Shonishin: Japanese Pediatric Acupuncture

A Text and Video Guide

Stephen Birch

Second Edition

Foreword by Charles Chace

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Shonishin: Japanese Pediatric Acupuncture

Second Edition

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168 illustrations

Thieme
Stuttgart • New York • Delhi • Rio de Janeiro

Library of Congress Cataloging-in-Publication Data
Names: Birch, Stephen, author.
Title: Shonishin : Japanese pediatric acupuncture / Stephen Birch.
Description: Second edition. | Stuttgart ; New York : Thieme, [2016] | Includes bibliographical references and index.
Identifiers: LCCN 2015040232 | ISBN 9783131500625 (alk. paper)
Subjects: | MESH: Acupuncture—methods. | Acupuncture Therapy. | Child. | Infant.
Classification: LCC RJ53.A27 | NLM WB 369 | DDC 615.8/92–dc23 LC record available at http://lccn.loc.gov/2015040232

Thieme Publishers Stuttgart
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Uttar Pradesh, India
+91 120 45 566 00, customerservice@thieme.in

Thieme Publishers Rio, Thieme Publicações Ltda.
Edifício Rodolpho de Paoli, 25º andar
Av. Nilo Peçanha, 50 - Sala 2508
Rio de Janeiro 20020-906 Brasil
+55 21 3172 2297 / +55 21 3172 1896

Cover design: Thieme Publishing Group
Typesetting by DiTech Process Solutions, India

Printed in Germany by Grafisches Centrum Cuno, Calbe (Saale) 5 4 3 2 1

ISBN 978-3-13-150062-5

Also available as an e-book:
eISBN 978-3-13-162612-7

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Foreword

Traditional East Asian medicine (TEAM) boasts a rich variety of literary genres. The medical discourse (*yi lun* 醫論), the case record (*yi an* 醫案), and the modern textbook are just a few of the most prominent styles of TEAM writing today. Stephen Birch's Shonishin: *Japanese Pediatric Acupuncture* certainly qualifies as a textbook, and it is to some extent a medical discourse and a collection of case reports. But it also belongs to another venerable genre of the TEAM literature that is still in its infancy in the West. In many ways, this is a "clinical insights" memoir.

An entire generation of TEAM practitioners in the West have now fully matured as master clinicians. With 30 or more years' experience in adapting this medicine to practice in the West, members of this generation have begun sharing their clinical insights with the rest of us. The present volume is a rich and very personal expression of this process of transmission by an eminent member of this generation. In this, it also represents the full blossoming of *shonishin's* development and assimilation into TEAM in the West. It is ample evidence that we have truly made this medicine our own.

As much and perhaps more than any other specialty of TEAM practice, *shonishin* rewards knack over theory. It is easy to learn but difficult to truly master. Each practitioner must ultimately "get" the technique in his or her hands. A skilled teacher, however, knows how to effectively communicate that knack to others. Steve brings the sensibilities of a professionally trained clinical researcher to the task of unpacking the *shonishin* practice with consummate skill. This is evident both in his writing and in the materials provided at the MediaCenter. thieme.com website. The book and website combine to bring the techniques vividly to life.

Children are remarkably responsive to therapeutic influence, making them much more prone to overtreatment than their adult counterparts. Though questions of optimal therapeutic dosage are familiar territory for all experienced clinicians, Steve has thought this issue out and articulated it with an unprecedented depth and clarity. The clinical ramifications of his dosing model extend far beyond pediatrics and into medical practice as a whole, almost regardless of the modality being used.

Nowhere in clinical practice is the demand for fluid adaptability to changing circumstances more pressing than in pediatrics. Steve discusses this often unspoken aspect of the therapeutic encounter as the "dance of treatment." Once again, one's sensitivity to optimum dosing lies at the heart of the matter. It is a dance that embraces moment-to-moment decisions concerning which technique to use, what tool to administer that technique with, precisely how much of that technique to administer, and with what degree of force. Then too, it is a dance largely choreographed by a squirming, sometimes squawking partner, and one typically overseen by a pensive parent hovering in the wings.

