ScarWork

Integrating Scar Tissue into the Fascial Web

2023 Manual

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ScarWork is my original work. I consider it a textural art form.

I want to give credit to my teacher, Dr. Ida P. Rolf, the founder of Structural Integration also known as Rolfing, a fascial tissue bodywork and movement education system. I was taught by her as an "Artistic Experiment", which meant that I was expected to learn the work without reference to anatomy. I was to learn with my eyes and hands. This foundation led me to the development of ScarWork.

I discovered ScarWork in 1973, However, I mistakenly assumed that I had re-discovered what all of the massage practitioners already knew. So I kept on exploring and learning about scars over the years as they were volunteered for work by my Structural Integration clients.

In 2005, I published an article, "On Scar Tissue" in the Journal for Structural Integration hoping to exchange knowledge about scars. I did not get any new information, but I did get requests for workshops. So I designed a workshop that fit the spirit of the work to pass it along to my Structural Integration colleagues.

After the first Fascial Research Congress in 2007, I took my first baby step into science with a "search of the literature" to see if anyone else out there was doing what I was doing. I did this and was surprised to see very little on scar tissue. I began teaching more classes and I started looking to train teachers. I started a quest for more science: some ultrasound documentation to get some numbers for my research oriented friends. I managed to gather and present three abdominal ultrasounds showing before and after effects of ScarWork at the Fascial Research Congress in Washington DC in 2015.

I have been fortunate that Robert Schleip discovered ScarWork. Robert recommended Beverley de Valois in the UK and she published a research article for us. I am very curious to see what researchers will discover. Perhaps research will improve our work.

Guidance

To practice ScarWork, you do not need to be large, strong, young, or particularly fit. You can work by yourself or work with colleagues in a team. You can sit or stand with your table at any height that suits you. You can use the ScarWork by itself or use it as part of a larger Sturctural Integration session. You can do the most of the work in one session or you can do it over time in shorter sessions. You can be calm, happy and reassuring. It is unlikely that your work will cause any discomfort. In fact, not causing pain is a major working principle so "putting people through it" is not an issue. Working with scar tissue is like speaking a different language in the world of fascia. My thanks to *Caroline Widmer* for this insight. Some of the guiding concepts and the working principles and goals are similar to those of Dr. Rolf's Structural Integration. The techniques are very different.

Scar tissue quality changes quickly and easily. All the irregular texture, the lumps, gaps, ridges, holes, bumps, knots, and strings in the tissue become smoother. The amount of change in one intervention is rapid and extensive. The quality of touch is light and casual. ScarWork is rarely painful - even for very new scars. Small changes that are almost imperceptible rapidly accumulate to produce obvious big changes.

Work on a scar can contribute significantly to whole body release and integration. Historic memories and emotions are often recalled. Improvements appear to be permanent and progressive. Work on new scars seems to speed the healing for a few weeks right after the work is done followed by months of gradual improvement. The same can be said for older scars. It does not matter how old the scar is, improvement is still possible after many years.

There is never a scar that is exactly like another. Each scar is unique. Typing and generalization of scars for the sake of shortcuts or formulaic learning does not work as well as we would hope. Protocols turn out to be an unfortunate waste of time. ScarWork is more like an exploratory surgery, in that it is a constant adventure into the unknown.

I don't think of scar tissue as extra material to get rid of. I think scars are made up of valuable tissues that are simply stuck together. The goal is to liberate these tissues back into the vital three-dimensional web of fascia. Once unstuck, the tissues "go home". If feels like you use all of the scar for mending with nothing left over when you are finished. ScarWork seems to only work on scars and is not a substitution for other methods of structural work like Structural Integration.

Attitudes towards scars are interesting. Scars are generally not loved by their owners. They are considered a loss and a disfigurement. Many people have an aversion to their own scars. Some people have not touched their scar since their surgery and have no idea what it feels like. I ask people to feel their scar before I change it so they can appreciate the change.

When I first inquire about scars, most people don't give me much information. Instead, they say diverting things like, "that was a long time ago" or "that doesn't bother me". It is as if they have closed the door on the trauma and do not want to open it.

I like to hear the story. I inquire for two reasons. It can help the physical release when they express themselves about it, and hearing the story of the how the scar was formed helps me to make sense out of the directional vectors I feel with my hands.

I think of reversing the scar. The force vector that created it is like a train track. The train goes precisely back up the track that created it to go home.

I try to understand how a scar happened and find out what the general circumstances were, what kind of forces were involved, what the medical world did, how the healing went, if there was infection or the stitches pulled out, how the long term progression of healing has gone for the scar, etc. If the history is not available, I simply work from the feel of the tissue.

If I can generate the precise counter vector, with the right amount of pressure at the exact speed, the tissue changes a tiny bit. Each application of pressure is a direct counter to the scar's vector or tissue's grain or direction. It feels like I am going head on into the most resistance.

