# Severe Scoliosis Client: A case study

Patti Selleck, Shonnie Carson, and Sharon Hancoff

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This client is a twenty-four year old male referred to Patti Selleck by the client's chiropractor. The chiropractor was using the Toftness Chiropractic Technique[1] and had come to an impasse. The chiropractor had concern for the client, as she was unable to help him with his issues of chronic pain. Additionally, the chiropractor felt he was lethargic, depressed, and had no hope or direction for his life.

Patti and the client used the first session to determine if Rolfing® Structural Integration would be a fit for him. In hindsight, a regrettable result is that pre-Session One photos were not taken. The client proved to be very willing and receptive to the work, and easily engaged in direction and change.

**Brief history**

The client's parents separated early in his life; since a very young age he lived between his mother and his father (a former Viet Nam vet challenged with PTSD) finally moving in with his father at age fourteen.

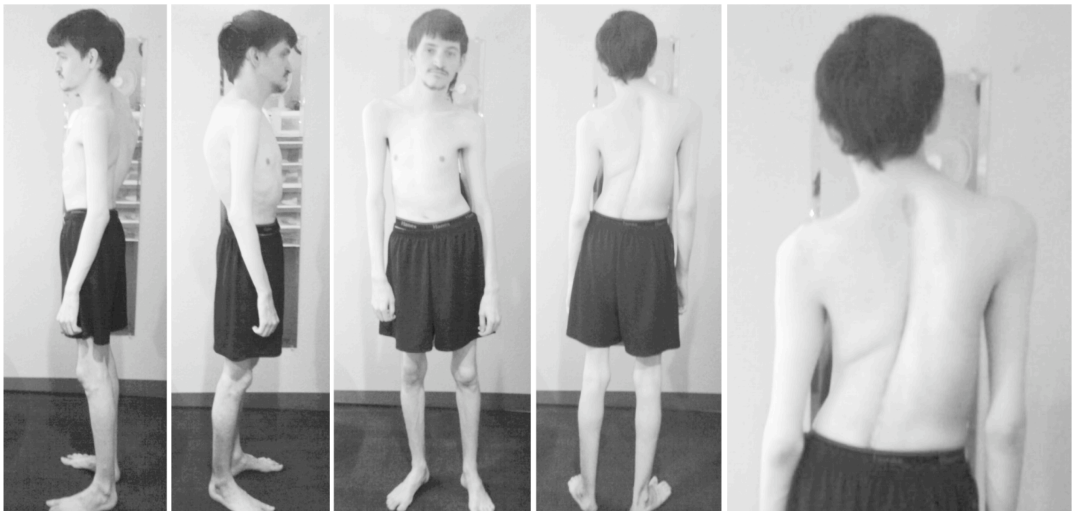
According to his aunt, he was a 'failure to thrive' infant with many health challenges and multiple hospitalizations for nutritional issues. She states, he "had a hole in his heart" that was repaired in early childhood, around pre-school age. There are no surgical scars on the anterior chest so we are uncertain how this procedure was performed.

The scoliosis appeared around the time that he first started school. He was thought to be developmentally delayed and didn't speak until after age three, when he had tubes put in his ears due to recurrent ear infections. At age five or six, he worked with a speech therapist to improve severe learning disabilities and was given an ADHD diagnosis. There was a concern about him perhaps being mentally retarded, but that was dispelled after it was apparent that his speech delay and learning difficulties were related to his hearing difficulties

**Pre-Session One, physical description**

The client was barely able to hold up his head, which was carried to the left with the chin rotated to the left clavicle and head almost resting on his left shoulder. He has left side-bend and rotation of the spine. The client reported several surgical interventions.

The first, at age sixteen, was the installation of a Harrington rod on the right side of his spine in an attempt to alleviate cardiac and pulmonary



***Pre-Session Two, June 14, 2010***

compression and other complications secondary to severe distortions in his ribcage.

