Chapter Fourteen

Early Surgery and Trauma

It is heart-rending to us that children sometimes undergo abdominopelvic surgery or trauma during infancy or early youth. The physical scars that form in the body of a child do not always grow with the rest of the body. Thus, early healing events can create extremely tight, restricted, or adhered areas in children. The internal and external scars that form during youth can cause moderate to severe pain and significant dysfunction as the child grows through adolescence into adulthood, and attempts to participate in normal adult activities.

Early scars bind nearby structures together and prevent tissues from performing the way they would without the restrictive adhesive bonds. These scars often tend to cause other problems, such as infertility, digestive dysfunction and decreased range of motion as the child matures.

As these children compare their bodies to their "perfectly formed" friends, deep psychological scars may form as well. While mental health counselors can address the psychological pain and confusion, we have found great value in addressing, mobilizing, and freeing the physical scars that have bound these patients for most of their lives. A few specific examples follow.

Female Genital Mutilation (FGM)

The problem of early childhood scarring was first brought to our clinic from an unlikely source: tribal Africa. Several years ago, a number of women applied for therapy from their homes in equatorial Africa. While their initial goal was to improve their fertility, it quickly became

obvious to us that most of them shared other problems, such as severe intercourse pain and diminished or absent sexual function (e.g., desire, lubrication, orgasm).

When these women presented at our clinics, even our most seasoned physical therapists were shocked and dismayed to see the results of the ritual surgeries that were performed on these women when they were children — some as early as the age of eight days old. In cases of infibulation (near-total closing of the outer labia), women who had actually been able to conceive were cut open for childbirth and then closed again, surgically.

In some parts of the world, children are surgically altered by tribal leaders or elders in accordance with beliefs or customs of that tribe. While some tribal surgeries are touted as benefiting the child (e.g., if the clitoris is removed, she will be less likely to get into trouble), others are clearly designed to benefit their families or future spouses — such as young girls and women who are cut and "tightened" for the eventual pleasure of the man who will become her husband. In an ironic twist of fate, one study of post-infibulation found that husbands of women who had undergone this extreme form of FGM were often injured when they tried to have intercourse with their spouses; the majority of them reported difficult penetration, wounds, infections and psychological problems. In fact, after marriage, most of the men said they preferred to marry a woman without a history of FGM. [29A]

According to WHO, 100 to 140 million girls and women worldwide are currently living with the consequences of FGM, and three million more girls are at risk every year.[30]

FGM reflects a deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is thus a violation of the rights of children. The practice also violates a person's rights to health, security,

life, physical integrity, and freedom from torture and cruel, inhuman, or degrading treatment.

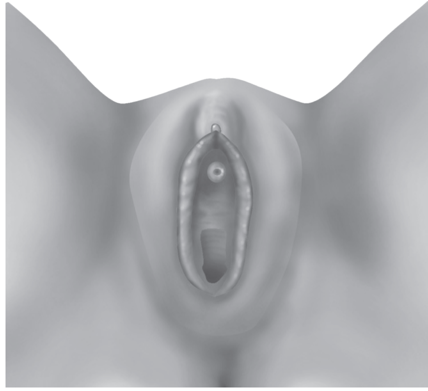
While procedures vary somewhat, all involve the partial or total excision of the external female genitals, and may include other surgical alterations. It is commonly performed during adolescence (typically before age 12), and may occur as early as infancy.

While sometimes performed by doctors, FGM is often performed in a non-sterile environment without anesthesia. In such cases, the "surgical instruments" used may include broken glass, tin can lids, scissors, or other items not designed for surgical procedures. The procedure can be fatal if the child goes into shock, hemorrhages, or becomes septic with infection.

Depending on the degree and severity of the procedure chosen for the girl, she may experience a lifetime of chronic pain, infertility, or sexual dysfunction associated with the trauma of the event and the scarring that occurs as the survivor heals. Because it is often done to several girls at a time using the same cutting implement in a ritual setting, FGM can contribute to the spread of HIV in its victims.