A lot of the work I do is unique a particular scar. I may never do the same thing ever again. I work with the texture, trying to smooth out all the various textural elements of the scar. I want it to feel even and regular, like "normal" tissue.

Unresolved history and emotion can surface with work around scars. While some of this can be intense, at least I have never had anyone re-live their surgical procedures. I have had people describe everything they were conscious for right up to the anesthesia. However, what happens during the surgery under anesthesia has not ever come up in a session. I do hear lots about the recovery process; the stitches coming out, drain tubes being pulled out, and the general good and bad luck of their healing process. Although every now and again I do hear about an intriguing journey of the spirit.

It is never too late to improve a scar. Scars that have been there awhile are the easiest to help. It is just for brand new scars that you need to consider how soon you can work.

For a less experienced practitioner, a good safety time margin for mercy work on dear ones is between two and three months after the stitches come out. You will shorten the healing time and make them more comfortable quickly, so there is value in lessening the pain and suffering and the time of healing, but as to the resolution of the function and restoration of the tissue, you will not loose your chance to help if you wait for months or years.

With new clients (for liability issues and absolute safety) I would wait until their doctor will prescribe regular massage before starting work on a scar. For most doctors, this timing is typically months after a surgery when the scar is well healed.

For family, and for dear friends, who are in pain and out of sorts, I will do mercy rescue work ASAP. For this circumstance, I prefer the scar to be closed over and dry because I am the most concerned with not introducing infection.

Doing early work and working with someone who is not yet medically discharged means interfacing with their medical team; this has it's fine points and most likely a fair amount of paperwork. I consider early work a specialty in Scar-work and prefer to teach it to a few of my over-qualified colleagues.

Some scars are well healed or small and only require a few minutes work, while at the other end of the spectrum, the more involved, larger scars may take up to an hour and may have whole body structural releases. These more significant scars may deserve to be the center of attention of a whole session.

ScarWork usually progresses from the surface, working all the way into the interior far reaches of the surgery including the internal organs. If I don't resolve the adhesion from the scar, I cannot have optimal placement or function in the involved internal organs.

All scars are Three-Dimensional. A surgical scar is a three-dimensional amoeba-like creation that connects all the places that were involved or surgically explored. So if the surgeons decided to take a peek at the gall bladder while they were in there for an appendectomy, the scar will have an arm or branch that reaches all the way to the gall bladder. This three dimensional form includes pools of fluids like blood and lymph that occur in the general vicinity in a random fashion. These are delineated by a fine fiber network without a capsular edge.

The surgical report, which details what was done for that particular surgery,

is somewhat useful if you are lucky enough to get a copy. MRI's are very nice to see. Some general knowledge of common surgical procedures is good to acquire. There are many ways to do the same surgery depending on where the procedure was learned, when the doctor studied and with whom the doctor studied. Videos of surgeries are available to see in medical school libraries and on the web.

Extreme positions that surgical patients are sometimes put in for the convenience for the surgeon can be a part of their structural troubles afterwards. Deep surgical cuts allow for things to slide further away from each other than is possible in their fascia-connected state. Things get stuck where I would have never have imagined it possible. Following scar tissue has led me into finding some fascinating surgically related structural distortions.

ScarWork may be used as a standalone intervention. It may be used with people who have not had any Structural Integration or any other type of bodywork. We ask for volunteers from the local community to be models in the teaching workshops. Some of these people have never had any structural bodywork of any kind. ScarWork was just as effective.

However, if the change from the scar is extensive, some kind of whole body integration would be a good thing to do. If you are not qualified for doing the work yourself, maintain a good referral list of complimentary therapists you like that you can send people to. There is not time enough in a lifetime to learn all of the disciplines that help people. I would recommend choosing something to practice that is interesting to you and that makes you feel useful.

Working Principles

ScarWork sensation levels are generally very mild. It is rare for any of the techniques to be painful. In fact, we made it a principle that we work with the body's pain alerts. We do our best to avoid causing any pain.

The quality of touch is casual and relaxed. Many of the motions are quick and light and easy. It looks a lot like kneading bread dough. My thanks to Libby Eason for this observation.

I relax my hand contact and I use flat hands against the skin quite a bit.When I apply pressure with a flat hand, it is distributed over a larger area and is comfortable. From the receiving side a relaxed hand causes the tactile outline of the hand to disappear. Then the hand feels like a warm area or spot.

One quality of touch I call *tissue-loving*. My fingers want to be in touch with the tissue - every part of my hand keeps contact to apply the counter pressure. Kindness, acceptance, welcoming, and respect are good attitudes to cultivate towards scars. Remember that the scar is made up of good tissue that is just glued, stuck, and clumped together. It is precisely the right stuff you need for the repair. It is even pre-measured to the exact right amount and located at exactly the right spot for easy access. It is a gift and a treasure.