The themes of therapeutic dose and the fluid dance of treatment run throughout the text. A brief glance at the table of contents reveals the comprehensive discussions of pediatric needling techniques, and expositions on individual diseases accompanied by prescriptive treatment strategies requisite for a textbook on a pediatric specialty.

But the entire book is constructed around case examples. Many of these are from Steve's own practice illustrating his personal approach to both the topic at hand, and its relationship to the dose and the dance. Many other case records are those of colleagues, illustrating a variety of creative approaches to treatment. It is a technique that is best transmitted within the context of specific examples as opposed to theoretical abstractions, though both are necessary for a full understanding.

In some ways, *shonishin* isn't much to look at. It is an unassuming technique that can easily leave one wondering how a bit of stroking, a little tapping, and perhaps even a touch of tickling could have any real therapeutic value. Yet experienced *shonishin* practitioners know how almost miraculously effective it can be. It can work where biomedical, naturopathic, and other TEAM modalities have fallen short, and it combines easily with all of them. In this book, Steve has shown us what a potent tool of efficacy and thing of beauty the *shonishin* dance can be.

Charles Chace
Boulder, Colorado

Preface to the Second Edition

It is only a few years since this book was first published. In this second edition I have updated some of the treatment descriptions and expanded them with newer case histories of my own and of colleagues. I have added a new chapter on the treatment of headaches. I have expanded the chapter dealing with emotional and affective problems. With the help of my colleague and friend Manuel Rodriguez I have also expanded the section on combining the treatment methods in this book with the treatment systems of Bach flowers and Chinese herbal medicine. Here we have focused on the processes of selecting these methods as additional treatments rather than describing how to practice each. I have also expanded the descriptions of how to use the techniques of *shonishin* and the Meridian Therapy root treatment. For these practical expansions I have described a series of exercises to help readers improve their skills and double-check the techniques. It would have been difficult to do this without the creative input and contributions of Manuel, who is great at thinking outside the box for issues like these. The second edition has more treatment information and examples as well as more practical skill development information to help readers develop their clinical skills so that they can perform their treatments better.

Stephen Birch
Amsterdam, June 2015

Preface to the First Edition

I have been treating patients with acupuncture for almost 30 years. I first applied treatment to children over 25 years ago. My practice, since finishing acupuncture school, has been to use Japanese acupuncture and moxibustion methods exclusively. I have studied in Japan numerous times, mostly with practitioners who have more than 40 years of experience (some with 55 to 60 years of experience) and often with practitioners who have extensive experience treating babies and children. In this book I have tried to pull together these experiences and the insights and genius of my teachers. It represents the accumulation of many practical experiences and treatment ideas. I hope I have done these lineages justice.

Over the years I have taught and come across many acupuncturists who hardly if ever treat babies and children. Sometimes this is because of the interests or focus of the practitioner, they specialize in fertility or pain, for example; but more often it is because acupuncture treatment of children, and especially babies, is too scary. Many acupuncturists are not exposed to such treatment in school, never developing the confidence to try. Many are afraid that what they have learned is not suitable for the treatment of babies and children. The child is suffering enough, how can we cause more suffering with our needles? This is a great pity. We sometimes see very inspiring results when we treat children, especially the younger child. It is as though the potential for acupuncture is more strongly expressed in treatment of children compared to treatment of adults. Sometimes the results when we treat children are completely amazing, even shocking. The child who has been diagnosed with a genetic anomaly and is unable to digest food properly suddenly starts digesting food following treatment; the child with a cardiac disorder who has been so tired that she has not been able to play like other children is suddenly running around tirelessly after the first treatment! What is going on? How can this be? Why don't more practitioners try treating children? The answers to these questions lie in how we approach the child and what we think acupuncture is supposed to be.

