Genital Mutilations – Case Histories
Castellino Prenatal and Birth Training
T10 M5 Surgical Imprinting
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Circumcision is considered a minor elective surgery where the prepuce or foreskin of the penis is removed during the neonatal period. The circumcision rate in the US dropped from 85% in 1979 to 60% in the early 1990s (Koniak). In the early 1990s, circumcision was still one of the 3 most frequent surgeries along with cesarean section and episiotomy (Sakala). Note that all three of these surgeries are birth related. Recent obstetric and pediatric books (Williams, Behrman/Nelson) strongly advocate circumcision for hygienic reasons stating that circumcision decreases "risk" of urinary tract inflammations and infections as well as penile cancer. Many parents request circumcision because they want their sons to look like their fathers. However, *Maternity Nursing* (Koniak), discusses circumcision as a controversial practice, stating that opponents of circumcision argue that good hygienic practices prevents medical problems. Physical problems that can arise from circumcision are pain, hemorrhage and mutilation.

Finally however, on March 1, 1999 it was reported that a seven member panel of the American Academy of Pediatrics changed its long-standing policy from advocating circumcision to saying the medical benefits are insufficient to recommend circumcision. The panel also recommended pain relief be provided when circumcision is performed.

Circumcision is often carried out between 12 and 24 hours after the boys are born. The rational is to give them time to recover from the birth. For others, the operation may be postponed for a week or more. Prior to the 1960's, the mistaken belief was that the procedure should be carried out early because the older the babies got, the more they were likely to feel. Studies from the 1970's and 1980's indicated that the boys felt pain during the surgery. Most circumcisions are performed without local anesthesia. There seems to be confusion as to how much of a baby's crying results from being restrained and how much from the procedure itself. Pediatric and psychosocial studies from the late 1970's and 1980's looking at cortisol levels, crying and recovery periods tended to conclude (including Brazelton) that "normal healthy" babies recover well from the surgery and are very resilient. Dr. Wendy McCarty, a former OB and pediatric nurse, reports that babies sometimes fell asleep during the procedure. Dr. McCarty notes that in her experience in the late 1970s and 1980s no one understood that falling asleep is a symptom of withdrawal shock. She reports pediatricians making statements to parents like, "See, it didn't hurt. He fell asleep."

Common Circumcision Practices:
There are two common circumcision practices. Either way the baby has to be restrained. Many pediatricians have the baby placed on his back in a plastic restrainer, which spreads his legs and exposes his penis.

> When a Gomco clamp is used, the prepuce is first slit in the sagittal plane of the penis. A metal cup is placed over the glans penis. Pressure is applied for 3 to 5 minutes before excess foreskin is removed.

If a Plastibell is used, a plastic cup fits over the glans penis. Suture is tied around the rim of the bell. Excess prepuce is cut away. The bell is left until it falls off during healing.

When working with boys, part of my intake is inquiry about their circumcision history. Jewish boys are customarily circumcised in the context of a ritual. I have had several reports from parents or adult males over the years of iatrogenic circumcision mishaps where physical injury occurred, often requiring follow-up from hemorrhage. In one case, the Plastibell was positioned on the baby's glans in an asymmetrical manor. These parents were faced with the decision as to whether or not to have the angle surgically repaired. They elected to leave it alone. Many parents have reported to me that they were shocked and unprepared for the impact of having their boys circumcised, even with informed consent preparation.

Case one: six month old baby boy.
The first is about Mikey who was born with a congenital anomaly of his penis called hypospadias, an abnormal opening of the urethra on the ventral side of the shaft of the penis. I first met Mikey several years ago when he was six months old. Unlike the way I began working with Mikey, I would have preferred to take the history from the parent on the telephone prior to the visit. I normally provide educational preparation with the parents before seeing the baby. Ideally both parents should come to the sessions. The father's presence during therapy is essential, as you will see in Mikey's story.