Functional returns and improvements commonly appear. They might be a by-product of smoothing out the tissue. Some examples of functions that return are sensory nerves and sometimes motor nerves, internal organ function, and blood and lymph circulation. There are improvements in the feel of the texture of the scar, the look and the color. And there are improvements in the range of motion, the strength and elasticity of the tissue.

These functional improvements were never intended. They are fortuitous and most welcome. They are so common that over the years, I have come to expect them. I wonder what I have missed when they don't occur. I even use their return to judge how well the work is progressing. However, if I were asked to return nerve to full function, I would be at a loss.

If there was a technique related to each function, I could write up some handy scar protocols. The closest I have come is associating sensory nerve return with some aspect of the Matching Layers technique. Perhaps in the sum of working the whole scar is the key to the generation of these kinds of functional improvements.

Almost all of the techniques are concerned with knitting tissue back together. Most techniques move tissue towards the scar or push things together. I don't pull or tear scars apart which is the medical model. I mend and reassemble scar tissue.

I can't use most of these ScarWork techniques on myself. When I am working, I need to pay attention to the hand that is giving the work. Just when I get to the depth where I can feel change happening, my attention slips from the giving hand to the receiving tissues which have just become the stronger of the two sensations. I become lost with my working hand because I cannot feel it as the stronger sensation wins my attention. I cannot seem to maintain my attention on the lesser sensation. When I take my hands off, there is after-pain, which means that I have damaged the tissue and I have just made some more work for my friends.

To find which direction to work on the scar tissue, I sweep my fingers across the scar from many different directions. Some irregularities only show up from certain direction and angles. Once the direction of the tissue is determined, I pick the most obvious, stiffest and most irregular place to start. I go head-on, or straight into the most resistance. I try a few of different techniques to see what might work best. I create forces and angles to counter what I feel under my hands.

Going Home ~ I want the dense stuff to become the adaptable, three-dimensional fascial web again by freeing the current adhesion pattern and allowing the tissue to go home. Thankfully, the tissue always goes home and not to another random place to stick down and cause a different kind of trouble. There may be something like a blueprint at work that celebrates the right order in tissue.

Bracing ~ Most of the scar tissue work requires two hands. *Bracing* with one hand is essential to capture and stabilize the scar tissue in most of the techniques. A *Bracing* hand holds the tissue in place or pushes and feeds the tissue into the other more active working hand. Some of the techniques don't use *Bracing*. *Dropping*, for example, uses only one hand and it deliberately distributes the force *through* the fascial web.

Press and Reset ~ is done again and again. It looks like bouncing up and down but it is not. It takes you down through the layers of the scar and each time you press you are in a different place. In the details of a scar, I capture

a lump of tissue, hold it down and press into it to free some of the adhesions and then I come off to release the tissue enough for a "Tissue Reset" which gives me a new field all ready for another press. These changes are so small that I don't clearly sense one of them, but I can easily feel the accumulated result of twenty.

Torque ~ a flowing, spiraling twist that facilitates passage through fascia. If an edge of a scar is turned under, I also use a twisting motion to level the two sides of the scar. I use a fair amount of *Torque* in working with burn scars.

Reality Check ~ look to see if you are actually doing some good. Look for change both locally on the scar and look at the whole body results before, during and after working. I check at least every five to ten minutes. This helps train your vision and memory.

Gestalt ~ helps to find the next place for work, look for what is easy to find and the most obvious- over and over. If working in the tissue becomes difficult to do, you may be in the wrong place. Keep looking for the obvious. Take on the first thing that strikes your senses and work with that. Chances are you will be on the "next right place".

Work from the surface layers down, creating good tissue through which you work to create more good tissue through which you work more tissue until you run out of scar tissue and you cannot find anymore.

Figuring out where the structure has gone is good, but if I haven't a clue, I just start working - I trust I will find out what the problem was after it releases. A scars is a three dimensional puzzle. It is a mystery that will teach you as it unfolds. Knowing what to do ahead of time is not necessary.

Techniques

There are many different techniques that change different qualities of scar tissue. Techniques are ways of changing the scar tissue that I find myself using often enough to notice a pattern. If I use that pattern on a fair number of different scars with success it becomes a technique. Each technique looks and feels different from the others and works a little differently. New techniques are identified or invented as I encounter unique scars. The names may change as people come up with better, more amusing names that stick. I like to credit people for new techniques, good ideas, and nice names. I update the manual frequently.

✿ Feather Light Sweeping ~ This is used as an all over initial entry beginning the process of re-establishing the fascial web. It is surprisingly restorative. I usually use it as a first time into exploration into unknown territory, to start to soften tissues. It is a thorough, light, all-over application of sweeping and brushing the surface of the skin. If you used a pinion feather ~ it has the tiniest bit of authority ~ going head on into the set of the tissues. A single finger can be used, any of the fingers or thumb may be used - depending on the angle you need to generate. The finger is moving before contact with the surface and keeps moving as it breaks contact. Multiple fingers may be used for a large surface. This might be similar to some Lymphatic Drainage Techniques.