The Harrington rod procedure was developed by Paul Harrington M.D. in 1953.[1] This is a very brief description of this procedure:

"The Harrington implant (or Harrington rod) is a stainless steel surgical device. Historically, this rod was implanted along the spinal column to treat, among other conditions, a lateral or coronal-plane curvature of the spine, or scoliosis. Up to one million people had Harrington rods implanted for scoliosis between the early 1960s and the late 1990s. The Harrington rod eventually became obsolete as newer, more effective types of spinal instrumentation were developed." [2,3,4]

We have provided additional links to further information on surgical treatment of scoliosis.[4] One link provides an interesting report on the results obtained in two adolescent patients with very good radiographic photos.[5]

If the reader takes the time to do some research on current treatment offered to people with scoliosis, it becomes obvious that there is a need for a formal research study on the effects of Structural Integration in correction of scoliosis. The majority of treatment approaches, for anything other than mild scoliosis, are surgical and generally involve only bony correction without consideration of the relationship of the muscular/soft tissue component in the deformation of the spine.

Certainly this is not a formal research study, but we do want to offer this case study as a starting point to hopefully trigger more interest in this subject.

According to medical records from 2000, previous to the 1st Harrington rod surgery, this client's standing scoliosis measured 54 degrees, causing cardiac compression. His voice was weak because of his lack of adequate breath capacity. The client stated that his doctors told him that his lung capacity was about 30 percent of what it should be. He complained of chronic pain in the right shoulder and left hip pain deep into the bone.

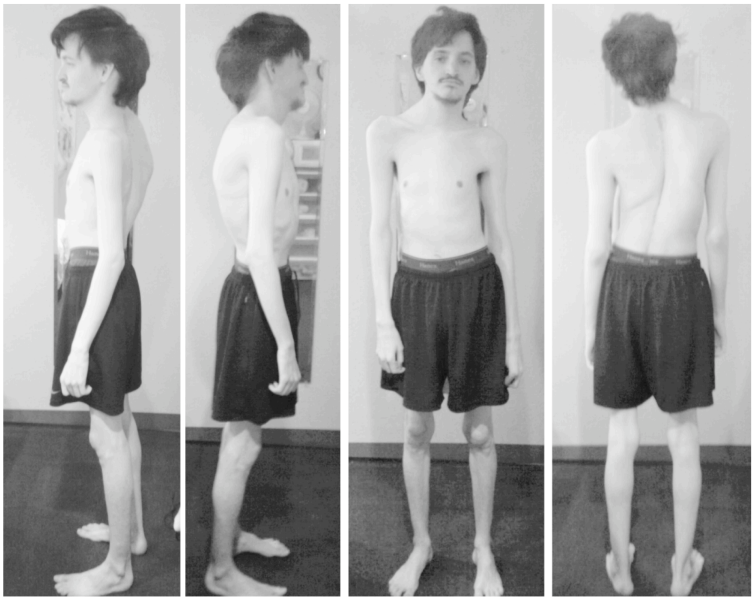
During the first Harrington rod surgery a bone graft was taken from the left posterior iliac crest. This continues to be an area where he experiences pain. He experiences chronic pain along his spine and neck, particularly on the right. This client is hyper-flexible in most joints. His joints are not hyper-mobile, yet he folds himself` in ways we have never seen anyone able to bend.

Evidently, during this surgery, the client was placed in a prone position with his head rotated to the left and the right arm/humerus positioned above the head. An incision was made along the medial border of the right scapula and apparently the scapular muscular attachments were separated so that the scapula could be rotated superior and laterally to open the surgical field. All of this surgically disturbed anatomy was likely re-sutured together in this

position (arm above head and scapula laterally rotated) after the placement of the rod. We were unable to obtain post surgical reports.

The client states he broke the first rod at age seventeen. According to his aunt, who has provided additional history, there were places where the rod didn't fuse. The client continued to complain to his doctors about the pain. After several years, there was a second Harrington rod procedure performed. The first Harrington rod was left in place and the second rod was placed next to it.

Postoperatively following the second surgery, stitches along the top of the incision might have torn out and the area become infected, because along the length of the entire incision, to the right of the spine, there is widening of the surgical scar, thickening, and granulation. Patti has done quite a bit of work on the scar tissue from the very first session to soften and elongate the fibers and create a more homogenous scar.



