



# **Birch, S.**

## **Shonishin: Japanese Pediatric Acupuncture**



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**by naturmed Fachbuchvertrieb**

Aidenbachstr. 78, 81379 München

Tel.: + 49 89 7499-156, Fax: + 49 89 7499-157

Email: [info@naturmed.de](mailto:info@naturmed.de), Web: <http://www.naturmed.de>

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### 3 General Considerations in the Treatment of Children

Children are generally more sensitive to acupuncture treatment than adults; thus greater care is required as to choice of treatment, regulation of dosage, and method of application. Also, given their sensitivity, children respond very quickly to treatment, and assessment techniques are required to minimize the risk of overtreatment. Successful acupuncture treatment of children requires a thorough understanding of these issues. This may be one of the main reasons why many, if not most, acupuncturists do not treat children, or find it difficult.

To properly address these important issues, we need to examine the following:

- Ascertaining the appropriate dose for patients—and a model for doing so
- Understanding how treatment manifests in babies and children (0–18 years)
- Modifying treatment methods, so as to be able to regulate the dose of treatment delivered
- Continuously assessing changes in the patient to determine when sufficient treatment has been delivered, both regionally and globally
- Recognizing and correcting treatment overdose

Estimating the dosage and tailoring the treatment to individual patients involve several important diagnostic and therapeutic considerations. Selecting the correct root treatment pattern and the correct acupuncture points for treatment is important, as is obvious in any traditionally based system of acupuncture. Likewise, it is important to match the choice and application of treatment techniques to the diagnosis.

It is also important to understand the goals of root treatment: are they to effect a cure, or to help patients manage their problems? In some cases acupuncture treatment may be used primarily to help patients through a difficult process or to help them deal with difficulties, rather than being used to eliminate those difficulties. For example, if we are treating a patient with a complex condition, such as terminal cancer, our role

is primarily one of palliation and support of the patient. Likewise, if you treat a child who is about to undergo a complex surgical procedure so that the child can recover more easily and quickly from the surgery, there are no symptoms to focus on. Treatment focuses on supporting the patient through the process, using only some form of root treatment. However, given the fact that most acupuncturists work in ambulatory care private practice, most of our patients are not so ill and so we generally attempt to cure those problems that we see. The pattern chosen, the treatment points, and the treatment methods are fundamental parts of any traditionally based root treatment (this is discussed in Chapters 9 and 10 in relation to pattern recognition and treatment in Meridian Therapy). Additionally, it is important to select appropriate branch treatment or symptom control treatment methods and apply the techniques properly at the correct locations (point location is covered in Section 4 of the book). But an aspect of the clinical individualization of treatment that is not usually discussed, if at all, in most acupuncture textbooks is the issue of choosing the correct treatment dose.

It is very important to tailor treatment to match the needs of each individual patient. The descriptions in the following chapters are based on my studies with Yoshio Manaka, and especially Toyohari Association instructors, such as Kodo Fukushima, Toshio Yanagishita, Akihiro Takai, Shuho Taniuchi, Koryo Nakada, Shozo Takahashi, and Yutaka Shinoda, and refining these ideas through clinical practice. I hope in a later text to describe these same issues in more detail as they relate to the treatment of adults, where the issues can become more complex. It is essential to be able to adapt and apply the acupuncture treatment approaches described in this book on children who come to you for treatment. *If you do not understand the issues of dosage you are better off not treating babies and children at all.* The material described in the following chapters makes it possible for you to adjust your treatment to

every child you encounter in clinical practice, and to arrive at effective treatments.

Chapters 4 and 5 focus on clinical issues involved in determining the correct treatment dose. This includes a discussion of reasons for lowering the dosage, requirements for particular patients, and reasons why some patients are more sensitive than others. This discussion also provides an overview of dosage judgment and how to modify and select appropriate treatment approaches and treatment techniques so as to match the dose to the needs of each patient. The chapters also discuss how to identify when a reaction to treatment might be due to a misapplication of the dose or the application of an inappropriate technique. These are often the same or related issues. If a child has a reaction to treatment due to overdose or application of less than optimal techniques, the child or parents may begin to lose

their trust in you as their practitioner, and treatment may be stopped. Dealing with patient reactions to your treatment requires many levels of skills. First, you must be grounded and able to react through controlled emotions without defensive responses. Then you must also be practical enough and patient focused enough to recognize and correct the treatment so that the patient will continue receiving treatment without resistance (Yanagishita 2003). When correctly applied, the appropriate treatment is clinically more effective. Although this book outlines several useful ideas, understanding the correct treatment dose can be a lifetime endeavor (Kasumi 2003).

Chapter 6 describes the *shonishin* treatment tools, their methods of application, ways of adjusting dose in their application and finally some simple practice methods to help train the very light methods we use to adjust the doses of treatment.