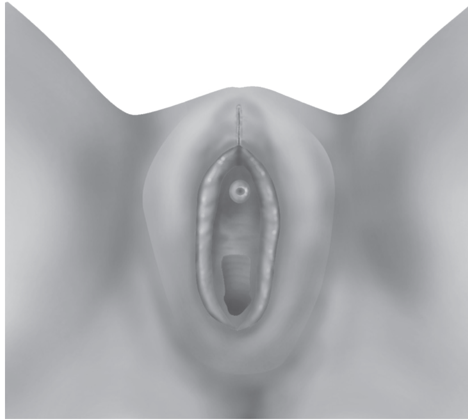
The Four Types of Female Genital Mutilation (FGM)

Amnesty International and WHO specify four main types of female circumcision or genital mutilation.



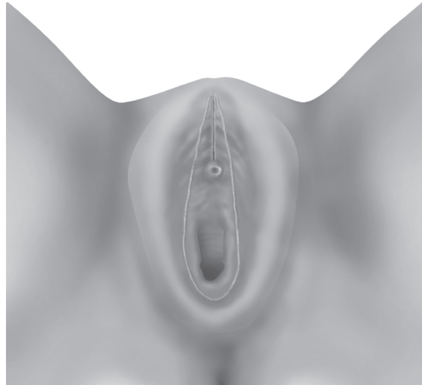
Normal external female genitalia

In a clitorectomy (type I) shown below, the clitoris is removed (partially or completely).



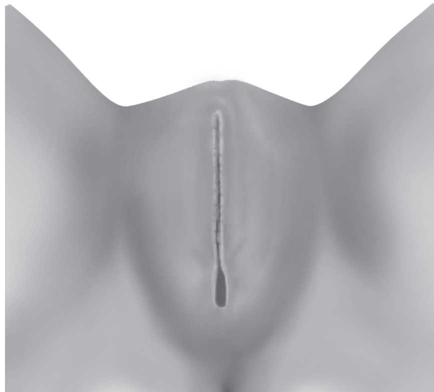
Type I mutilation: the clitoris is partially or totally removed

If an excision (type II) is performed (below), the clitoris and the labia minora (inner lips of the vagina) are removed.



Type II mutilation: both clitoris and labia minora are removed

Type III refers to an infibulation, in which the vaginal opening is narrowed generally by stitching the outer labia together, often with the creation of a covering seal, leaving only a small hole for urine and menstral fluid to pass through. As noted earlier, this “operation” is often repeated in adulthood, after a woman is surgically reopened to give birth to her own child.



Type III mutilation showing the external labia sewn together, leaving only a small opening at the bottom for urination, menstruation or intercourse

Type IV FGM refers to a combination of any of the above, and any other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping, and cauterizing the genital area.

Restoring fertility and a fruitful sex life after FGM

Clearly, the scarring from such practices can be massive. We have treated women who were mutilated as early as eight days old. The scars that formed from these "surgeries" prevented the normal growth and function of the urogenital area in these women, dooming many of them to a lifetime of pain and dysfunction unless they could find someone knowledgeable enough to decrease their scarring and return mobility to the area.

One of the first women to come to us with a history of FGM arrived seeking help with her fertility. However, upon questioning during her initial evaluation, she revealed that she had "number ten (out of ten) screaming pain" whenever she attempted intercourse with her spouse.

When we examined her vaginal tissues, the adhesions were severe. She told us that they had been there since she was an infant. The poor lady was so bound down by vaginal adhesions that we could barely touch her.

Using a gloved hand, we gently and slowly examined her introitus — the entrance to her vagina. Although we were unable to place a single finger into her vagina at that time, we were able to evaluate the opening.

With a delicate touch, we began to evaluate and treat every centimeter of her vaginal opening. In some of her worst areas, we were only able to use what felt like a feather touch. In some areas we could apply more normal pressure, but even moderate pressure would elicit searing pain. We also moved on to her legs and nearby tissues that pulled into her scarred areas.