*Pre-Session Six, August 10, 2010*

**Two-handed work, Sessions One to Four**

Patti did the first four sessions solo and these are her comments:

"The preliminary session was a modified Session One, as mentioned earlier, to evaluate if the work would be appropriate . This first session made significant changes. When he arrived he was barely able to hold up his head and it was very difficult to hear him speak because of diminished breath capacity. I had to ask him to repeat his responses, as he had no vocal volume. His thought processes and reaction times were slow. On numerous occasions he would comment about memory issues. At the end of the first session he was able to hold his head more vertical, his skin color had improved from pale to pink. He expressed a sense of hope that there might be a positive purpose for what he had previously viewed as a useless body, which had only been a source of pain. I saw that he could become a great science project for his Rolfers. His chiropractor was able to see great physical improvement and was amazed at his energy and attitude shift.

I have taken care during the sessions to empower him to recognize how special he is. He is a delight to work with, and there is an emerging sense of humor and evidence of a very bright mind.

By the time I got through the last solo session, I realized that he was like a coiled wire. I would touch one place and then have to chase the other end. I didn't have enough hands. With each session, as he was trying to integrate, he would have interesting visual occurrences. He would see predominantly out of one eye or perhaps see multiples of me. His airway would sometimes feel narrow, diminishing breath. The deeper the layers we unearthed, the more it became clear to me that he definitely needed four hands working on him."

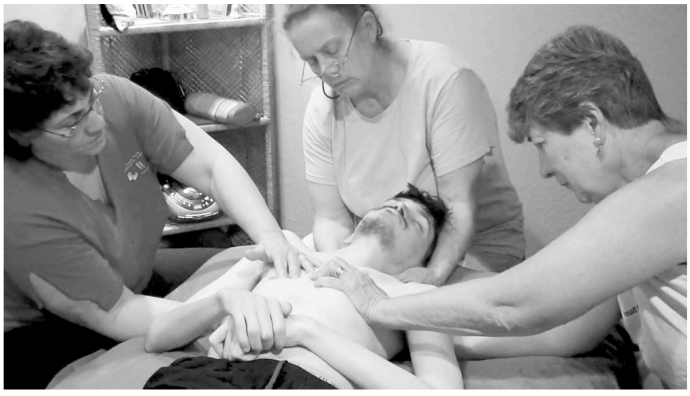
**Four-handed work, Sessions Five to Seven**

I invited Shonnie Carson to join me in working with this client. Together we did Rolfing Sessions Five though Seven. We were able to use four handed work to stabilize torsions and various distorted patterns in his structure. At one point, as we had hands on either side of his spine, he commented that he had waited his

whole life for that kind of relief. Shonnie and I did some rather creatively designed work with him. At times we would be working opposite sides of his spine/ribcage and feeding into each other's hands or one of us on the top and other on the bottom of the torso, etc. His body had made so many accommodations for the various distortions that it was like working with a multidimensional living canvas. As we approached Session Eight, we both felt strongly it would be very beneficial to have Sharon Hancoff work with us. Sharon has developed an amazing body of work, both with scar tissue and changing bones. We invited Sharon to fly down from Washington and join us for three sessions of six-handed work. These three sessions were done over the course of four days.

**Six-handed work, Sessions Eight to Ten**

Prior to the sessions with Sharon, the client had a set of spine x-rays taken so we could see where the hardware was and the magnitude of what we would be working with. Because of her medical background, Shonnie was able to provide translations and explanations for the medical treatments and the spinal x-rays, in addition to adding her hands to the Rolfing work. We took photos of the x-rays, but unfortunately the x-rays were dark and the photos are so unreadable that we decided not to include them.



***Shown left-right: Patti, Sharon, Shonnie***

Sharon observed that from a side view, this young man's anterior to posterior mid-chest space was severely narrowed. His right rib cage had a sharp angular border as though folded throughout the axial posterior ribcage (vertically) with extreme distortion through the A-P axis. The right upper ribs and scapula were elevated and rotated forward and the right posterior ribcage angled upward causing an awkward thickness through the A-P dimension. Every time he moved his right arm to bring his right scapula backward there was a grating of tissues that sounded like crushing glass.

