üzerinden iletişim kurabilirsiniz. Çalışmaya olan katkınızdan dolayı teşekkür ederiz.

Yukarıda Eliz Soğular tarafından yürütülen çalışmanın tam metnini okudum. Çalışmanın amacını ve gönüllü olarak üzerime düşen sorumlulukları anladım. Kişisel bilgilerimin gizli tutulacağını ve istediğim zaman neden belirtmeksizin çalışmadan ayrılabileceğimi anladım.

☐ Çalışmaya katılmayı kabul ediyorum.