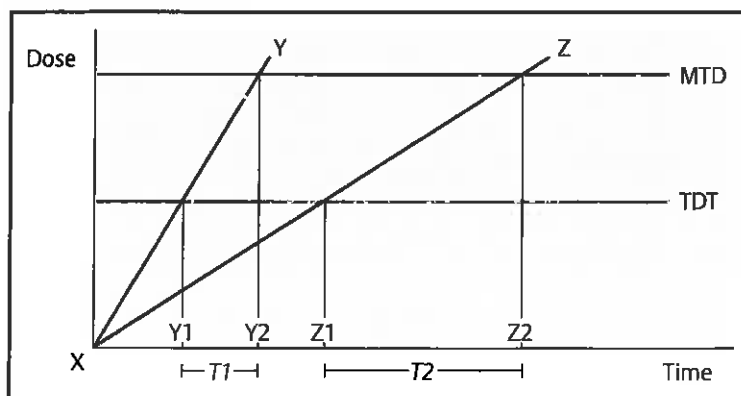
## 4 A Model for Judging the Dosage Needs of Patients

### The Therapeutic Dose—A Conceptual Model

In mainstream medicine, it is generally well understood that there is an optimal dosage range for a particular drug to be effective. The concentration of the drug in the blood should lie roughly between two values for it to be effective. Below the lower value, the drug is less effective or ineffective, and above the upper value the drug is in too high a concentration and can cause unwanted side effects or lead to a treatment overdose. This general idea is quantitatively based, where the optimal dosage range is often based on body mass and the upper and lower dosage ranges are numerical values. But it is possible to extend this idea to a more qualitative illustration of dosage needs—qualitative because there is no laboratory value to measure. We can make qualitative estimates of need only. The following ideas are extensions of explanations that Yoshio Manaka made about treatment dose in relation to the intensity of stimulation delivered (Manaka, Itaya, and Birch 1995, pp. 118–119). My teacher Dr. Manaka explained this to me as an argument for why one could say that “Japanese acupuncture” approaches were generally better than “Chinese acupuncture” approaches because Japanese needling approaches tend to be much gentler and milder than modern Chinese approaches.

Upon reaching the therapeutic dose threshold (TDT), a therapy starts having its expected therapeutic effects. If the treatment dose exceeds the maximum therapeutic dose (MTD), the patient may experience unwanted side effects due to overtreatment.

With a medication, the dose taken and the intervals between doses are often coordinated so that the medication's concentration in the blood remains in the optimal range—between TDT and MTD (Fig. 4.1). For an acupuncture treatment, this figure is interpreted differently. Two treatments, Y and Z, are charted. Both treatments start from point X. Treatment Y has a relatively high-intensity stimulation, the dose buildup is quicker than that for treatment Z, which delivers a stimulation of milder intensity. Y1 and Z1 are the times that treatments Y and Z cross the TDT, respectively, and Y2, Z2 are the times that treatments Y and Z cross the MTD, respectively. The time that the practitioner of treatment Y has to judge the correct dose of treatment is T1 (the distance between Y1 and Y2), whereas the time that the practitioner of treatment Z has to judge the correct dose of treatment is T2 (the distance between Z1 and Z2). Because T2 is larger than T1, we can say that the risk of reaching treatment overdose is less with treatment Z than with treatment Y. It is therefore easier and safer to administer treatment Z. Hence, Dr. Manaka argued, the milder needling approaches represented by Z are better than the heavier needling approaches



**Fig. 4.1** Dose levels for normal sensitivity patient with different intensities of treatment (Y, Z). TDT, therapeutic dose threshold; MTD, maximum therapeutic dose.



represented by Y, where Y, figuratively speaking, represents modern Chinese needling methods and Z modern Japanese needling methods.

This model is an oversimplification. For example, in homeopathy the lower the physical dose of treatment (the more diluted), the higher the therapeutic dose (energetic). Manaka hinted at these things with his X-signal system model of acupuncture (Manaka, Itaya, and Birch 1995, pp. 118–119). A lower intensity form of acupuncture (as physical stimulus) is not necessarily a lower treatment dose because, at very low energy content (very low intensity stimulus treatment), the more the treatment's energy level approaches or approximates the energy level content of the physiological systems, the more it could be therapeutically active (i.e., the less the physical stimulus, sometimes the stronger the signal system mediated therapeutic effects). See Manaka et al (1995) for a detailed discussion of this idea. But, for the purposes of the model here, if we assume that within the context of a particular treatment model the foregoing graphical representation of the treatment doses is applicable, then it is possible to illustrate what happens with sensitive patients.

After learning this basic model from Manaka I gradually extended it to incorporate patients with different dosage needs. The following is a model that I developed and that appears to work well for understanding what happens with "sensitive" patients.

## The Sensitive Patient

A sensitive patient will typically show two characteristic differences compared with the typical

patient. First, the TDT drops and can be very low, meaning that it takes very little to trigger change. Second, the width of the optimal dose range narrows considerably; once the TDT is crossed a very slight increase in therapeutic treatment can cross the MTD. Of course, it is possible that the sensitive patient may be very healthy, in which case the TDT is very low and the MTD is high, so that the optimal therapeutic range remains very wide. These are the ideal patients, for whom very little treatment is required to trigger healthful effects and for whom one can do a lot more without any adverse effects. These patients are, in my experience, very rare. Most sensitive patients who show the lowered TDT also show a lowered MTD and thus have a low optimal dose range. This can be seen graphically in Fig. 4.2.

If treatment Y from Fig. 4.1 were administered on this sensitive patient, the time to judge proper dose, T1, is very small, and an overdose of treatment is hard to avoid. Even treatment Z, which has a lower intensity of treatment, would be difficult because T2 is also very small. One has to administer a treatment that is extremely low dose, has a very low intensity, and is mild and gentle: treatment A, if one wants to have any chance of avoiding overdose of treatment on this patient. Here the time to judge treatment dosage (distance from A1 to A2), A3, is much larger than T1 or T2. The use of a very low intensity treatment allows the dose to build up much more slowly, so that one has more time (T3) to make the clinical judgment to stop treatment. This idea is important and is clinically very helpful.