Tediously and meticulously, we palpated and treated every centimeter of her introitus for two days — the first eight hours of her anticipated twenty hour regime. By day three, we were able to access the deeper reaches of her tissues, and by the end of that day, we were at full depth inside her vagina. There, we found the cervix stiff and retroverted, pulled back towards her tailbone by thick internal adhesions.

By the end of her five days of therapy, we were able to access and deeply palpate all of her vaginal tissues without eliciting any pain at all. Basically, her pain was gone at the end of therapy.

We and our patient were both very pleased that we were able to make such huge gains for her within a week. (Actually, she was thrilled, unaware that anything could be done for her painful intercourse.) We feel confident that she will now be able to have a more normal life with her husband, and hopefully create the family of her dreams.

We are stunned and dismayed at the prevalence of the debilitating pain and dysfunction that comes from the brutal procedure known as female genital mutilation, or female circumcision. There is no good reason we can find for this surgery that causes so much pain and misery to so many women each year.

Physical and Sexual Abuse: Lasting Scars

Medical science recognizes that physical and sexual abuse can create deep psychological scars in its victims. Sound counseling can help victims come to grips with the confusing and conflicting emotions so often associated with abuse. Generally, the perpetrator was stronger, older, or otherwise overpowering — and may no longer be present as an object for venting unresolved feelings our patient may have. In many cases, conflicting experiences of pain and pleasure mixed into the setting of being with a family member or “friend” led to underlying emotions of guilt, mixed with anger, resentment, and helplessness.

In addition to the emotional scarring, many victims also experience physical pain or dysfunction after the abuse. Palpable physical scars can exist deep within the body's tissues for decades after the abuse has ended. These scars can endure a lifetime if left untreated. We have found that therapy can greatly help locate, treat, and eliminate the physical scarring, pain, and dysfunction associated with the abuse. In many cases, freeing the body from its physical scars has proven to be a valuable factor in unlocking a lifetime of psychological scarring associated with the trauma(s).

Reclaiming a pain-free and enjoyable sex life

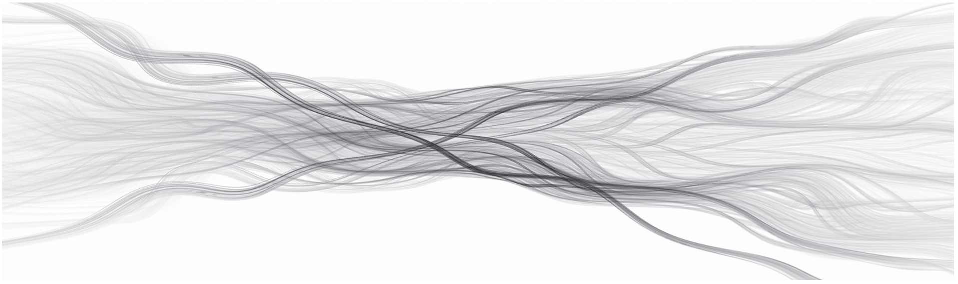
Adhered areas can form on the surface and deep within the body as a response to the physical trauma of abuse. These scars can cause longstanding pain, tightness, or dysfunction. They often seem to create a physical space that houses the psychological trauma.

In some instances, our patients have experienced their trauma as a direct force, such as being struck or subjected to one or more forced sexual or physical encounters.

In other instances, the trauma may manifest more slowly. For example, when a person enlists a protective mechanism that must always be "on guard" against a recurrent perpetrator, the ongoing muscle spasm can cause physical adhesions to occur slowly over time (as naturally as they do from a direct strike). For example, we have treated some adhesions and pain in the neck or shoulders of patients who were bracing against repeat aggression by an abusive parent, spouse, or sibling. Thus in a very real sense, trauma creates internal adhesive straight-jackets that can immobilize body tissues, whether from a single devastating incident or from a series of traumatic events.