✿ The Eraser ~ For this one I mostly use my index finger. I hold my finger curled with the tip pointing down and brace the first finger from the palmer side with my thumb. I often *Brace* from the dorsal side with the middle finger. There is some squeezing in the *Bracing*. Staying at the same depth in the scar, I rub with the fingertip forward and back with a motion similar to using an art eraser. I use my other hand to stabilize the surrounding tissues very much like holding a piece of paper flat. *Erasers* can be made with the medial edge of the thumb braced by the first and second fingers. For a large area, sometimes I use my three middle fingers with the thumb and little finger squeezing to brace. I use the Thumb side heel of my hand (the *thenar eminence*) as an eraser on large, rough textured burns. The *Eraser* is also good for smoothing out "road rash" and scraped surface skin. Skin graft donor sites also respond well.

✿ Scraping ~ This consists of Bracing by pushing away from the scar with one hand, while using a clawing motion with my index finger through the tissue into the gap. I pick up and do this again in the same direction rather than flip back through the tissue to the starting place. On the larger scale, for example, on a long and large hip replacement scar I use all my fingers at the same time. I usually scrape both sides to the middle to fill in the scar gap. I use all my fingers for *Scraping* forwards and backwards for some cross fiber work in some of the more ragged "natural" scars, a little like using a brush with an arcing lifting motion.

✿ Filling In ~ This is good for gaps and holes. Using one hand to hold and stretch the area some so you have something to pull against, work all around a hole or gap sweeping the tissue into the area. One finger starts and before the first is finished the second starts, before the second is finished the third starts and before the third is finished the fourth finger starts. I use two, three or four fingers one after the other in sequence. It looks a little like "drumming the fingers". I have found that if the hole is due to the loss of tissue, this does not fill in very well.
It seems you need all the pieces to really complete the job and if something large enough is gone, the hole won't fill in all the way.

✿ The Cat ~ This one works well for a deep ragged scar. I compress the tissue from above so the torn edges meet up and then smush and mush the edges together, fitting and tucking... It looks somewhat like wiggling under pressure. I will *brace* into my own pressure from the other side if I am not using both hands and if I can reach that far. *The Cat* can be added to many of the other techniques; like *Dropping* with the Cat. Sometimes this looks like little bit like kitty kneading.

✿ Matching Layers ~ On both small and large scale. *Matching Layers* uses a flat contact. On the small scale, two flat index fingers with most of the pressure in the distal section of the finger. Put one finger down flat on either side of the scar parallel to the scar. Push down until contact is made. Wiggle forward and backward in the horizontal plane, one hand going forward, the other backward as well as up and down looking to match the layers, combined with pushing together with some torque. When a match is made the layer feels like it disappears and I pick up the next layer to work. I work through the layers in the scar. This meshes and knits together the layers in C-sections and bridges big gaps. It can be done with the whole hand as well for big scars. With the whole hand, I sometimes use a touch of *Torque* to aid in the meshing. Impaired nerve function often resolves in the course of using this one.

✿ Dropping ~ This can be done on a small scale and on a large scale. Small scale is with a fingertip into a piled up scar. Relaxing the hand and arm, the finger drops into the tissue just to the depth of working... and takes a little of the scar down. It sounds a little like raindrops. This is done over and over in the scar, taking it on down until the scar is smooth. I usually don't use any *Bracing* with the other hand. On the large scale it can be done with the whole hand to break those odd adhesions resulting from an over expansion of pregnancy or the strain left from the swelling from an infection or interior bleeding. Whole hand *Dropping* will also release a pattern of stuck in over-expansion like a drowning episode where the diaphragm is bulging out with the strain of not breathing. Shayna Alexander, a Structural Integrator from Israel who also teaches Karate agrees with me that *Dropping* has something in common with Karate's soft break. The whole hand drops into the abdominal area with a soft plopping sound. You don't have to lift high or use any added speed. *Dropping* restores all the abdominal fascial layers.

✿ Combing ~ This is good for the edges of long scars. On a long cut, there is drying out and retraction over time. The longer the time before closing, the more distinct both edges of the scar become. I usually *Brace* a section of scar stretched between thumb and fingers with one hand and with an thumb or finger edge sometimes backed closely by a nail for a little stiffness I use long sweeps up and down along the fibers along the direction they run with the idea of separating out the strands, like *Combing*. Sometimes it feels a little like scrubbing for the some of the shorter strands. I put quite a bit of tension on some of these edges with both the *Bracing* hand and the *Combing* hand.

✿ Playing the Piano ~ Line up all the fingers of both hands along the rope of the scar. Push at the most obvious lumps and keep pushing at different ones that become emergent as you take down the other places under your fingers. Think of the Whack-a-Mole arcade game. Where the pressure comes up - you push down. Sometimes I wiggle my fingers to blend across the rope.