It is necessary to assume that *all* children, even teenagers, fit this profile of the sensitive patient. Certainly, all babies and smaller children fit this profile, but even older children can.

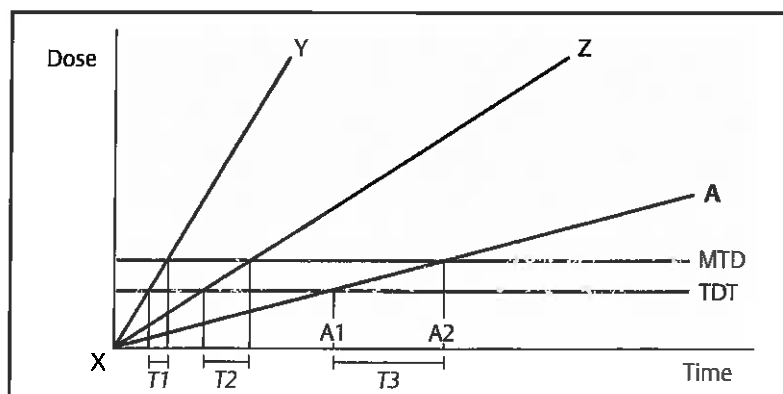


Fig. 4.2 Dose levels for the very sensitive patient (child) with different intensities of treatment (Y, Z, A). TDT, therapeutic dose threshold; MTD, maximum therapeutic dose.

Thus, at least until one has evidence to the contrary, one should approach even older children as being more sensitive. The next section discusses how to adjust techniques to increase or decrease dose and how to match this judgment to each individual child.

## Explanations of Increased Sensitivity

There is a long-standing tradition in Asia that addresses the need to regulate one's emotions. This is an important theme in Confucian, Daoist, and Buddhist thinking. The early medical literature in China followed this theme when it discussed how all emotional expressions represent some kind of disorder of *qi* movement or function in the body, and classified several common emotions in relation to the primary organs (*zang*) in the body (Chiu 1986; Matsumoto and Birch 1988; Unschuld 2003; Birch, Cabrer, and Rodriguez 2014b). These dominant emotions were said to injure their corresponding organ, and each was described in relation to particular *qi* disturbances. The emotions were discussed in relation to health problems. In larger social discourse, the ability to manifest correct behavior and help regulate oneself is necessary to regulate one's emotions. In fact, emotions were not only seen in relation to *qi*, all emotions were defined as or thought to be some *disturbed* movement of *qi*, whether excessively or mildly expressed (Birch et al 2014a). Thus anything that we can do to help control emotional expression can be helpful if our goal is to regulate the *qi* of the patient.

Babies are unable to talk. Instead, they express themselves via their emotions. Of course, we see different manifestations of this: a liver-related expression is an angry one that manifests with a lot of explosive crying and an inability to settle, whereas a kidney-related expression is one of jumpiness, of fearful reactions. But the important issue is that babies and small children have no ability to regulate their emotions. Communication in babies and smaller children is achieved by emotional expression. Thus, in babies and small children, many forms of normal healthy communication can trigger disturbances in *qi* movements and functions in the body. This has immediate consequences: it

tends to make babies and children very sensitive because their *qi* is easily changed involuntarily. Thus one of the goals of treatment is to try not to cause the child emotional distress. As therapists we are trying to help regulate the *qi* of the patient, but if what we do causes emotional distress so that the child starts crying and becomes very upset, this can counter the effects of our treatment and can trigger unexpected reactions. Further clinical implications of this for the treatment of babies and children are discussed in Chapters 17 and 21.

This same issue holds for all children, even teenagers. Sometimes a 4-year-old child can be "very mature," being more in control of his or her emotions than other children of the same age, and it is easier to deal with such a child. Conversely, a 15-year-old may be a physically well-developed child who is emotionally very unregulated and thus "immature." It can be difficult to deal with such a child, who is unable to control his or her responses. The 4-year-old can handle things better than other 4-year-olds, whereas the 15-year-old cannot handle things well in comparison to other 15-year-olds. This becomes apparent in the responsiveness to treatment and how one handles the child.

I will provide various examples of this later, showing how, with a good understanding of this, one can demonstrate treatment effectiveness in how one approaches and deals with the child, and with how one adjusts one's treatment techniques. For example, below the age of 5 we prefer not to have to insert any needles, but beyond the age of 5 we start to think about how and whether we need to insert needles. This is a double-edged idea. On the one hand, needling is frightening, and thus potentially more distressing to a more immature (younger) child. On the other hand, needling is a bigger dosage than the standard *shonishin* techniques described following here; thus it is more difficult to control the treatment. However, there are always exceptions—the emotionally mature 4-year-old can (with good needling techniques) handle being needled better than the immature 15-year-old.

There are several consequences of this for application of treatment with children. First of all, *try not to upset the child during treatment*. This requires attention to several details. Take time over the course of treatment to make sure

that the child is comfortable with you and what you are doing. Don't try to force things unless it is necessary. The therapeutic relationship is very important in acupuncture treatment, especially with children. Some children will immediately like you and what you are doing; others take time to develop trust, especially if they have been chronically ill and have seen many health care providers or have had many treatments. It is thus advisable to take the time over the first treatment to make sure that the child is settled, comfortable with you, and not frightened by you. This has to do with your manner and behavior, and also with how you apply your treatment techniques—how you handle the child. Thus we modify how we apply treatment techniques so that they are not distressing, and we try to choose only those techniques that can be applied without upsetting the child. One pediatric specialist in Japan even recommends not making eye contact with the child during treatment because babies and small children can be easily frightened. Although this last idea can be useful with some babies and small children it is not always advisable. There are some with whom it is better to maintain eye contact to help them feel secure and comfortable.