Mikey's mother brought an older sibling for treatment. While I was working with the older child, the mother asked if I could look at her younger son because he has some cold and colic-type symptoms. Mikey's mom was unaware of the impact on Mikey of describing his birth and circumcision. She immediately began to tell me how wonderful Mikey's birth was. He was born at home. They had a relatively easy two-hour labor. She said that Mikey's first eight days were idyllic. While she spoke, I observed Mikey and noticed that he had little or no cranial molding. Then she reported that Mikey had hypospadias a congenital change in the formation of the underside of his penis. She began to tell me about the repair surgery for the hypospadias, which she referred to as circumcision. She reported that after they returned home from the surgery, Mikey began to bleed from the surgical site. His father had to take him back to the hospital.

I must admit I was taken unawares and Mikey's mother had no awareness of the effect her comments were having on Mickey. I immediately asked mom to wait before telling me any more. I told Mikey that his mother was telling me about the surgery he had on his penis. I did not want Mikey to hear the story in a dissociated state. As his mother continued to tell the story, I attended to him directly. She then said, "I could still almost cry. It was horrible." Mikey immediately began to express feelings that appeared to be rage, terror and betrayal. While I tracked Mikey, he made frequent eye contact with me. At one point, his mother reported that the feelings he was expressing were the same as when he was having a bout of colic. She said the colic began five

days after the surgery. During this session I made no physical contact with Mikey. I tracked him, maintained empathic connection with him and paced the session so that Mikey could begin to get the sense that he had some control over what was happening in the session. At the end of the session, I suggested that the father come the next time.

Mikey's father came to the next two sessions. Dad told his part of the story. He reported that he had to take charge and get Mikey to the hospital. There was no time for him to be soft or even stay with his own feelings about what was happening. Dad regretted the whole episode and reported that he had felt helpless. As dad shared his part of the story, I asked him to stop and tell the story at a pace so that Mikey could let us, especially his dad, know how he felt. Mikey expressed more tears, rage and betrayal. While dad held his son and told his story, I tracked Mikey and worked with his energy. Within a few moments, Mikey gave me a look that could kill, a dagger look. He expressed his rage full on. It became clear that I had become the transference object of the pediatrician performing the surgery for Mikey. I coached the dad to take Mikey and protect him from the pediatrician. We did several rounds where I would approach and dad would take Mikey away to protect him. Each time Mikey was able to express to his dad more feelings with his crying and voice. Even though the feelings expressed were very intense, Dad and Mikey kept clear visual, auditory and kinesthetic contact.

Mikey's dad came for one more visit. At the end of that visit, Mikey was no longer responding to me as if I was the pediatrician. He had calmed down and the energy of the surgery was completely gone.

In 1998, when Mikey was more than 5 years old, I talked with his mom. She reported that he was doing very well. He is a strong independent child. She and Mikey's father observed no residual psychological effects from the surgery.

Case two: middle-aged man.
The following story is about John. You will see how John's life has been profoundly influence by a circumcision mishap. At the time of our sessions, John was a 44 year old professional.

He has a brilliant intellect, and has been working very diligently over the past years to open more to his emotional experience and learn how to have what he called "connection" in his intimate and primary relationships. He has two children. In his first marriage, he felt suffocated and for the past several years has felt as if he were dying. He says women who are overweight repulse him. He says that he married out of duty. He never knew that he could consider his own needs and wants. He states that the only thing he has in common with his wife is their children. He wants a divorce. He reports that he did not become sexually active until his mid-twenties when he married. For all the years of his marriage he has been plagued by premature and painful ejaculation with an extremely sensitive glans penis. He attributes this sensitivity to a violent circumcision, which he had remembered in a previous session.

During that session he recalled that the end of his glans penis was cut when his foreskin was removed. He remembered the anguish, terror and physical pain he experienced when, several hours after the operation, he was still bleeding. He said he thought he was going to die. He has confirmed the difficult and "bloody" circumcision in talks he has had with his mother.

As we began the session, he asked that we review with the baby doll and pelvis model the birth stages. He asked what we know about how the prenatal life during the pregnancy influences the birth process. I told him that the birth process is a compressive physical, emotional, somatic experience, which fully recapitulates the preconception, conception through discovery and the three trimesters of pregnancy. The birth, by virtue of its somatic recapitulative nature, locks into structure any trauma unresolved from prenatal life.