Many acupuncturists are afraid of treating children because they are afraid of using on children the needling techniques they have learned in school. I know I was, and most people I have talked to have expressed the same fears and concerns. I feel that this is because most people have been trained in only the modern Chinese needling methods, which use relatively thick inserted needles that are manipulated until the sensations called *'de-qi'* are obtained. It seems most acupuncturists think that this is acupuncture. While it seems to be the more commonly found form today, it is by no means the only form of acupuncture. Many styles of acupuncture have developed over the centuries, and, for various reasons, relatively gentle techniques have developed in Japan. Recognizing the sensitivities and needs of babies and children, a specialized style of acupuncture for treatment of children called *shonishin* developed in Japan over 300 years ago. This not only survived but, in the second half of the twentieth century has flourished in Japan. This style applies various surface stimulation methods using specialized treatment tools. Inserted needling is not always needed and often is unnecessary. It is neither painful nor scary. Practitioners who have learned it, patients who have received it, and parents who have observed and experienced it no longer feel afraid of the idea of acupuncture for children.

Another issue that makes it difficult for many acupuncturists to treat children lies in the belief that the kind of acupuncture treatment that they use on adults can be adapted simply by modifying the techniques to some degree (make them softer) but that the same theoretical basis of diagnosis and treatment can be used as with adults. I feel that this is an unreasonable assumption. There is not a lot of published literature in European languages about differences between children and adults based on traditional East Asian medical (TEAM) literature. The historical TEAM literature is not so detailed either; instead we have hints about what those differences may be. Of course the basic physiology must be the same or very similar; children breathe, eat, drink, digest, ex-

crete, sleep, move, etc. with the same organs that adults use. They require the same basic functional systems in order to do these things. But there are some fundamental differences about how things occur, the rate and quality of changes that make children fundamentally different from most adults when it comes to how they respond to treatment and thus how treatment can be applied.

By focusing on those differences and highlighting the characteristics of children, namely that they are very sensitive and thus can be influenced by very little input (the "less is more" model), it is possible to develop a practical approach to the treatment of children that is much less theoretically complex. In this book I have tried to explain and highlight these issues to show how, regardless of how complex a model or pattern another system might construe for a pediatric patient, especially one with complex problems, we can find adaptable, practical solutions with a simpler model of practice. This is key to understanding the treatment approach for babies and children.

For a number of years I have wanted to write a practical book about the treatment of children using the unique treatment approaches from Japan called *shonishin*. I kept delaying, in part because of being busy and in part because I was not quite ready; I needed time to work out a strategy for making the book both practical and realistic. This text and its accompanying DVD are the product of those desires, plans, and strategies. I also resisted writing a *shonishin* book before because I did not want to write the same type of book that is often found in the field. Many books focus on telling the reader what points to treat for which symptoms or patterns. Once the correct points have been selected, then everything is supposed to right itself, so we almost never find descriptions in these books of what to do if it doesn't work. I find this approach rather unhelpful, even when such books are based on a traditional system of diagnosis and matched treatments. I find many of these books so theoretically driven that they are not typically rooted in clinical practice and are not structured to help the reader easily adapt to changing circumstances, ineffective chosen treatments or matching to the individuality of each patient. I wanted to avoid falling into the same trap with the book I wanted to write. I have also been concerned that too many practitioners think they can learn practical skills just from reading books. I know from my own experience that this is not realistic. Imagine learning to play the piano from reading books! Thinking about these problems I was delighted to find that my colleague Rayén Antón had worked in the media of film and editing before, so I found I was able to start this project with the plan that we could at least let people look at what is to be done, which is definitely better than simply reading about it. I believe the old adage "a picture is worth a thousand words" starts to cover this idea. Working with Rayén I have been able to complete this project. We both hope that the format and content of this text and DVD will sidestep the limitations I have worried about, will help to get more practitioners started in the treatment of babies and children, and will enhance the effectiveness of those who already treat them.

The first section deals with the origins and nature of the *shonishin* approach. It explores the origins of its approaches in the historical early Chinese literature and shows how these were adapted and adopted into Japanese traditional medicine several centuries ago.