✿ Skidding ~ This takes a whole plane of tissue and repositions it. Sometimes in surgery, the doctors take a large "Flap" of skin and fold it back. When this large piece of tissue comes back into contact with what it was severed from - it adheres, usually slightly out of place. I use a flat contact as much as I can of the whole surface involved, push down to the depth of the scar and skid sideways in the direction of the most resistance. The whole sheet comes loose at once and will reposition. I use the palmar surface of both hands sometimes with a touch of torque. When the sheet hits home, I use the Cat to set it in. In a C-section, often the lower half of the incision with the fat pad

can often be skidded back up into place.

✿ Big Picture Skidding ~ Tissue has a tendency to puddle and slump during a surgery. When it slumps with gravity and stays there awhile, it gets stuck in the slump. As though the bed sheets were rumpled and then starched into the rumples. Place your hands to cover as large an area as possible and shove as much as you can control up towards the scar… then do the other side of the scar in the same fashion. If you break the whole adhesion pattern the area suddenly looks normal. This is particularly good for hip replacements.

✿ Compression ~ This consists of pushing things back together both large and small scale. I usually use flat fingers or flat hands with quite a bit of force. *Compression* has a slower pace to it than most of the techniques. It has the feel of gathering things together towards each other... of fitting parts together. I usually do it with both hands at the same time from complementary angles. I usually find many *compressions* from many angles effective. In surgeries sometimes tissue (not "Tissues") is retracted and held with quite a bit of force over a long time. *Compression* will release the surgery retraction pattern. It also helps release the residual ballooning from the practice of inflating the abdomen during surgery.

✿ Rolling ~ On the small scale, this is a pinch and shear motion with thumb and first finger, or the first two fingers. The shear or roll is done within the limits of the tissue, gradually increasing the range of the shear as the tissue lets go. I have used this for ear piercings that were badly done, a dog bite on the lip or on scars on the ends of the fingers. For anything larger, one hand on top and the other from the bottom I use for things the size of fingers and forearms. The larger size body area limits the use of this one.

✿ Zig Zag Sewing Machine ~ This one works well for little tiny striations left within the wide, pulled apart white part of a scar. These are possibly generated by the stitches as the scar pulls apart. The striations feel a little like tiny splinters embedded in the scar and usually go crosswise to the long cut. I hold my stabilizing hand in the area to be worked using a spanning, spreading motion with the thumb an fingers while I move with a superficial fast loose zig-zag motion through the surface of the scar *with* the grain of these splinter like scars. This is also good for smoothing the little dots left by the stitches or staples on either side of the cut.

✿ Breast Lumps ~ This is used to disperse the lumps in "fibrocystic breast disease". Using flat fingers on the tissue, walk your fingers across the area like a breast exam to capture, pin down, and gently smush any lumps you find with a *gimbaled*, downward *Cat* against the ribcage. It looks like playing piano with straight flat fingers. Walking is reminiscent of a multiple-legged caterpillar's leg sequencing. It is essential that the other hand feed the tissue from another other side of the breast to generate pressure into the lump. When the pressure from both hands is focused, the lump suddenly disappears and is not there. Some lumps do not disappear and may be due to other conditions in which case stop working. Mammograms miss 60% of breast cancers in "dense breast tissue" which is what fibrocystic beast lumps are called. Two main reasons for clearing the breast. First, doctors want to take a biopsy - repeatedly - to make sure things are OK which is traumatic and anxiety producing. Second, if all of the lumps are gone and you do develop a new lump you will have a better chance of feeling it.

✿ Inch Worm ~ I use this to work my way up and down the length of a ropey scar to lengthen the tightness. One contact picks up a little and moves less than a half inch along then the other follows behind it a little like an inch worm. Each contact stretches the scar. It feels a little like stepping along a tightrope. I *work* along the whole length both forwards and back from both sides of the body. Sometimes I shove the rope around - forwards and back.

✿ Down the Rabbit Hole ~ by Jan Trewartha

This works brilliantly where a 'scope' has been inserted into the body (laparoscopy, arthroscopy), as well as for drain sites. The scope or drain being inserted and removed creates tracking adhesions. With drains, there is just a straight 'in and out' but where a surgeon has been investigating, you will feel yourself being pulled into the areas where that scope has gone. This also works well in cases of abdominal congestion, placing the finger in the navel and the other hand gently over the congested area. The technique is as much about intention as anything, so keep your mind on your finger and allow your intention to be there in your fingertip. Put your fingertip on the scar. In navel laparoscopy scars this is sometimes impossible so just put your finger in the navel. Index finger usually works best but whatever is right or you. Do not apply pressure. Just stay there, lightly, and follow the tissue. If there is anything to clear, you will feel the tissues drawing you in until, if your eyes are closed, it might feel as if your finger is fully inside the body. The client may also feel this as the intention and touch transmits into the deeper fascia, especially in the abdomen. When the movement eventually stops, you are done. N.B. A laparoscopy may generate up to 3 scars so be sure you work on each one.