Sharon's work focused on changing bony relationships to ease the connective tissue adaptations that have developed in his body. With her amazing sensitivity to detail we were able to resolve/normalize most of them.

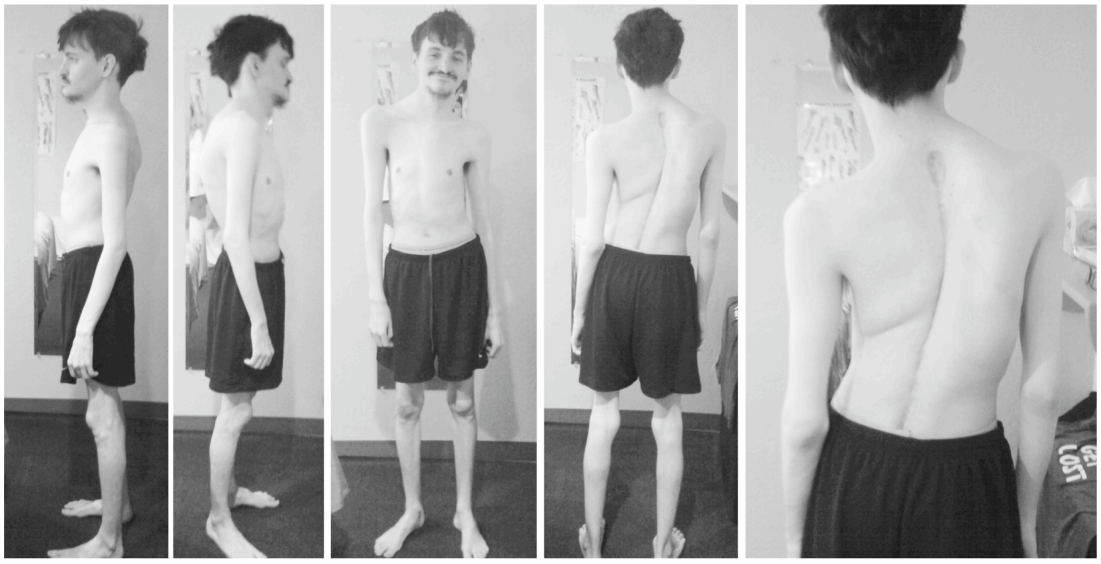
In Session Eight, the first of the three six-handed sessions, our work focused on his neck, shoulders, and ribs and on inviting the sacrum to accommodate the changes without opening the proverbial Pandora's Box before the next session. Some of the distortions were:

The left side of his ribcage is unusually narrow in the A-P axis with a severe vertical axial rotation to the left, which expresses roto-scoliosis throughout the length of the spinal column. This gives the left rib cage the appearance of being significantly behind (posterior of) the right ribs. From a front view the right anterior chest is diminished in width and severely rotated left while the left side appears too wide and is posterior of the structure center. The left clavicle is more horizontal with the left humerus hanging lower and posteriorly. His midline is drawn significantly left of center and a torsion can be seen through the abdominal viscera.

The right transverse process of T2 was caught under the inside of the right first and second ribs.

The right first rib is pulled caudal in front and cranial in back. The right ribs were twisted and highly angled. The right clavicle was driven deep at the medial (sternal) head and rotated posterior and elevated on the distal (humeral) end. The right scapula was adhered to the ribs.

The right humeral head was rotated posterior and elevated and driven medially. Many of the right ribs were caught at the transverse processes and angled almost vertically, with an inability to lift up with movement or breathing.



*Post-Session Ten, September 21, 2010*

The left scapula was also adhered to the ribs, with ribs T10-12 rotated and compressed together.

In Session Nine, the second of our three six-handed sessions, our work focused on the head, face, mouth, anterior neck, and down the spine that revealed mirrored pelvic accommodations. Some of the distortions addressed in this session were:

The occiput was displaced to the right and rotated to the left. C5 was rotated to accommodate the pattern. The atlas was rotated right with the odontoid process tipped to the right.

