

## Working with Radiation Fibrosis and Droop Neck Syndromes

Ritchie Mintz



Ritchie graduated with a B.A. in 1969 and moved to Boulder in 1971 to work at the local music store. One day, structural integration teacher Peter Melchior dropped by the shop. That chance meeting led Ritchie to a lifelong study of the human body, its mysteries, and its magic. Ritchie trained at the Rolf Institute® in 1978 and did his advanced training in 1981. Ritchie is celebrating his 40th year as a Rolfer™, and is the author of two books on structural integration: *Foundations of Structural Integration* and *From Adam & Eve to Ida Rolf – What is the Random Body?* He now makes his home in Austin, Texas.

### Abstract

*Radiation fibrosis and droop neck syndrome are conditions whose treatment are within the scope of practice of structural integrators. Case studies and common symptoms of these conditions are discussed, along with relevant treatment strategies. This article is an abridged transcript of Ritchie Mintz's presentation "Radiation Fibrosis and Droop Neck Syndrome" at the IASI Symposium on April 28, 2018, in Vancouver, WA.*

Way back in the 20th century, I had this woman I was working on. From the very first moment I touched her, I knew that she was different from everybody else I'd ever touched. I asked her if there was anything, like any accidents or injuries that had happened to her, that could've changed her tissues. Except for the usual fender-benders and falling off her roller skates as a kid, "No, nothing." This went on session after session, and in each session I would ask, "Are you sure that you never had some kind of wreck, or something that happened to you that might have changed your tissues?" And the answer was still, "No."

This went on week after week, until the ninth hour when—about halfway through—I stopped again. I took a breath and said, "Search back through the feelings of my input on your body. Are you sure that you've never had any kind of wreck, or a fall, or an accident, or something that might have changed you in some way?" I could see that she was leafing through the Rolodex of her life, and all of a sudden her eyes lit up. She said, "Well, I was hit by lightning when I was 19. Is that what you mean?" [Oohs and ahs from the audience.]

Then, we just looked at each other. After a long

silence, I said, "Well, bless your heart. You didn't think that was worth mentioning to your Rolfer?"

And she said, "I just remembered. It happened so long ago, I never thought about it again."

Then the story came out. She was a counselor at a camp. There was a thunderstorm during the day, and she went running back to the bunk to secure the tent flaps so that the beds wouldn't get wet. The tent flap was tied to a nail in a tree, and just as she touched the nail, the tree got split in two by a bolt of lightning. She was badly burned, and they took her to the hospital. She stayed there a day, was released, and that was probably the last she ever thought of it.

When she told me that she had been hit by lightning, all of a sudden the whole thing made sense to me. This was a very different kind of injury. This was not an injury that came from the outside and progresses through the body. In this case, every atom, every cell in her body was instantly lit up by millions of volts. Here we are, all structural integrators—we know a little bit about fascia, so think of what that does. It turns out that the body's interstitial fluids are ionic by virtue of their salt content. That is a perfect medium to distribute all of that power everywhere to every cell in her body instantly, and that's what

happened. Fast-forward, and then here I was years later feeling that every layer, every fiber of tissue in her body, was burned and boiled together, that the fluid within it had been vaporized, and then the whole thing was stuck together in a way that was different from everybody I'd ever worked on, and probably different from everybody you've worked on.

In the normal course of the ten series, you work your way through, and usually you get to a point where things just start to let go. You've untied enough knots, and then you get to a point where the deep layers and things that are really stuck deep, they just go: "Okay, I get it," and they give it up and let go. Not here! To make matters worse, she was hypersensitive and hypervigilant. Every touch elicited a pain response. Here I am, trying to work my way in according to the ten-session recipe. By the way, Ida Rolf was very insistent that, as Rolfers, we work from the outside in. Here I was trying to do that, and everything I inputted got bounced back at me. Here I was, nine-and-a-half sessions in, when all of this came up.