When we apply techniques that could be distressing, such as inserting needles, we do it in such a way that the child does not feel pain or discomfort. Likewise, if one needs to bleed a *jing* point (which is not often required) it needs to be done in such a way that the child feels nothing and sees no blood. This requires the use of needling techniques that are guaranteed to be painless and sensationless. Such methods of needling are discussed in Chapter 15. A consequence of this basic rule is that we have to be careful how we choose to apply some of our treatment techniques. It does not help to try negotiating with a small child who is frightened of needles. First, get discreet permission from the parent, and then needle in such a way that the child cannot feel or see what you have done. With older children this can be trickier. The example of George shows the successful needling of a 6-year-old.

Besides the difficulty with regulation of emotions, there are other causes of the increased sensitivity we see in children. The more ill a patient is the more sensitive he or she becomes.

### Example

George had been having problems with repeatedly catching colds and having prolonged periods of bronchitis over the last year. He had tried homeopathy but the current episode of bronchitis was not clearing up, and the symptoms of coughing, congested lungs, and disturbed sleep had been ongoing for a few weeks. He agreed to come to try acupuncture only because he had been promised that "Steve will never insert any needles in you." A typical 6-year-old with these symptoms will usually benefit quickly from a few strategically inserted needles, but this was not an option. For the first visit, the task was to make sure that he liked what was being done and that it was comfortable and not frightening. I applied a simple version of the non-pattern-based root treatment described in Chapter 7. I found hard knots around BL-13 on both sides, and left press-spheres<sup>1</sup> on these points.

He came back a week later and there had been some improvement in his symptoms, albeit slight. He was still very wary about the needles and nervous that I might insert some. I repeated the treatment at a slightly higher dose. He returned a week later, with a further slight improvement in his symptoms, but this time he was more settled with me and less worried that I was going to use needles on him. After doing the basic treatment, I turned my back on him while I prepared a 3 mm-long intradermal needle held with tweezers. I turned to him, putting the tiny needle in front of him and asked "Is it alright if I insert this in your back?" He laughed and replied "You can do what you want with that!" I then inserted two intradermal needles at the knots at left and right BL-13, giving instructions to his mother on how to care for them. When he returned for treatment a week later the coughing, lung congestion, and sleep were much better. He took his clothes off, threw himself onto the treatment bed and said "Needle me!" After this I could

<sup>1</sup> There is much more information in Chapter 12 on using press-spheres, but, briefly, the press-sphere, or *ryu*, is a stainless steel ball bearing usually no bigger than 2 mm in diameter. It is secured to a circular piece of tape that can then be pressed onto the skin. In Japan, the press-spheres are placed mostly on body points that are particularly sore and are retained for a maximum of 3 to 4 days.

use a larger variety of treatment techniques to help him fully recover, and to help make sure that the next colds would not linger on as chronic bronchitis.

This means that, in very ill children, it is better to do minimal treatment—even less than usual. Examples given here describe how even the usual low dose of treatment for some children can be too much and can trigger overdose reactions when a child becomes additionally ill with, for example, a cold. I can speculate on why the more ill a patient becomes the more sensitive. Very likely this involves an increased emotional sensitivity. Parents will tend to agree on the observation that when their child is poorly he or she is usually more emotional and more emotionally needy and cries more easily. Thus, when treating a very ill child, it is better to do less. It may seem counterintuitive at times, but it is a better strategy to do less at first while you determine over time what the child can tolerate and what range of dosage is better.

The more run down and weakened a child is, the better it is to do less treatment. Thus, when treating a child after an acute infection like bronchitis, where the child has been ill for 2 weeks with fevers, coughing, antibiotics, poor appetite, poor sleep, and loss of weight, do less treatment at first. Similarly, the child who has had an acute gastrointestinal disturbance with repeated diarrhea will be in an acutely weakened state, so do less treatment.

I would also like to speculate that an additional reason for the increased sensitivity of children, especially smaller children, is that their physiology is accelerated compared with that of adults. Children are continuously growing and require an accelerated physiology to support this. Hence we see a more rapid heart rate, more rapid breathing, and so forth. Because everything is in a more accelerated state we can also see a quicker response to treatment. This makes it necessary to use lower doses of treatment, to do less, to trigger the same degree of change that we trigger in an adults using larger doses of treatment.

## 5 Assessing Changes, Recognizing and Correcting Problems of Overdose

Traditional texts instruct us to gather information through the primary senses to assess a patient and decide what treatment to apply. The “four diagnoses” are the primary modes of information gathering, and among these some of the information is very malleable and sensitive, showing changes very easily and quickly. The color and complexion of the patient can be observed to change quickly so it is reassessable while you are applying treatment. A lusterless complexion can become visibly more lustrous during treatment. Sometimes this is very clear, and the parent as well as you will notice it. But at other times the changes in complexion are subtle, and the lighting source can make them difficult to observe. A more useful and reliable indicator of change is the palpable texture of the skin. With proper training, one can observe this in adults, and it can be very useful. However, with babies and children it is an essential and indispensable observation because the surface of the child's body changes more easily and quickly than that of an adult, and the changes are literally quite palpable and obvious with only a little training. Besides, we direct much of the treatment on babies and children to the skin, the surface of the body.