✿ The Cliff Hanger ~ by Jan Trewartha

Used when there is a 'lip', or overhang that doesn't respond to the Twist and Flip. Only possible when there is enough space to, without forcing, tuck your fingertips over the edge, as though you are hanging onto the edge of the cliff. Now just wait. If this technique is going to work you will feel the tissue start to move, to give, to let go of the tension. Just allow this to happen and, when the area you are working on has opened up, move along to the next section.
Thanks to Donna Mazzotta for the name.

✿ Delete Key ~ This is a good way to start to soften up a large burn area. Press into the tissues enough to *just* break the adhesion, key-press all over the burn. It feels a little like pressing a computer key down without making the letter print. Creating a softer more pliant layer gives you a place to work from as you resolve the uneven texture below the surface. Thanks to Cheryl McCarthy for the nice name.

✿ Twist and Flip ~ This is for an edge of tissue that is turned under on one side of a scar. Follow the angle of the curled under piece and think of sticking to it. Then scoop and flip rolling your whole arm with your contact to break the adhesion and bring the piece of tissue level with the other side.

✿ The Double Flip ~ by Aric Spencer

Use this stroke to draw scar edges together, at any depth that feels needed. I use my index fingers, both turned so that the fingernails are face to face and touching or close to touching, depending on the scar's width, or what is needed. The elbows stick up and out. I press down on the scar with both fingers and roll the fingers, the right finger clockwise and the left finger counter clockwise. The scar edges are "captured" and rolled simultaneously into each other. This action draws the scar's edges together, either at a deep level, or just at the surface, pressure used. I like to wiggle or shift my shoulders (or hands) back and forth during the double flipping to add a micro-sheer effect. When the stroke is finished, the finger's pads are facing up.

✿ Squirrel ~ for multiple surgical incision sites. I scrape towards the center of the cut with curved fingers lined up to create one long edge. Before I finish with one hand, the other is already on it's way through the tissue. Done at speed, it is reminiscent of a squirrel burying a nut.

✿ Cartilage ~ Pressure is applied in a very slow rolling motion: work at glacial speed. My attempts to speed up this process with cartilage have not been successful so far. The speed feels a bit faster than melting ice with your fingers. Thanks to Laura Covington for the ice analogy. Ear cartilage fractures at strange angles, a break is scalloped and twisted, not straight. Pinch up the tissue between thumb and fingers from both sides of the fracture and very slowly roll through with the pressure applied a tiny increment at a time. The ear will mend up whole and pliant within the session. The cartilage of the nose may be straightened and fit back with the nasal and lacrimal bones. It looks like cartilage in other areas like in the knee may be smoothed out with precise placement of slow rolling pressure. Possible areas of success are Keloids that are hard like cartilage. Initial change softened the Keloid without making it red and inflamed. Martha Jordan of Santa Cruz cleared both of her husband's hands of Dupuytren's contracture in a few months. The Dupuytren's responded to a very light working contact using the cartilage technique with the fingers of your hand resting into the middle of the thickening "letting the ice chips melt" speed rolling your finger with glacial slowness from place to place chasing down the contracture.

✿ *Burns* ✿

Burns have their own requirements and seem to be among the more difficult scars to restore. Burns from fire are the most common, often with large areas of damage. If the healing of a large burn is not carefully managed there can be extensive scaring. Burns seem to heal quite slowly, leaving time for further damage and infection, which makes the surface rough, often crisscrossed with raggedy strands. The hollows are delicate and seem to damage especially easily. Some burns they feel like some of the surface fat cells have "melted" leaving the deeper granular layer exposed. For burns with rough inclusions in the scar, pressing in and adding rotation or *Torque* helps to change the rough tissue into goof three dimensional adaptable sheets.

Over-Irradiated tissue (from x-rays or other high energy sources like synchrotrons, cyclotrons, or linear accelerators) is one of the most difficult burns to restore. These burned tissues seem to lack the long fibers Structural Integrators rely on for directional vectors. Their thick denseness is probably a form of atrophy, and the over-radiated tissue can feel and look like yellow/brown thick leather. I have seen the tissues so devastated they were reminiscent of the look of a dried mummy. With high radiation doses, the area can get very red, kind of puffy, fragile and subtly weepy for many months after the radiation. Great care must be taken with these bright red "cooked" tissues, if any swelling occurs, discontinue working until the tissue heals enough to take light pressure without causing edema. With both hands, use a spreading motion with all of your fingers and also spreading between your two

hands. Go many different directions to establish long fibers for resilience and bounce. ScarWork can restore resilience and better color to radiated tissues.

Most burns will respond to short applications of fingertip *Scraping* and *Dropping*. The motions are often extra small and light and short until some resiliency is established. *The Delete Key* is also good at establishing a resilient top working-layer. *The Eraser* works for some of the surface crosshatching, and roughness. Sweeping over the surface for smoothing with fingers or a broad flat hand surface seems to work reasonably well.