Then we just looked at the birth stages. As I put the doll through the pelvic model, he said, "You know? I'm beginning to drop in," meaning he was beginning to regress. I determined his lie side by looking at the lie side visual protocols. He immediately began to feel his body "take over" as his head turned into his right lie side birth pattern. It felt "right" to him. We explored his birth schema in the stages and the conjunct pathways slowly with attention to short incremental movements. He verbally described his felt experience as he proceeded.

With his permission, I put my hand 16 inches above his head, over his right parietal area. He is a right-sided lie pattern inlet pattern conjunct trauma site. He immediately picked up the pattern in his body somatically and started to move further into his birth process with awareness of his movement patterns, physical sensation and emotional feelings. I followed the pattern with my attention and hand still 16 inches from his head. As he moved toward the end of the inlet dynamics, physically feeling the memory of the compressive forces that he experienced in his mother's womb, without my prompting, he moved his hand down the inlet conjunct pathway to the area of his right sphenoid great wing. He said, "I get this far and everything goes away, gets faster, I don't know where I am."

I observed his cranium move into an exaggerated side-bending rotation.

His right hand moved to the upper neck and right occiput, his left hand and arm contracted and folded in with the joints of the wrist and elbow flexed, the shoulder internally rotated. His head simultaneously turned to the right and extended at the neck. His knees pulled up into his chest. His breathing became labored. He began to cough and wheeze. His face scrunched up, contracted. He made grunting sounds as he extended his legs pushing. "I don't want to go! I don't want to go! This is disgusting. Mom is disgusting!" His whole body remembered. His head moved as it did when he emerged from the birth canal. He said, "Fat, this is disgusting!" He began to ‘surface’ from the regression. Only 10 to 15 minutes have passed since we began. Again he said, "Fat! When I was fourteen, my father said to me one day, ‘We like our women, fat.’ Nobody told me. I remember when I was 4 or 5 years old looking at women in

the Sears Roebuck Catalog and deciding that I was going to marry a slender blond woman. I knew what she would look like."

I say, "Mind/body split."

He paused and droped back into his birth experience. Stage four, head out, compression on body. Labored breathing, coughing. As he pushed with his legs, extending and twisting his body, his left hand reached down and clutched the left side of his groin and left testicle. With agonizing pain on his face, he says, "Not this again! I thought I had worked this through." Later, during debriefing, he told me that he was remembering his circumcision. In a previous regression he had learned that his circumcision was very bloody and painful. He had no warning. He thought they were cutting his penis off. "Why? Why? I am bleeding to death!" Terror. This time he told me that he saw them making the incision and circumscribing the foreskin over his glans penis. Anger! Then Rage. His hands clutched his genitals. Then he said, "Wait, I want to go back further. Can I go back further?"

"Yes," I answer, "go back. You can go back."

"I am going back into the womb." He made fish-like motions with his mouth and tongue.

I said, "Prenates swallow amnion and breath amnion."

He said, "Earlier. I need some help. I need some prompting."

"How far back do you want to go?"

"Before." he says, "I can barely talk."

"Go back before."

He again clutched his left groin and testicle, then pointed his fingers down into the testicle. Wiggling toward his feet, he said, “I can't get out. I don't know." He screamed, straightened his body out and continued making fish-like motions. He began to push his forehead into a pad against the wall. He wiggled and pushed as if to push through the pad. He screamed, curled his whole body into a ball, laid on his side and rested. Just about one hour has passed since we started this session.

John's case will get further explanation in the book. Look at the next paragraph and see if you can see how the following components were exemplified by John's story.

- Coex matrix: implantation, stage II, circumcision.
- Emotional association or coupling of early experience with present experience. Recapitulation of beliefs: mother's "fat," with repulsion from wife after she gained weight. Future therapeutic work needs to work on uncoupling the associated material.

- The association of the terror of a mismanaged circumcision with life-long sexual dysfunction.
- Treatment principles and strategies: Use of visual cue: doll and model of pelvis. Verbal interaction. Tracking autonomic, somatic and emotional cues. Pacing and slowing the movement pattern so John could stay cognizant with the process and not dissociate into shock imprinted consciousness.

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