We understand the deep scarring that occurs from physical and sexual abuse and have successfully treated many severe patient cases. We treat the scars and adhesions that form within our patients as a result of the abuse. Like tiny but very strong, straight-jackets with a tensile strength of nearly 2,000 pounds per square inch, adhesions

form wherever the body heals, binding down tissues that should be able to move freely, as they do for people who have not suffered abuse.



Like the small strands that comprise a nylon rope, microscopic cross-links join to create larger adhesive structures.

When we are able to physically free these adhesive straight-jackets using a manual soft-tissue therapy, patients report a dramatic reduction or resolution of their symptoms. Their bodies become much more mobile and pain-free.

Many have found that the process of freeing these internal physical bonds also opens the door to help heal the psyche and spirit, paving the way for greater resolution of their issues, so they can move on, less hindered by the shadows of the past.

Over the years, we have treated the physical aspect of scarring from physical or sexual abuse for many women. Some of our patients had developed multiple personalities as their only available defense against an untenable situation. Several of these women have told us that the physical release of adhesions opened a door to a deeper level of psychological healing. Some felt that the very act of being touched by caring hands, sensitive to direction and permission from the patient, contributed to their overcoming earlier barriers to intimacy.

It is perhaps unfortunate that psychologists are precluded from touching their patients. We have found that for many victims of abuse, the process of learning that touch can be caring, nurturing, and appropriate is an important component of their rehabilitation.

Along with that, we make certain that each of our patients understands that she (or he) retains the right to give (or rescind) permission for that touch at all times. Reflecting the views of a civilized democratic society, we feel the therapy room must provide a healthy, self-empowered setting where each person retains control over her body, and gives permission for each step of therapy. Along with that, each patient should understand that she is in a safe place, free from judgment or pressure to achieve anyone's goal except her own.

Prior Sexual Abuse

- Kelly's Story

Tight hips, chronic constipation, and pain and stiffness in my hands, shoulders, and neck. Somehow, all of the problems were interrelated.

I went to Clear Passage Therapies (CPT) for help with problems caused by sexual abuse which had occurred almost twenty years ago. I had a feeling that the therapy would help me resolve the pain and inflexibility in my vaginal area which had resulted in sexual dysfunction.

My manual physical therapist did a terrific job, the therapy worked beautifully, and I have had no pain since the treatment.

> What I did not realize was that there were many other problems that would also be resolved — tight hips, chronic constipation, and pain and stiffness in my hands, shoulders, and neck. Somehow, all of the problems were interrelated. In the months following therapy, I discovered I had an entirely new body, which was flexible, strong, and ready to get back to work! I now run regularly, enjoy going to the gym, and I've lost about ten pounds through my healthier lifestyle.
>
> Finally, and most mysteriously, I notice I'm less stressed-out these days. In the past, even when everything was OK in my life, I was always a little nervous. I had trouble sitting quietly, just doing nothing. The tension disappeared immediately after treatment and hasn't returned. Perhaps it was my body trying to tell me something was wrong. In any case, I've become a calmer and happier person.

Early Medical Surgery

Surgeries performed by physicians on infants and young children are designed to save lives, improve the child's appearance or quality of life, or for health or religious reasons. The scarring that is the near-inevitable by-product of most surgeries (see Chapter Sixteen) occurs in children with a few added complications.

One complication of early post-surgical scarring is that pre-verbal children cannot easily communicate any pain, pulling, or other sensation that follows surgery. A more lasting complication is that scars and adhesions bind tissues together. As the child grows, the scars from an early surgery generally do not grow at the same rate as the natural underlying structures. The body attempts to grow around the adhered tissues, but the constant strong pull from the surgical repair causes a dysfunctional state of growth. The affected tissues, whether muscles, organs, nerves, or connective tissues are unable to

develop normally, since they are glued down by powerful adhesions in one or more places. This can cause pain or dysfunction in the child that can persist, and even become worse, as the child enters adolescence and adulthood.