Overall I do not get the same level of resolution from burns that I do from other kinds of scar work. Perhaps it is the missing tissue that has been destroyed. Burns take more time for work. They often have profound emotional residue. They probably do best with moderate interventions over time.

Plastic Surgery

Plastic surgery has its own unique considerations. Plastic surgeons will bevel the edges of cut before stitching, which gives a cleaner join, but with tissue trimmed away, the resolution is not going to have the feel and fit of "Home and Finished", that other scars that are not trimmed and beveled or are missing pieces will have.

Plastic surgeons are better at matching internal layers and they use more internal dissolving stitches. They match up the cut edges of an incision more evenly with less excess tissue to "tuck" in at end of the scar. The typical procedure of stitching a long scar like a tummy tuck is to start at one end and sew to the other. This sometimes leaves some extra tissue to deal with. Devices like medallions may be used to take up the extra tissues from joining the two unavoidably mismatched edges. Medallions look like a circle about inch or so in diameter with the tucks done all around the circle. The circles are surgically removed later.

Plastic surgeons mostly do their cuts with one hand, which means the arcs they cut are not a mirror image from side to side. Using only one hand to cut with creates an interesting asymmetry in the scars for us to be aware of. The angle for work will be different on each side of the face.

The long arcing cuts of plastic surgery at the hairline may be helped by *Scraping* a shallow plane along the line of the cut with the little finger edge of the hand or the first finger side. Bracing the tissue behind the *Scraping* with the opposite hand helps. Running a ripple ahead of a flat surface through the

flat scar, like running a wrinkle through the carpet to reposition it, can also help. ScarWork takes away the stiff mask like quality and returns mobility to the features without losing the “lift".

Huge stiff areas like tummy tucks where the whole top sheet of abdominal tissue is cut loose and pulled down like a window shade and reattached are helped by lots of the Cat and whole hand *Dropping*. I drop in to where the layers are joined and then sometimes I will be using a little bit of the *Cat* to reconnect the top layer to the layers below so it feels soft and bouncy like a tummy again.

Often at the eye corners you find a piled up hard knot that feels like it was perhaps improperly stitched together. Plastic surgeons will schedule another surgery to take care of these knots. *Dropping* with one finger is particularly effective for reducing these knots and flattening the tissue out again.

ScarWork Contraindications

Before you work on a scar for a client please ensure:

~ You follow the rules of your country for your licenses and certifications.

~ Your client has a recommendation from their physician for you to work on work on their scar.

~ The scar is not open, infected, inflamed, weeping or painful. And there is no redness or swelling around the scar due to inflammation or after radiation therapy.

~ We recommend not working on pregnant women.

~ ScarWork works with the pain alerts of your client's body, not against them. When you work on a scar please advise your client that they must give you feedback on pain. If there is any pain, ease off the pressure or try another technique. Check in with them regularly to ensure they are comfortable and not 'being brave'.

~ If any unusual reaction ensues from ScarWork such as extreme redness or swelling, please refer the client to their physician for further evaluation.

Disclaimer

The purpose of this manual is to provide information for hands-on therapists on the subject of Scars. This manual does not offer medical advice to the reader and is not intended as a replacement for appropriate healthcare and treatment. For such advice, readers should consult a licensed physician.

This manual is intended for use with a training workshop.

The Story of the First Scar

Sharon Wheeler

It was 1973 when Hector Prestera and I moved from living in a wonderful hand-made wooden house on Hudson's Mountain, 1500 feet above Esalen, into Carmel Valley. We wanted to live as close as we could to our dear friends at Esalen and still be near a decent school for Hector's two young boys. Esalen did not have a school for small children until several years later when the director Dick Price had a daughter, that Esalen's own Gazebo School was created.

Hector is a fine physicians, board certified in internal medicine and cardiology. He was also trained as a Rolfer by Dr. Ida Rolf. He studied acupuncture with Jack Worsley and many others. He treated many of his medical patients in Monterey with acupuncture and Rolfing with quite good success. Lucky for us, Hector started his medical career in Monterey reading EKGs at the hospital. The other doctors got to know him and got to see how very competent he was and they voted him hospital privileges. A doctor without hospital privileges is not allowed inside the hospital to treat his patients. This makes him rather useless when his patient ends up in the ER. This is the way doctors have a good old boys club that unofficially polices their ranks for the unconventional. Hector said that if the other doctors had known he was planning on treating his patients with Rolfing and acupunctures, most likely they would have voted no for his hospital privileges. Rolfing and acupuncture were exceedingly unconventional in 1973.