The first thing I did was completely abandon my original plan of getting her to where I could get everybody else in ten hours, and I developed this different way of working that I will get to in a few minutes. What I took away from this is that getting hit by lightning is very rare. Anybody here worked on somebody who's been hit by lightning? You may never. And, you know I never had such a client again until long years after when it all came roaring back in another form.

That was when I met Miss Gloria Gene. Gloria is my wife and, in a very similar way, the first time I worked on her, I said, "Well, this feels really different." By the way, I have Gloria's permission to talk about her medical history. She told me that she is a three-time cancer survivor. The first one was Hodgkin's lymphoma, and the cure was to irradiate her like the core of Chernobyl. I started putting this all together. I hadn't felt anything like this since... Oh, my God, it's the lightning lady all over again!

What I realized was that radiation is very similar to a lightning strike. It lights up the body in ways that a normal injury doesn't. It doesn't act like it comes from the outside, even though it's a beam. It penetrates right through and it goes through everything, with no distinction between diseased tissues, healthy tissues, muscles, organs, or fluids.

Once again, like a lightning burn, we have layers of tissue that are burned and boiled together in ways that make for a very daunting ten series.

## Radiation Fibrosis Syndrome

Radiation fibrosis is not an exception to anything that we know or do as structural integrators. All the tools that you bring to any other client would apply. Radiation fibrosis is not an exception to the rule – it's an exaggeration; it's a super-exaggeration of what it means to be a random body. In random bodies, one of the qualities is that the tissues are stuck together. If you have two layers that fit together like this, if one of them wants to go a certain way, it can, but only as much as the other layer will let it. What you have is a body that is welded, boiled, and burned from stem to stern and from port to starboard, in all directions—left to right, front to back, top to bottom, inside to outside—and at all the levels—local, regional, global, and universal. Here's a body that is stuck together everywhere, from head to toe, in all the directions and at all the levels. When you get that, plus the hypervigilance and the hypersensitivity, it makes for a daunting long-term project.

The main scientist in the field is Stubblefield (2011; 2017). The research says any tissue within the radiation field can be affected – nerves, muscles, blood vessels, bones, organs, the whole nine yards. That is another exaggeration of the random pattern, because in your average random body, not every fiber of tissue is as stuck as other fibers. You have your strategic places where you work that loosen things far away, but with radiation burns there's no distinction between lungs, heart, organs, vessels, fascia, fluids. Whatever's in the way of those proton beams gets affected, so that's another factor making radiation fibrosis a daunting long-term project.

Here's an interesting conflict. Gloria's doctor is one of the top oncologists in the world. Gloria was telling him about her knees hurting and he said, "That couldn't be affected by the radiation, because it wasn't in the field." Yet, there's a whole other body of knowledge that says that it doesn't have to be within the radiation; once something is fixated, it can fixate something else far away. Does that sound familiar to a structural integrator? That's another example of how radiation fibrosis is not an exception to our rules and principles—it's an exaggeration of them.

### ***Radiation fibrosis affects fascia***

Stubblefield says it's impossible to cover all the potential complications of radiation fibrosis, because every organ system in the body is burned including the spinal cord, nerve roots, and plexi. Then it gets into an interesting little sidelight [quoting slide]: "Common manifestations of radiation treatment in Hodgkin's lymphoma survivors include weakness of the neck extensors, aka: dropped head syndrome." I'm pretty sure that the reason why Stubblefield and the other researchers mentioned physical therapy is because they don't really know we [SI] exist, and they have no idea what we're capable of. Radiation fibrosis is a fascia issue. That puts it square on our tables.

There are chemical and histological changes that occur in these irradiated tissues, so certain elements are removed from the body. Then other things are secreted by the body. There's a change in body chemistry, so the medical approach to all of this is to take away what shouldn't be there and introduce what should be there. There's this chemical dance they're trying to do on this radiation fibrosis, but the point is—and this is what's really important—no matter what causes radiation fibrosis, no matter what histological changes, chemical changes, or cellular changes happen in the body, the end of the line is the fascia. That's what puts it on our tables. Regardless of how it started, the end result is that you've got these layers that have lost their volume. What are you going to do with them?