The second section explores the nature of the physiological and treatment response differences of children with most adult patients. Principally it focuses on their innate increased sensitivity and the clinical implications of this in terms of dose and regulating the dose of treatment. It also describes how one can practically grasp and attend to these differences and, through palpatory feedback, continuously adapt treatment as it is being given to ensure proper clinical applications. It also describes the various treatment tools. Here I have focused on showcasing my private collection of *shonishin* tools organized along traditional ideas of treatment method.

The third section describes two basic forms of applying "root treatment" (Chinese "*zhibenfa*"), the principle purpose of which is to strengthen the body's natural healing abilities by helping regulate physiology. The first of these is the "non-pattern-based root treatment" system which is the core of the *shonishin* treatment method. This method, regardless of the child's symptoms and any "traditional patterns" of diagnosis, applies light stimulation in set patterns to the body surface using the tools described in the previous section. This approach targets an improvement of the vitality and mood of the child and through this a strengthening of the natural healing abilities. The second root treatment system

is the "pattern-based root treatment" approach, a simplified form of traditional Japanese acupuncture called *Keiraku Chiryo* or Meridian Therapy. First I outline the use of this approach on adults and then its diagnostic and treatment modifications for children. This method focuses on regulating the *jingluo* (Japanese "*keiraku*") or channels while at the same time strengthening the child's vitality and natural healing ability. In actual clinical treatment, one can use only the Meridian Therapy root treatment approach, only the "non-pattern-based" *shonishin* treatment approach, or a combination of these two. It is also possible to teach the parent to do a simplified form of the core *shonishin* non-pattern-based treatment at home regularly. This is also described in this section and can greatly enhance treatment effects and speed up recovery time.

The fourth section describes symptomatic treatment approaches, the use of normal acupuncture treatment methods strictly adapted to the unique needs of children. This covers adapted forms of needling, moxa, retained dermal stimulation methods such as press-spheres, press-tack needles and intra-dermal needles, cupping and bloodletting. Point locations are also covered as needed both for the main root and extra symptomatic treatment points.

The fifth and final section of the book describes how to use all of the diagnostic skills and methods and treatment methods carefully selected in adaptable and evolving treatments for a number of different health problems. Most importantly I wanted this to be practical, thus many case histories are described. I received help from colleagues around the world who sent me some of their most inspiring cases. For each condition I give clinical example(s) of how the systems are used and a range of treatment ideas and suggestions for each condition, with details of how to select between them and what to do if they are not working. In this section I also describe treatment of underlying issues as well as specific symptoms. For example, there is a chapter on constitutional diagnosis and treatment, which is important when dealing with children with severe and complex health problems. Similarly there is a chapter on strengthening the vitality, which is the principle reason for applying a "root" treatment to begin with. But in some children, one can only focus on treating to improve the vitality so as to strengthen the natural healing ability, for example prior to surgery, so as to improve recovery afterward.

Nothing works on everyone. No system of treatment is ever fool proof. No single individual practitioner is free of limitations. We must start with these axiomatic truths to build a practical, adaptable, and responsive system of treatment. It has been my hope and intention in the writing of this book to keep these limits in mind while laying out strategies that allow the reader to develop a practical system that they can make work for them. I have placed a practical palpatory based understanding of qi at the heart of the treatment approach, which is natural given my teachers and training in Japan. I hope you find the book useful and stimulating.

Stephen Birch

Acknowledgments

As always, writing a book is not possible without the help and support of others. First, thanks to my family and friends for their support and understanding.

Second, this project is as good as it is because of the work and talents of my colleague and friend Rayén Antón who helped me with the structure of the project, all illustrations, and video work. Her assistance and collaboration have been invaluable. I feel fortunate to have worked with her and look forward to future projects.

Third, the contributions of my friend and colleague Manuel Rodriguez have been really helpful in this second edition. His creative thinking and down-to-earth approach is invaluable.