There were numerous distortions throughout the cranium and facial bones. Among them, the bilateral zygomatic arches were compressed medially and depressed inward and down. The right eye socket was higher and more mid-line. The frontalis was narrowed. The sphenoid was tilted downward and compressed.

During the work on the neck and head, we discovered the posterior trachea was adhered to the cervical vertebrae. Releasing that adhesion allowed the "tubes" to move more freely and the head and neck began to assume a more normalized medial alignment.

During Session Ten, the third of this series, we did significant work with lumbar, pelvic, and leg distortions. Some of these distortions worked on were:

Anterior and posterior sacral and iliac distortions, with specific attention to the bone graft site. Internal organs were caught up in the interior edge of the iliac crest and anterior sacrum. Freeing the internal organs helped to increase movement and more medial alignment of the pelvis and lumbars.

There was an up-slip of the left ilium relative to the sacrum with the L5 transverse process migrated downward and stuck inside the ilium. The left ilium was compressed medially at the bottom and flared laterally at the top. The right ilium was tilted anteriorly.

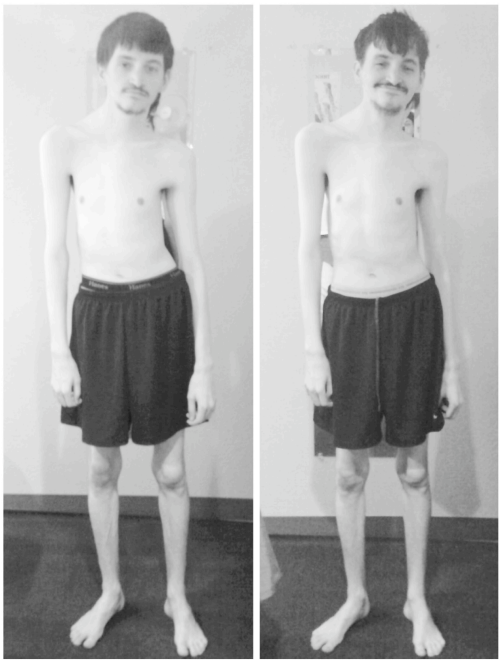
The left ramus and ilium were compressed together and there was an increased bend at the cornu of the sacrum. The left ilium was twisted at the symphysis pubis and bilaterally the ilia were compressed and "stuck" at the symphysis.

The left femoral head was rotated medially and compressed up into the hip socket and was displaced medially at the knee.

**Changes following Session Ten**

Immediately following Session Ten, Sharon observed the tissues becoming less gristle-like. He now has to work at making this grating happen where before it was a regular occurrence.

Subsequently, more changes have been documented. The client is accommodating weight-bearing through his structure with more ease and an increased sense of a "midline". His head carriage is more vertical, more centered, and the clavicles are closer to level.



*June 14, 2010 & September 21, 2010*

He still has pain in the left hip at the SI joint, where the bone graft was taken. This varies with activity. He appears to organize himself around that spot. His right shoulder and neck pain are significantly lessened. He still gets some headaches. He has had extensive dental work since the first ten Rolfing sessions involving hours in the dental chair, which are most likely contributing to the headaches.

Patti has observed that he has a tendency, following a session, to stretch or "pop" things in such a way that ultimately returns his pain. He has poor eating and sleeping habits. Having an awareness of his poor eating habits and probable nutritional deficiency, she suspects that his pain level is contributed to by those factors. Patti is addressing that by encouraging/educating him to better health habits in the overall picture.

He has agreed to continue his Rolfing sessions.

The six-handed sessions with Patti, Sharon, and Shonnie have been fascinating to participate in and we have filmed them. These sessions are on DVD and show approximately seven hours of very detailed work. Copies of these DVDs can be obtained by contacting Patti Selleck.[7]

We will offer our comment that viewing these DVDs clearly demonstrates Structural Integration as being separate and very different from massage work.

This client's unusual structure has been a gift to all three of us, to work with and to learn from, and we appreciate his willingness to allow us to share this experience with the larger SI community in this article.

"When all is said and done, pictures *are* worth a thousand words!"

**References**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