Nobody in the therapeutic touch world has the goods like we do. The point is that this is on our table, and there is a tidal wave of work out there that we can take on. I do believe that if we can step up to this, it would put us on the map.

### ***Volume***

With radiation fibrosis, you'll notice a loss of volume [in the body]. Where did that volume go? A lot of it was water. When I say water, I don't mean water per se—I mean the body's interstitial fluids. I theorize that the loss of volume coincides with the sticking together in these layers. The water is lost, and the layers stick together. Normally, you could have perhaps hundreds, thousands, or tens of thousands of micro-layers that should be resilient, moist, and fluid, until you jam and stick them all together.

What we're looking at [referring to slide] is a loss

of volume, and that's why this spine, spinal cord, the whole thing, is getting squeezed. You can imagine the stress that puts on the entire nervous system. Notice how the sleeve is choking off the core. Where's the volume? Where's the lift? What's happening here is the exaggeration of everything we know to be the random pattern. The clavicles are rotated down. Each rib is rotated down. That's the other side of this ultra-kyphosed back: each one of these ribs has rotated downward. It doesn't have to be symmetrical—it could be that one side is more rotated downward than the other, but each one of these ribs is turned downward in its long axis. That contributes to the droop neck.

### ***Droop neck syndrome***

What's important to know about droop neck syndrome is that it is not just the neck. You can see [referring to slide] that there is a kyphotic curve that starts all the way down [the spine]. That's why you're not going to get a droop neck back and up by working on the neck alone. It's the entire rib cage, not just the upper spine. It's held in this extreme random pattern by all of this fibrosis and fixation. It starts—well, it starts in the feet, as we know—way down here in the thoracics. The whole idea is to turn these thoracic vertebral bodies back so each lifts the vertebra above, instead of drooping forward.

Nothing about radiation fibrosis violates any of our theories, rules, or practices, but it takes it far to the extreme of what it means to be a random body.

## **Reversing the Effects of Radiation Fibrosis**

### ***Shaving the balloon***

Stubblefield says reversing radiation fibrosis is virtually impossible, but is it? My experience with the lightning lady and many radiation fibrosis clients told me that there really was only one strategy: to peel the onion in tolerable increments. I developed the technique that I called "shaving the balloon." Shaving the balloon is delicate and tricky business. You want to get that close shave, but if you go too far, you pop the balloon. Popping the balloon, in this case, means eliciting any pain response—even a twitch. I developed this way of working that peeled layers in order, from the surface.

### **Outside-in and inside-out**

Dr. Rolf was pretty insistent that, as Rolfers, we work from the outside-in. I thought about that long and hard, and it turns out that there are other modalities of bodywork that worked from the inside-out. Chiropractic comes to mind, and we all know about Dr. John Upledger. Upledger worked in fibrocartilage, the body's deepest tissues, like cranial sutures and spinal disks. He had a way; if he could get his hands on any wisp of fibrocartilage, he could work from the very inside of the body, outward. This is exactly the opposite of what I was taught in training. There are probably many reasons why Dr. Rolf developed this way of working and why she taught it to us. One reason for this is that a new practitioner, who hasn't developed a feel for tissue, should be working from the outside-in for safety reasons. Another reason is because she knew that she would not be here to oversee the application of her invention, so she wanted to give us a safe way to do it. I worked that way without question for my first 15 years; then I took some Upledger workshops and started thinking about how he was able to work from the inside-out. I started thinking about outside-in and inside-out. What a dilemma! How to pick? It turns out that I didn't have to choose one way over the other, because I developed a way of doing exactly both at the same time.