Fourth, thank you goes to a number of other people: Junko Ida for helping me with translations of the Japanese materials that provide the background for the materials organized and presented in the book; Josephine Haworth for help with editing of the text; my editor Angelika Findgott for her support and encouragement of the project, and her team at Thieme Publishers for their care and assistance; my colleagues Brenda Loew and Paul Movsessian, for their support and encouragement of the project, and Manuel Rodriguez for giving an extra hand; thanks to Michael Blanz of mb Film & Video and David Ferrando Navarro of Xochipilli Producciónes for their technical help with the video materials; to David Ferrando Navarro also for photography; to my teachers who helped me improve and deepen my skills, in particular Yoshio Manaka, Toshio Yanagishita, Akihiro Takai, Shuho Taniuchi, Koryo Nakada, Yukata Shinoda; to a number of colleagues listed here alphabetically who agreed to send me their cases to be included in the book: Rayén Antón (Spain), Mourad Bihman (Germany), Joke Bik-Nwee (Holland), Zoe Brenner (US), Marian Fixler (UK), Bhavito Jansch (Switzerland), Brenda Loew (US), Paul Movsessian (Australia), Diana Pinheiro (Portugal), Sue Pready (UK), Bob Quinn (US), Manuel Rodriguez (Spain), Dan Zizza (US)—their contributions add much to the book; to Hitoshi Yamashita who helped track down pictures in Japan, and to the Harikyu Museum, Osaka for permission to use these pictures; to Sayo Igaya for help tracking down historical information about *kanmushisho*; to Wolfgang Waldmann and the European Institute of Oriental Medicine, Munich for permission to videotape my workshop there in November 2008; to Stefan Maegli of Liestal, Switzerland and Hamid Montakab of the Academy of Chinese Healing Arts, Winterthur, Switzerland for permission to videotape my workshop there in February 2009; to the various children, parents, and students who participated in the workshops at these acupuncture schools, especially those who appear in the video; to Elias and his mother Hetty for agreeing to star in the video; to the original practitioners of *shonishin* in Japan several centuries ago who created this wonderful system; and finally to my patients for teaching me about healing and to their parents for helping with the treatments.

Finally, I dedicate this book to my son Nigel, for living this with me, and to my mother for making it all possible.

Section I Overview and History

1 Introduction

The term *shonishin* (小兒鍼) is a Japanese rendering of the older Chinese term *erzhen* (兒鍼). It literally means "children's needle" or "children's needling." Acupuncture has been used for a long time on both adults and children; hence we find the term *erzhen* in the early Chinese literature. However, today the Japanese term *shonishin* refers to a tradition that dates from the 17th century. Although there is speculation about its precise origins and its development, its widespread use appears to have started in the late 20th century in Japan. Several practitioners, such as Yoneyama and Mori, who wrote a text entitled *Shonishin Ho—Acupuncture Treatment for Children* (1964), and Shimizu, who wrote an extended section on *shonishin* in a well-known Japanese acupuncture journal, *Ido no Nippon (Journal of Japanese Acupuncture and Moxibustion)* (1975), helped set the stage for a more widespread adoption of this method within the acupuncture community in Japan. This was further reinforced by the publication of articles about *shonishin*, pediatric acupuncture, by various other authors. Today, many acupuncturists treating children use these methods or variations of them in Japan. These methods started spreading outside Japan to the West by the 1980s, where further modifications began to appear.

I have used these methods in the treatment of children since 1982 and have played a role in introducing these methods in various regions in the United States, Europe, and Australasia over the past 20 years. This book is a culmination of having used and adapted these methods to a modern Western-based acupuncture practice over the past 30 years. This book is primarily a practical guide for using these methods to treat children, but it also briefly covers the history of and theoretical justifications for these methods.

In the West, the common styles of acupuncture are Chinese based and Western anatomically based. Both styles consider acupuncture to involve *only* the use of inserted needles. I have found that, because the methods of *shonishin* often do not involve the use of inserted needles, it is conceptually foreign to the acupuncturist trained in both Chinese and Western styles; thus it is not yet well known among the acupuncture community in the West. I have also found that many acupuncturists in the West are afraid to treat babies and small children because they have to insert needles, which makes pediatric acupuncture less popular overall than it could be. This is unfortunate because it is very effective, and children generally respond more quickly to treatment than adults. After teaching *shonishin* to acupuncturists in the West, especially in Europe, I have found that it often has a transformative effect on how those acupuncturists practice. Many feel able for the first time to treat babies and children, where before they had been afraid to. Sometimes remarkable results can be seen. In the United Kingdom, there is a saying, "The proof of the pudding is in the eating." Knowing that the reader will not take this at face value without evidence, I have consulted with several colleagues in Europe, the United States, and Australasia and asked them to submit their cases. The evidence will speak for itself. It is hoped that, after reading this book and going through the online content available on MediaCenter.thieme.com, so as to properly grasp the methods, readers will try the *shonishin* method themselves and understand the power of the system.