### Palpating the Skin of Babies and Children

To palpate the surface of the body on babies and children we need to be confident and calm. Use the palm of the hand and the whole palmar surface of the fingers. Touch very lightly so that your hand does not cause a depression in the skin. Apply simple touching and light stroking methods. [MediaCenter.thieme.com](http://MediaCenter.thieme.com) shows the methods of touching and examining changes in skin condition. In general, the skin texture changes in the area one is working on and should be monitored continuously. When change is seen, move on

to the next area. Touching is applied quickly to match the application of the tapping or stroking techniques (which are also applied quickly—see Chapter 7).

The signs of improvement in the skin condition are evidenced by the following changes in skin texture: it becomes springier, a feeling of soft fullness develops, and it may become slightly warmer. If the skin had been dry, it might feel slightly less dry.

A sign of overtreatment is the skin starting to feel moist. One must pay attention to the earliest signs of increased moisture and not wait until the skin pores are quite open and the skin becomes obviously damp or the area starts sweating.

### Reactions to Overtreatment

Sometimes a patient returns to us following a treatment or a parent calls to report that there are difficulties. For example, symptoms are worse, new symptoms have occurred, or the child has been behaving badly or has been much more tired than usual. Our job is to figure out what happened and correct it if possible. Signs of overtreatment must be distinguished from the following:

- Improper treatment
- Healing reaction to treatment
- The natural course of a disease
- Reactions that have little to do with your treatment but are due to lifestyle issues of the patient

As one can imagine, this is sometimes complicated and difficult. To understand when reactions are likely to be due to overtreatment, it is necessary to briefly discuss when reactions are due to these other factors.

The most common sign of overtreatment in children is that the patient is more tired. This

tiredness can last for the rest of the day, in which case it is not so bad and may just be a normal healthy reaction to treatment. If it persists into the next day and especially beyond, you can suspect that you overtreated the patient. On a couple of occasions I have seen young babies become “floppy” for a while following treatment, where they were so relaxed the muscles were acutely and temporarily hypotonic. This did not last long, and although it may be distressing to the parent at the time, it is not a bad sign, merely indicating that you should do less treatment next time. The more common reaction is seen while the child is still with you in the treatment room. He or she becomes quieter, less active, even falls asleep. As you observe this process starting, you know to do less and less for the rest of treatment, and possibly less on the next visit. As mentioned, unless this state of lessened activity persists for extended periods, it is not a problem but is an indication of the probable need for more careful dose regulation. On a few occasions, treatment has led to the child falling asleep and having to be carried out of the treatment room, which can be inconvenient for the parent.

Sometimes overtreatment can lead to increased activity. Usually this is not a problem, but on occasion it has been. On two occasions, despite trying to be careful, first-time treatment of young (5- to 6-year-old) hyperactive children has triggered acute bouts of increased hyperactivity, which were not only stressful in the treatment room but created a period of prolonged hyperactivity that was very difficult for the parents to handle. This is not common, but it can happen. Thus I recommend on a first visit with hyperactive children being even more careful than usual about stimulation levels and dose. Sometimes parents will report on a next visit that they had difficulty getting the child to sleep during the week since the last treatment. This is most likely due to overtreatment, and you need to look carefully at what you did and make appropriate modifications as a result. Typical causes of this kind of reaction are the objects that you leave as mild continuous stimulation of points, such as press-spheres (see Chapter 12) and especially intradermal needles. Not using these things on the next treatment, or leaving them in place for much less time, is usually enough to stop the reaction. Sometimes this

type of reaction to treatment can take a couple of sessions to adjust your approach sufficiently. These can be very complicated clinical cases to handle.

There are atypical reactions to overtreatment, as may be seen in the example. They usually depend on the condition of the child as to how they manifest. The following is a rather extreme example of overtreatment. It is not at all common to see this, but I describe it to illustrate that reactions can be quite severe, even though you appear to have done an extremely light treatment and find it hard to believe it is possible to cause reactions like this.

#### Example

Dianne, a 4-year-old girl with Rett syndrome with the main symptoms of autism, mental development problems, structural and postural problems, and instability (see Chapter 25 for her case study), had a severe reaction to overtreatment. Progress had been good and she was handling treatments well. However, she missed an appointment due to a bad cold, and when she came the next week I misjudged her condition (which was weaker than usual due to the cold). Her reaction to overtreatment was a fear reaction that made her unable to take a step. After she was lifted off the treatment table she would not move. It was necessary to lift her to dress her and then to carry her to the car. This persisted for several days, which was very distressing to her mother. After I acknowledged what had happened and explained why, her mother was happy to continue. With appropriate treatment modification, the effects were improved, and this never happened again. Dianne's strong and prolonged reaction was specific to her disturbed neurological condition.

You must always be honest both with yourself and with the parents about these circumstances. Becoming defensive is a sure way to make the parent lose confidence in you. One of my teachers, Toshio Yanagishita, goes so far as to say that you must accept responsibility for anything that happens after the patient leaves your treatment room (Yanagishita 2003). This is not such an ex-

treme idea, but is more about how you present yourself to your patients. It is an expression about your mental attitude and focus.