I found that I was able to access the interosseous membrane, for example, which is what we're doing in a second hour. A second hour is supposed to be superficial work because it's in the first three sleeve sessions, but if you can get just the slightest bit of movement between the tibia and the fibula, you would have affected the interosseous membrane – that's working from the inside-out. It happens in the routine course of any any structural integrator's sessions, whether they're thinking inside or outside, or not. But by doing it deliberately instead of inadvertently, I found that I was able to access these deep layers in the early sessions, as early as the opening moments of a first hour.

If you are working simultaneously from the outside-in and inside-out, it implies that there will come a time when the two directions will meet and cross. That's the "magic moment!" I'd heard about the magic moment in my training; nobody ever made a big deal about it, but I latched on to it and

couldn't let it go. The idea is that you're working from two directions at once, and that when those two directions meet and cross something amazing happens: The sleeve of the body lets go of the core, and the front of the body lets go of the back. When you get that, that's like eight of the proverbial nine yards. We want to get the front to let go of the back, and in radiation fibrosis repair, we certainly want to get the sleeve released from the core.

Let's look at the relationship of sternum to spine. When that relationship is fixated, it can't change, and – again – wherever one moves, the other has to follow. What it can't do is lift in the front. But when the front does let go of the back, the sternum can lift, the spine can drop, and "the line" emerges. This happens routinely in the course of any series, but when I started doing it deliberately, instead of just kind of accepting it as a side effect, I found that I was actually able to control when the magic moment happens.

For the most part, magic moments happen for me in the fifth hour. In my first book, *Foundations of Structural Integration*, on page 92, I have a chapter called "The Magic Moment – How I Get the Recipe to Work for Me." That chapter is my love song to the fifth hour. Throughout my career, every one of the sessions has been my favorite for a time, but I have a special affection for the fifth hour because, for me, that's where it all turns around. If the magic moment happens in that fifth hour, it means that everything up to number five was in preparation for number five, and everything after number five is in support of what happened in number five. When the front lets go of the back and the sleeve lets go over the core, that's what gives the body the plasticity that allows us to sculpt in the line in eight, nine, and ten.

I started thinking about that in relation to people burned through by radiation. I thought that if you're going to peel your way through only from the outside, it could take forever for cases like this. Working simultaneously from the outside-in and from the inside-out, if you can do it, is a good idea – it will accelerate the process, because it allows you to work from both directions at once.

### **Tissue loading**

After shaving the balloon and simultaneously working outside-in and inside-out, I have a third

way I address bodies that are burned through: it's a technique that I call "tissue loading." Tissue loading comes later, because a body isn't ready for this until you have decompressed it enough to relieve the pressures that make it hypersensitive and hypervigilant. Once you reach that point, then you can start tissue loading.

What tissue loading means to me is that I find tissue that has any degree of looseness at all that's not stuck down, and I load that against any local, handy, bony margin. When I do that at just the right pressure and angle of incidence, an amazing thing happens. It penetrates. It "feeds through" from sleeve to core. This is another idea that I haven't really heard much about.

Irradiated tissues lose their volume. That's what causes the sleeve to choke off the core. The question is: Where does that volume go, and how do you bring it back? Enter tissue loading and feeding-through. I load the tissues against a bone, and I feed length and volume into the periosteum of that bone. That distributes it everywhere. I don't know if you can get a feel for what it is to feed through, but when I feel it, I know it. I put bodies together by feeding from sleeve to core, which means I am translating bulk in the sleeve into volume for the core. That's how I restore the lost internal volume.

One of the things I've noticed about Rolfed bodies is that they get bigger. Not only do they get taller because the spine lengthens, but they get bigger overall. In other words, if you took a random body, dunked it in water, and caught all the water and measured it, then did the same for that body after it had been Rolfed, the Rolfed body would displace more water. That happens by feeding from sleeve to core. I'm also feeding from front to back. I'm also feeding into all the directions: left-right, front-back, top-bottom, and inside-outside, but what I'm mostly concerned with, especially in radiation cases, is the relationship between sleeve and core. I translate the bulk from the sleeve into length and volume for the core so that the whole body can expand.