The treatment works, and it works well and quickly in many cases. This book focuses on practical, reproducible methods. The content available on MediaCenter.thieme.com also makes the materials covered more practical and reproducible. A more detailed description of conceptual and theoretical explanations will have to wait until a later time. This is a pragmatic system, the practice of which requires minimal theory. Readers are encouraged to think about how the treatment works after they have practiced it for a while and seen the often surprising results.

The historical, theoretical, and associated diagnostic sections are consequently relatively simple, short, and easy to understand. The bulk of the text is more practically oriented. It includes discussions on how to work with children, how to modify what one usually does as an acupuncture practitioner to treat babies and children, how to use the unique methods that arose in the *shonishin* tradition, and how to combine all of these to match the needs of each individual patient.

This book does not take a typical textbook approach by describing which points and techniques are good for which diseases or symptoms; rather, through varied case histories, it illustrates how to use the tools and methods described within to help patients. These cases are taken mostly from my own experience, but a number of them have been provided by colleagues worldwide who have been using the *shonishin* methods for their pediatric patients. To successfully treat infants and children, we have all found that it is necessary to be very flexible and adaptable. This material has been selected and presented in a manner that best illustrates and encourages such flexibility and adaptability.

The basic *shonishin* treatment method takes a very practical approach to treating babies and children, using a basic treatment methodology that does not require differential diagnosis according to traditional principles and methods. It does not have to differentiate the types of patterns that are found in, for example, traditional Chinese medicine (TCM) acupuncture using the language of *qi, zang fu*, channels, and so on. The characteristic treatment of *shonishin* is a "non-pattern-based root treatment." It is a simple, easy-to-apply general treatment on the surface of the body that is used for all babies and small children and many older children. This general treatment helps restore and stimulate the body's natural healing mechanisms, which is the goal of a "root treatment."

When treating adult patients, I mostly use the Japanese system of *Keiraku Chiryo* or Meridian Therapy (Shudo 1990), especially the Toyohari approach (Fukushima 1991) and the methods of Manaka (Manaka, Itaya, and Birch 1995) along with miscellaneous Japanese methods (Birch and Ida 1998). When treating children and babies it is hard to put all this information aside. Rather, it is natural to integrate aspects of these approaches along with the *shonishin* approach. For almost 25 years I have routinely combined selected aspects of these treatment approaches with the *shonishin* methods to treat babies and children. In particular, I combine a simplified form of Meridian Therapy and Japanese acupuncture methods along with the *shonishin* methods. This allows the application of a simple form of "pattern-based root treatment" according to the principles of Meridian Therapy and the addition of an expanded range of treatment methods to target symptoms. Thus this book will cover sufficient information to describe how to use these additional approaches and will give examples of the integrated approach that I use. I have taught this integrated approach for over 10 years throughout Europe and have found it is easily learned and adopted. My colleagues and I find it to be a very effective and flexible combination of treatment approaches.

Readers will naturally seek to integrate the new *shonishin* treatment system into their own practice, using at least some of the ideas and methods that have been learned on adults. Therefore, it is important to show how to do this. However, I do not use the common styles of acupuncture found in the West, such as some forms of Chinese needling or some forms of the Western anatomical approach, and so cannot illustrate specifically and through experience how to integrate *shonishin* with these methods. But, having taught many acupuncturists who primarily practice these styles **(Fig. 1.1)**, it is my experience that, by illustrating the principles of treatment of children and babies and giving examples of how to integrate adapted forms of my usual (adult) acupuncture methods with the *shonishin* methods, this will be a useful guide for others on how to integrate their methods of acupuncture with *shonishin*.