To illustrate this phenomenon, let's consider a subset of early surgeries that are frequently performed on infants and young children.

Congenital Adrenal Hyperplasia (CAH) and Reconstructive Surgery

Congenital adrenal hyperplasia (CAH) refers to a family of inherited disorders associated with an inability or deficiency in the ability to produce cortisol, a hormone made by the adrenal glands. In affected individuals, the disease begins early in gestation and leads to conditions that may become obvious or visible at birth.

In some females, congenital adrenal hyperplasia causes an excess of androgen, a hormone that stimulates the development and maintenance of masculine characteristics. This often comes to medical attention due to physical anomalies in the female infant's urogenital and reproductive structures when she is born.

Classical congenital adrenal hyperplasia (CCAH) is considered a relatively common condition in Europe and North America, affecting one in 15,000 newborns. Overproduction of androgen hormones in classical CAH can cause the clitoris to become enlarged in the female infant to the point that it may look like a small penis. Further, the labial folds may join to resemble a scrotum.

These external anomalies do not affect the function of the internal female reproductive organs, which remain intact. However, the visual appearance of the anomaly may be so great that the female infant may initially be misidentified as a male.

In addition to medical (hormonal) treatment, parents of affected infant girls often want to save their daughter from a lifetime of

embarrassment due to her visible anomaly. Thus, many parents of infant girls with classical congenital adrenal hyperplasia schedule the child for one or more reconstructive genital surgeries. These may begin as early as infancy.

While the early surgery may help the child look more "normal," these surgeries can leave scarring and adhesions that can cause pain and dysfunction during their youth.

At whatever age surgery is performed, it can cause severe scarring and adhesions at the delicate tissues of the vagina, perineum, clitoris, labia or vulva. The adhesions which formed at such an early age may result in significant problems later in life, such as painful intercourse, inability to have normal intercourse, or other types of sexual dysfunction, (e.g., decreased or absent desire, lubrication, and orgasm).

Creating a Pain-free, Functional Life

Children are delicate, and most do not understand why they received debilitating or ugly scars, when all their friends seem "perfect." Like the cases of CAH or FGM surgeries cited in this chapter, the early scars of genital surgeries formed in the most delicate and private areas of the body.

Over the years, we have come to understand well the physical scars that occur at and around the reproductive organs. In fact, we have been treating post-surgical vaginal adhesions for two decades. Our work in this area began over 20 years ago, when Belinda began her search for relief from her own post-surgical vaginal and pelvic adhesions. We have treated pelvic and vaginal adhesions in hundreds of complex patient cases since that time.

While we find it is best to treat post-surgical scars early (optimal is to start 8 to 12 weeks after surgery), that opportunity has generally long passed by the time a patient is referred to us. Perhaps this is for the best in children, since adults are better able to understand why we are touching their scars in intimate areas. Early surgical adhesion

patients tend to come for therapy from adolescence to adulthood. Parents of minor children are welcomed to inquire, and required to attend all therapy sessions with their child, in all of our clinics.

A therapist must understand the need to treat these delicate tissues in a "safe place," with the dignity and sensitivity each unique situation requires. While our work is physical, we also understand the psychological issues that can naturally accompany a lifetime of pain, dysfunction, or simply knowing that you are somehow different from everyone else. A physical therapist should always be available to consult and work with physicians or counselors before, during, or after therapy.

In therapy, we use our hands to slowly peel apart adhered tissues, working with respect for the patient's comfort and tolerance levels. Like meticulously breaking apart a nylon rope composed of hundreds of tiny strands, we work to detach the adhesions from structures that are causing pain, tightness, or dysfunction.

We have found that this manual focus on adhesions can open doors of mobility which have not existed in the body for years — or decades in most cases. Most post-surgical patients find that when we free them of adhesions that formed so many years ago, their bodies become mobile and pain-free in ways they have never before experienced. This paves the way for them to move on in their lives, no longer hindered by the powerful physical scars, pain, and dysfunction that have been their unwanted companions for a lifetime.