In the following sections I discuss how to modify the dose of treatment with the root treatment approach, different techniques, and the symptom-targeting treatment techniques. Details of how to avoid and compensate for overtreatment will be covered in each relevant section.

As a general rule, *when you first see a patient for treatment, don't do too much treatment, keep it very light and simple so it is easier to figure out what to change if there is some reaction to your treatment.* If you at all suspect that the child is even more sensitive, then do not leave anything (e.g., a press-sphere, or an intradermal needle) on the first visit.

#### ■ Incorrect Treatment

It can be difficult to distinguish causes of children's bad reactions to treatment. In general, it has been my experience that applying the wrong techniques or wrong treatment (rather than too much of the right treatment) only worsens the child's symptoms. For example, in Chapter 7, where the various surface-stimulating root treatment methods are described, the dominant methods are those of light tapping and light stroking. The stroking technique is contraindicated for patients with skin conditions like eczema or atopic dermatitis. On one child whose main symptoms were asthma, the rubbing techniques that were applied started irritating and increasing the small patches of eczema. As the asthma symptoms improved gradually the mother realized that the skin condition was worsening. This can happen in the atopic patient anyway, but I realized that we should use only tapping instead of rubbing, and I switched techniques. The eczema symptoms immediately started improving, while the asthma remained improved. Although this was a mild, and in the end, quite successful case, it is an example where the technique of treatment was discovered to be inappropriate for the patient.

I have over the years also figured out that the tapping technique is better avoided or minimized on children with problems of hyperactivity. It does not cause problems in many chil-

dren, but it can increase the risk of causing problems, and I feel it better to minimize or avoid the risk. This is discussed in Chapter 21.

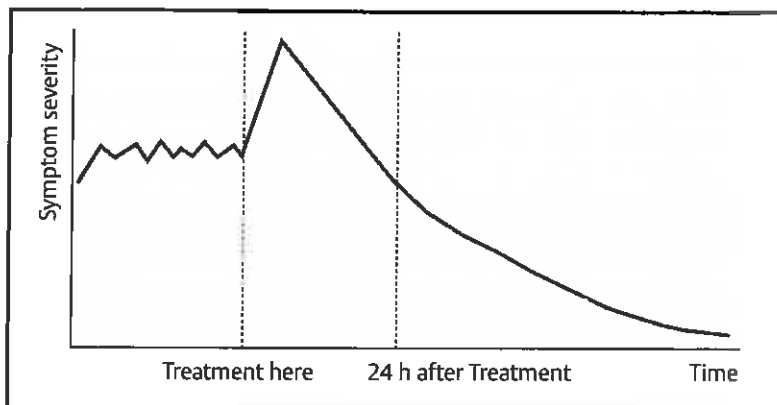
#### ■ Meng Gen—A Healing Reaction

Chinese medicine has the concept of a healing reaction—the *meng gen*. It doesn't seem to happen very often, and most schools of Traditional East Asian Medicine (TEAM) therapy rarely explore it or mention it only in passing. If this *meng gen* reaction should happen, why does it occur and how would it manifest?

In simple terms we can consider that most patients are in a stable state in which symptoms are occurring. We have an idea about a different state that they could be in, where they would have fewer or no symptoms (our diagnosis and root treatment usually target a return to that more ideal state). Our treatment tries to move the patient's system from the current, not-so-healthy stable state, to a healthier stable state. However, the body of the patient thinks that its current state is normal so it resists this change and tries to maintain the status quo. Sometimes this process of resistance triggers some reaction to treatment, such as a worsening of symptoms. A second explanation is that the treatment succeeds in pushing the patient's system out of its unhealthy stable state, but not yet into the targeted healthier stable state. So it stops for awhile in a different stable state in which new symptoms arise or old symptoms recur.

The typical sign that a *meng gen*-type reaction has occurred is that the worsening of symptoms, occurrence of new symptoms, or recurrence of old symptoms *lasts no longer than 24 hours* and is then *followed by a clear and prolonged improvement in symptoms* compared with the level of symptoms before the treatment was given (Fig. 5.1).

Usually this improvement is long-lasting (days, weeks) but sometimes is only short-lived (a couple of days). This short-term worsening followed by improvement can be a clear pattern, but parents can be confused about it, or they may call you as the symptoms develop or worsen. It is not advisable to make any judgments about it too quickly. To understand if this is indeed what has happened requires a longer-term look at the pat-



**Fig. 5.1** Example of *meng gen* symptom intensity changes following treatment.

tern of changes. If the parent calls on the day of a treatment to say that things are worse, it is often impossible to know what is really going on. It may be better to advise to wait until the next day and see if things have settled down. If the parent calls the next day and things are still bad, with no sign of settling down, and it is more than 24 hours since the treatment, you can start to suspect that it is not a *meng gen* reaction and that something else is going on, perhaps a wrong treatment, or more likely an overtreatment. In that case you may want the patient to return to see if you can help. If, for example, you have left an intradermal needle, press-tack, or press-sphere on the patient you can instruct the parent to remove it. If this triggers an improvement in complaints you can then suspect that the intradermal needle, press-tack, or press-sphere was an inappropriate treatment method (which is occasionally the case) or that it created an overdose of treatment (a much more likely explanation). This helps you to understand that the patient is more sensitive than you had thought, and that you should be more careful about the use of that technique in the future.

However, if a patient returns the next week for treatment and reports a short-term worsening or development of symptoms immediately after the treatment, followed by a clear improvement, without having called you about it, it is easier to understand what may have happened. With the time frame of a week you can see the pattern of changes more clearly.