Here I am feeding from sleeve to core, but the question is: feeding what? Nobody ever told me. I never heard of it in my training. I never read of it in any book. I'd never heard about it so I had to make up my own name for it. I call it: "IT" (Mintz, 2012).

IT. That's an interesting word, because one of

the ways that I shave the balloon is by working IT at carefully-chosen oblique and shearing angles of incidence. When I do that, I feel something move. It goes from one place where there's too much of it to another place where there's not enough, but what is it? One way to translate IT is, it's space. What is space? Space is nothing. Dig it—by giving people space, we make a living selling nothing. When I talk about this IT, it's very real to me. When I teach this in workshops about working with IT, it flows like a river that I can feel. It's like I'm holding a hose that has water flowing through it – my hand is not getting wet, but I can feel the water flowing through. For the people I have introduced this to, their eyes light up like Moon Pies; it's clearly the first time they have felt it.

## Demonstration

I want to demonstrate what I do. Let's start by asking: Has anybody here had radiation treatment? [No response from audience, so volunteer model was selected at random.]

[Working on volunteer model.] I talked about the magic moment as working from the outside-in and inside-out simultaneously. If you had a view of the skeleton, or if you bring it up on your cell phone, notice there is a space between the talus and the distal tibia. It's a space that you can literally look through. What I'm doing is finding that space, using minimal movement and pressure.

I don't work by depth. I never work ninety degrees down to her body. I'm always working at these oblique and shearing angles, and what I'm doing right now is feeding her from sleeve to core through that space that you can look through between the long bones of the foot.

Another thing about the way I work is, I don't like to tell people what to feel; but I do like to tell them what I feel, because if I feel it, it's there to be felt. A lot of these talks that we've been listening to [at the Symposium] talk about people's awareness of their body and what we're doing. As I tell people what I feel, I say, "Maybe you can feel that? This is happening." For example [speaking to model], "Maybe you can feel that your tibia and your fibula are letting go of each other and, as they do, there's a space that's coming into you. That is, you might be able to feel how much looser that leg turns in, and that was only three minutes of work. That is shaving

the balloon. Maybe you can feel me making my way through these layers.”

**Audience Member:** “How are your hands placed?”

I’m on the inside and the outside of the shin at the same time, and then I’m right on the front ridge of the tibia. Here I am working my way into a body at the outer extremes of random. A radiation fibrosed body doesn’t have any spring or bounce to it because all the costal and sternal joints are fixated to the end of their travel. Such a rib cage is hard and dense; it has all the flex of a Franklin stove. But as we start to turn these joints loose, you get some spring and some bounce that wasn’t there before. I’m making my way in now. I’m watching. I’m tracking. If you were a real radiation fibrosis client, I would be watching your face. I’d be watching for any resistance, even a twitch.

**Audience Member:** “If you were working, for example, where the radiation had been through. Do you follow the recipe?”

Yes. These techniques are a way to work the series. I’ve been shaving the balloon, working in tolerable increments, working my way in. When I was working on her feet, I was equally working from the inside-out and outside-in.

**Audience Member:** “How are your hands now?”

My right and left thumbs are on her right and left mastoids. I have my fingers down here at T1. T1 is one of my favorite vertebrae, because one of the random patterns is that the front hangs from the back, and that hanging point is T1. I don’t know if you’ve ever noticed that the spine is not in the center of the body. It’s in the posterior compartment. The spine is in the posterior compartment, and because of the way the ribs and the pelvis articulate with the spine, it puts all the weight of the ribcage and pelvis out in front of the spine. Therefore, there is already a natural tendency built into the body for the front to drop – that’s what the Line is! The Line is the ability of the body to lift from the center.