We bought into a new medical building in the planning stages to be built in downtown Monterey. I got to work with the architect to redesign our medical suite with health in mind. Ours was the only office out of the eight suites in this new state of the art medical building where all the windows opened and had screens. The lights were fill spectrum. We had a large plant in most of the rooms, which did splendidly because of the lighting. The carpets were natural wool to avoid chemical off-gassing of formaldehyde and they had extra anti-fatigue padding. We had extra sound insulation in the walls for privacy which worked so well we later had to install an intercom for patients to call us if they needed something. With the addition of sliding glass door, a very large planter

outside of Hector's personal office became a private walled outdoor patio. Two black iron chairs and a small table made the patio a very good place to relax outside for lunch and breaks. One treatment room was designed for the future installation of one of John Lilly's Isolation Tanks. The Tank Room was the largest treatment room and was big enough to do Rolfing in. We even installed a shower so Hector and I could freshen up after a long day's work before going out to dinner. We had a huge supply closet with an autoclave to sterilize the acupuncture needles and other instruments. The three exam rooms tables were finally crafted in cherry wood with steps up and drawers with dovetail corners with a beautiful natural dark finish. They were made for Hector by a grateful master carpenter whose wife Hector has helped. At the carpenter's suggestion, I had the tablets upholstered with real rubber padding with matching back supports and knee bolsters. Our little old ladies would remark that they were more comfortable at our office than at home.

For about a year and a half I ran the office, doing all of the reception, appointments and charts, taxes, insurance claims work, and dealing with the drug company representatives. I learned a lot. I also, maintained a Rolfing practice and was taking care of Hector's two boys who were five and seven years old. After everything at the office was running well and we were making good money, we hired some medical staff. I am amused to say that it took five people to replace me. A nurse to follow Hector around and keep him supplied a book keeper who also did the insurance work, a tax accountant, a nurse receptionist and a janitor.

The nurse who took over reception in the front office was the person who had the first scar I worked on. She became curious about Rolfing and decided to try it. She both liked the work and was in an educated position to appreciate what Rolfing was doing for her. We did ten session series at our office using the Tank Room.

She had been the driver in a car accident where the car had rolled over about six times. She was not wearing seat belt and was thrown part way out of the window of the driver's side. As the car rolled, it caught her legs just above the knee and broke both of her femurs. She could not fold one her knees to 90 degrees so she could not sit for long without pain. By noon every day she was on muscle relaxants and pain killers. Her doctors had done five surgeries using the same scar through her right *fascia lata* to try to make it so her knee would fold again. They had even trimmed the top of the fibula off to make room for it to fold but with no luck. The last surgery had been about 15 years earlier. The doctors told her she was about as good as they were going to get.

When I got to the third session, I was supposed to create a "mid-line of the sides". I did OK for her left side and then started on her right. I found that I just could not get her right knee to move straight ward and straight back

because that scar was so stuck down it would not let her knee track properly.

This scar was about 8 inches long and with a deep, wide, square-edges groove wide enough and deep enough that I could almost hide my first finger out of sight in the groove. For an inch and a half around the scar, the discolored red-brown tissues were plastered to the bone with leathery, ropey ridges and strings. I looked shiny and felt stiff and hard and very uneven with lumps and holes everywhere. There were large areas of numbness and loss of sensation around the scar.

I remember asking Dr. Rolf about scars. Her advice was to ignore them and establish the function. I had done everything I could think of and ignoring this scar wasn't working out. I had the thought if I could ease the rigidity of the tissues around that scar perhaps that would help. So I asked her if it was OK to work on her scar. She had no problem with the idea, and I set about working on it.

Since I had never seen Dr. Rolf or anyone else work on a scar, I let my fingers just go and do whatever they wanted, and after about ten minutes of work, I had stopped to get a good look at what I had done. Where I had worked, the deep groove had completely filled in and smoothed out all nice and even feeling. All of the ridges lumps and holes had disappeared. Except for a white line, it now looked pretty much the same color as the rest of her. Where I had not worked was just the same as before.

I had her sit up and look at her scar over because I could not believe it. She said to me "I didn't know you could do that.' I replied, "Me neither." We both agreed that neither of us had any idea that it was possible to change scar tissue like that, Then we joked that we'd better not tell anyone because no one would believe us.

As I went back to work on the rest of the scar, I had a moment of panic as I realized that I did not clearly remember all the things I had done to get such a dramatic change. I was afraid I would not be able to repeat what I had done and would be unable to match the scar up. In an interesting spilt of consciousness, I let my fingers fly again. Only this time I was also watching and learning. I was able to get the same results for the second half of her scar.

With the slack I gained from working on her scar, I was able to unstick her fibula and roll it out of the back of the joint to where it belonged on the side of the knee. Then she could fold her knee very close to full range again with no pain. One surprising result was that all of her lost nerve sensation area became fully functional again. There were no more areas of numbness and diminished sensation around the scar. All of this occurred within this single

session.

At the end of the ten session series, she was free from pain and off of all of her daily pain medications. Without her pain, she was able to let her naturally sunny disposition shine! She became warm and friendly and cheerful, the most perfect person for our front office.

I hope Joan is pleased to be remembered as the start of this work.

The End

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