A cautionary note on this topic: I have had a few patients who have some form of brain damage or neurological problems (such as the 4-year-old girl, Dianne—see earlier example) where the reactions to treatment are more prolonged than 24 hours. It is even more difficult in these cases

to distinguish between *meng gen* and overdose of treatment. My recommendation is to always approach such cases as an overdose reaction, and adjust your treatment accordingly.

### Modifying Treatment Methods to Regulate the Dose of Treatment and Deliver Treatment Successfully

If, while you are working on a child, your continuous palpation of the areas you are working on reveals changes, albeit very subtle ones, you can start to understand that the area you are working on may be “done.” Once you recognize this, stop working on that area. Sometimes it is hard to feel these changes; they can be very subtle. You may be treating an unusually sensitive child, and things change much more quickly than you imagine they might. In this case, despite your continuous monitoring by touching, you are beginning to overtreat the area. Stop working on that area the moment you notice this, and assume that the child may be more sensitive than you had previously thought. Consequently, when you go to work on other areas with stroking, tapping techniques, and so on, first, you will be even more attentive and focused on feeling change, and, second, you should be automatically applying less treatment to those regions. This is a very interactive process. Many things may be happening during treatment—the child is moving around, resisting, crying; a sibling keeps trying to interfere or play; and you are continuously dancing around the child to stay ahead of his or her reactions



to you during the treatment.<sup>1</sup> You must remain focused and calm.

In my experience and observation, a common mistake that we practitioners can make is to misinterpret the idea of “intention” and/or the idea of “compassion.” Somehow, armed with our intention or compassion, we try to do everything that we can to address the child’s problems. By this we overtreat the child. We need to be aware that having intention and compassion is more than just doing everything that seems reasonable for the child; we need to keep our sensitivity and clinical judgment foremost. If you can keep your awareness and sensitivity focused while keeping your critical assessments well honed, you can much more precisely fine-tune how your actions guided by your intention and compassion affect the child. These are skills that develop through practice.

Another problem is the overapplication of theory. By this I mean the imposition of a theoretical model on what we are doing, where this hypothetical model becomes like the cloud obscuring the clarity of the blue sky of our actions. It is natural for most of us who practice acupuncture to be interested in and excited by the theories that form the base of our practices. For many Westerners this means the traditional theories from TEAM and, equally for many Westerners and an increasing number of Asian practitioners, the modern anatomical, physiological, and pathological models of biomedicine. When our minds are clouded by too much theory, we can become less sensitive to what is happening in front of us, which can impair the cultivation and development of the skills necessary for optimal application of treatment on sensitive patients like babies and children.

### Thoughts on the Issue of Regulating the Dose of Treatment

In the foregoing brief discussions and explanations I hinted at how complicated it can be to understand the issue of dosage. Homeopathy uses incredibly low dose remedies, where lower doses remove known physical properties and substances. The lower the dose (the more diluted), the stronger the remedy. We have also found in our

studies of Japanese Meridian Therapy, especially the Toyohari system, that there are additional, almost paradoxical, explanations and clinical applications. If the adult patient is too sensitive, he or she may not be able to tolerate the use of a regular needle (even though it is not inserted), so we are instructed to use a *teishin* to lower the dose. The *teishin* has a round, seedlike point on it (see Fig. 2.7 in Chapter 2, p. 9). But sometimes even that is too strong for the patient and we need to lower the dose yet again. Here we are instructed to use gentle stroking with the *enshin* to lower the dose further. The *enshin* is a kind of needle with a round-ball head (see Figs. 2.5 and 2.6 in Chapter 2, p. 9). But sometimes even this is too difficult for the patient to tolerate, so we are instructed to use shallowly inserted thin needles to treat the patient. The act of penetrating the skin is more physically stimulating than the noninserted needling use of the *teishin* or *enshin*, yet it gives a lower dose that the sensitive patient can finally tolerate. This example shows that the simple model described earlier may not be sufficient to explain what is going on in all cases. One possibility is that the different techniques activate different receptors in the patient, triggering different reactions; but this is only conjecture until appropriate research is conducted. However, in the great majority of patients, and for the purposes of clinical explanation, the foregoing model is adequate and has proven to have great clinical value. Recently, a colleague in Spain writing a traditional Chinese medicine (TCM) text on pediatrics included the basic idea, as he has found it to be of great help in using various TCM treatments with herbal medicine, *tui na*, and acupuncture (Rodriguez 2008, pp. 42–44). Another recent pediatric acupuncture text in German has borrowed this model (albeit slightly incorrectly), signifying that the author also finds it to be useful (Wernicke 2009, p. 105).

### Final Thoughts on the Issue of the Sensitive Patient, and Practical Recommendations on How to Improve Your Skills

I have described how judging the sensitivity of the patient can involve various observations

<sup>1</sup> See the discussion of the “dance” of treatment in Chapter 7.

and analysis of specific reported information, but practically, once treatment starts the main method is that of touch. Thus a natural question is: how can you improve your tactile skills?

The obvious answer is practice, practice, practice. Just like the piano teacher would recommend. And, although this is an obvious answer, we can also add some simple exercises. The following recommendations relate to training your skills at touching and your ability to perceive the tiny changes in skin texture that signal changes in the patient or the region of the patient you are working on.