Chapter four of my new book (Mintz, 2018) is called “*The Line and the Spine Coincide*.” In the random body, there’s a story we tell that the random body has no alignment of its segments, and in fact, there is no line that lifts from the center. But if you collect all of the vectors of force in a random body, you would find that the resultant line of support and the spine are co-located. In the random body,

the resultant vector of lift is coincidental with the spine. A random body has a line, but it’s spelled with a lower-case l. It’s not a Line with a capital L, because the Line with the capital L lifts from the center, in front of the spine. In the random body, everything hangs from the spine. The spine literally is the line; the random line – the resultant vector of lift – and the spine are co-located. It’s not supposed to be that way. The Line that we structural integrators install is supposed to be in front of the spine; it’s supposed to lift from the center.

[Performing pelvic lift on model.] We have a study group in Austin called the Austin SI Study Group. We meet the second Tuesday of every month, and have for five years. We once spent an entire night talking about what a pelvic lift is. I talked about front and back. Ida Rolf had a definition for a balanced joint. She said, in a balanced joint, when the flexors flex, the extensors extend. Here in this pelvic lift, I have a whole handful of flexors, and I have a whole handful of extensors, and I’m getting the flexors and extensors to relate. You can feel how it didn’t take much – but she’s not a random body, and she hasn’t been exposed to radiation.

## Summary

To read the literature, treating radiation fibrosis and droop neck syndrome is hopeless. Even Stubblefield implies that. If it’s anything short of hopeless, it’s because the only hope Stubblefield offers is in the recommendation of physical therapy that is carefully tailored to the individual case. The only reason researchers recommend physical therapy is because they don’t know [about SI], they don’t know we exist. They don’t have any idea what we’re capable of. No matter what the histology shows, no matter what the reason for this fibrosis is, the bottom line is that, at the end of the line, the issue is in the fascia. By working these techniques, I’m able to free the layers and restore the volume without exceeding the client’s boundaries. If I exceed his or her boundaries and get a pain response, then I lose their trust, and that kind of loses everything.

The idea is to peel these layers in order, in tolerable increments, until I can get inside and work my way out. I tissue load to feed IT, whenever that is, down right into the periosteum. When I do that, it loosens up the sleeve so that it’s not choking off the core. As we saw, that increases the internal volume and, by

God, if you're really lucky and it's a good day, you'll see the Line emerge.

If you want to get involved in this, there's a tsunami of work out there. Find your local cancer centers and people who do integrative medicine. Get to know them. Introduce yourself and, if I were you, when they say, "Who do I send you?" I'd say, "Send me your hardest cases first. Send me the people who have been everywhere and tried everything." If you do that and you get one success story—remember, you don't have to turn them into some kind of Roling specimen. All you have to do is get enough change so that they can feel it. If they go, "Yes, I can feel it. I can feel like there's more volume, I feel less choked off, I'm in less pain." If you can get that one person, it will fill your book. On a worldwide basis, it would put structural integration on page one, above the fold. ■

## Resources

A video of the presentation upon which this transcript is based can be viewed here:

<https://bit.ly/2PvOFqo>.

## References

- Mintz, R. (2012). *Foundations of Structural Integration*. Austin, TX: Author.
- Mintz, R. (2018). *From Adam & Eve to Ida Rolf: What is the Random Body?* Austin, TX: Author.
- Stubblefield, M.D. (2011). Radiation Fibrosis Syndrome: Neuromuscular and Musculoskeletal Complications in Cancer Survivors. *PM&R*, 3(11), 1041-1054. <https://doi.org/10.1016/j.pmrj.2011.08.535>.
- Stubblefield, M.D. (2017). Clinical Evaluation and Management of Radiation Fibrosis Syndrome. *Physical Medicine & Rehabilitation Clinics of North America*, 28(1), 89-100. <https://doi.org/10.1016/j.pmr.2016.08.003>.