### ■ Exercises

Organize to meet with a few adult friends or relatives or perhaps some colleagues. With each sitting quietly on a chair, have them each roll up their sleeves so that you can palpate their forearms.

Palpate using only your left hand (if you are a right-handed person) or right hand (if you are a left-handed person). When you touch, keep your four fingers together and somewhat relaxed. When you touch, do *not* touch with the pads of your four fingers, rather, touch along the length of the fingers. When you touch, touch very lightly. If your touch causes a depression in the skin it is too heavy. The purpose of this touch exercise is to learn to feel texture differences of the skin, not the underlying subcutaneous tissues and especially not deeper underlying muscle, tendon structures.

#### Exercise One

Examine the palmar surface of the forearms of your friends or relatives.

1. Place your fingers on the skin with either your small finger abutting the wrist crease or your index finger abutting the wrist crease (depending on which position is more relaxed for you to place the fingers). Place the fingers for a second or two, remove and place again. Repeat a couple of times as needed so that you can note the texture, springiness, firmness-looseness, and temperature of the skin. With this touch you place your hand on-off, without any sliding movement. Compare left and right forearms. Perhaps you notice already that there are clear

differences between the left and right forearms of the person you have palpated. Make a mental note of those differences.

2. Repeat this palpation in the middle of each forearm, making a mental note of what you observe on each arm and especially any left-right differences.
3. Place your fingers on the forearm close to the elbow crease and then smoothly, with relatively slow and constant light pressure contact, slide the fingers up to the wrist crease. Repeat this a couple of times and then do the same on the other forearm.
4. After you have done this very light stroking of your fingers along both forearms moving with the flow of the channels from elbow to wrist creases, now repeat the palpation touch applied in 1 and 2 above. How does each forearm in each area feel? Are they different? How is the comparison of left and right forearms? Make note of any changes you observe.

This is very simple and light touch followed by stroking can trigger subtle and sometimes more obvious changes in the skin texture when you re-examine the same areas. Repeat this on the other friends or relatives that are present. You will notice that some will exhibit very little obvious change and you have a hard time noting any differences, whereas for others you will note much clearer changes and differences.

Sometimes, stroking your fingers along the channels as you did in item 3 does not cause much change. If this happens or if you wish to see what larger changes can feel like, you can repeat the gentle stroking at 3, but instead of using your fingers alone use one of the *shonishin* stroking tools, such as the *enshin*, *chokishin*, *Yoneyama*, or *bachibari*, holding it and stroking in the manner demonstrated at MediaCenter.thieme.com. Usually the changes are stronger when you apply stroking using one of the metal *shonishin* tools rather than just your fingers. If one of these tools does not come to hand, you can use the rounded surface of a teaspoon instead, as demonstrated in the home treatment section at MediaCenter.thieme.com.

In this simple exercise when you touched each area of the forearm you did so by extending your senses to feel those areas as sensitively as you could. When you stroked along the fore-

arms you would have been less focused on trying to sense or extend your senses, but would have done so either neutrally, not so much focusing on what you feel, or with an idea in your mind that you are trying to change the forearm so that you can feel changes when you repalpate. This exercise is about training your ability to sense or observe subtle differences and subtle changes in skin texture. The next exercise is to help train you to learn how to touch neutrally, trying not to influence or change things. This is important because a very sensitive patient can start responding to your touch even when you didn't mean to create changes so it is important to train this neutral touch to minimize this possibility. Also, when you palpate on babies and young children, they are often not still and your touch is applied not in a static on-off mode but in a moving or sliding mode. This movement, whether applied deliberately by you or as a result of patient movement, has the potential to create change—thus again the importance of training the neutral touch.

### Exercise Two

Palpating and trying not to create changes as you palpate requires attention to two additional issues: First, what is your internal difference when you palpate and try not to create change versus when you palpate and try to create change? Second, by what measure can you evaluate this?

You can apply the touching and stroking in the same manner described in the first exercise but we need to look at what you are doing that might or might not create change and what to do to monitor or observe if things change.

Practically speaking, both of these aspects feedback to each other, so I describe two methods together by which you can evaluate what is hap-

pening and at the same time monitor what was involved.

Obviously applying touch and feeling whether there is a change or not can be applied, but this is more useful if you have another person also apply the palpation while you do the touching with intention to create change or not. Another less direct, but perhaps more practical, method is to look at how the radial pulses change. In my recent book on *qi* and the channels (Birch, Cabrer, and Rodriguez 2014a) we describe a series of exercises in the last chapters. Palpation of the radial pulses for feedback and two exercises using it are described (Chapter 10, pp. 457–466). You can feel the radial pulse during or after you apply the palpation method or a colleague can feel the radial pulse while you palpate. The key to doing this and getting the more useful feedback is to monitor basic pulse qualities of depth, strength, and speed and see how those change. If there is no or minimal change in the depth, strength, or rate of the pulse as you apply your palpation, you are not creating any meaningful change as you palpate. If, however, the depth or strength or rate of the pulse change as you palpate this tells you that you are creating change with your palpation. By practicing repeatedly and varying your focus, attention, intention, or, more generally, your inner approach as you do the palpation trying to create and trying not to create change, you can see which helps create change or no/minimal change and then try to both remember what was involved and what it felt like. Studying repeatedly with simple techniques like this allows you to accelerate the rate at which you learn to feel the subtle changes in the skin condition that can occur and learn to detect them more easily and quickly. This allows you to refine your diagnostic assessment, your treatment techniques, and your judgments about dose of treatment.