Because there are several other texts available on pediatric treatments within the field of Traditional East Asian Medicine (TEAM) that describe the standard information on normal development, growth, and physiology of children, I will not repeat this information here; rather, the reader is referred elsewhere for that standard

Fig. 1.1 Treating Pim in class.

information (in English, see Scott and Barlow 1999; in Spanish, see Rodriguez 2008). There are also many acupuncture books describing point locations, pathways of the *jing mai* (channels), functions, and so on of the *zang fu* (organs). For this basic acupuncture information, readers are referred to an appropriate text, such as Ergil and Ergil (2009) *Pocket Atlas of Chinese Medicine* and Hempen and Wortman Chow (2006) *Pocket Atlas of Acupuncture,* both also published by Thieme. For the most part, the system of *shonishin* is very practical and not very theoretical; thus it is not necessary to use so much of the information available in other texts. The history and diversity of acupuncture practices dictate the need for flexibility. Acupoints, for example, are not fixed anatomical structures; they are instead related to movement of *qi* in the body,[1] which means that they are found within a small region rather than at a fixed point. Further, the different traditions of practice have located many acupoints in different locations (Birch and Felt 1999). For the reader unfamiliar with Japanese traditions of acupuncture practice, some of the point locations in this book will, however, be new. Where appropriate, point locations are described.

[1] This is discussed by Sivin (1987:51), Lo (2003:31), Lu and Needham (1980:14), and Birch (2014:193–202).

2 History and Theory

Shonishin for babies and very small children does not use regular acupuncture needles; rather, it uses a variety of tools that are tapped, rubbed, or pressed onto the body surface in a very gentle, noninvasive treatment approach. **Fig. 2.1** shows several typical tools used today, and **Fig. 2.2** shows photograph of tools in Hidetaro Mori's historical collection.

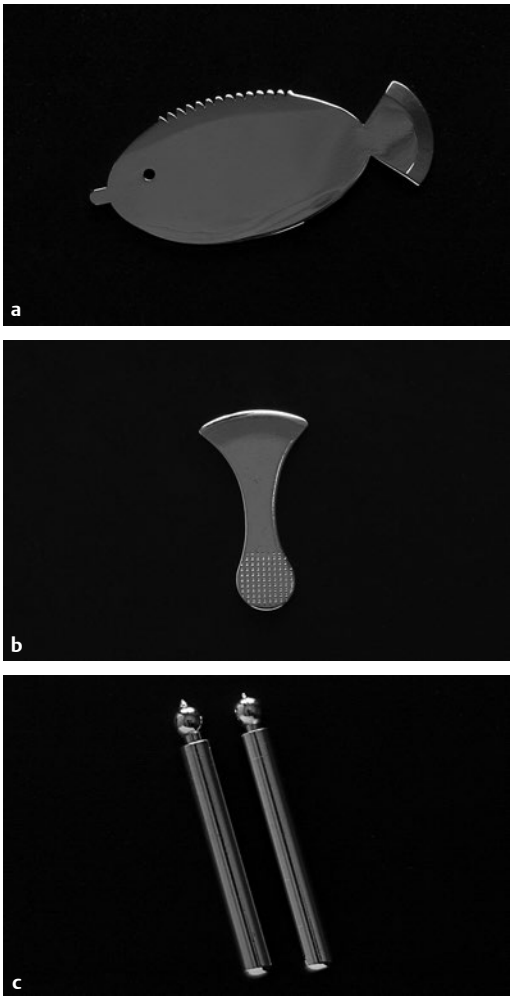

Fig. 2.1(a–c) Examples of modern treatment tools.

These tools do not incorporate needles; they are not inserted into the skin and thus not into acupuncture points. In fact many tools are applied over areas of the body surface rather than targeted to acupuncture points. **Fig. 2.3** shows areas of the body that are typically stimulated.

So what is the history of this method and what are the precedents for such ideas and methods? It is believed that *shonishin* began as a medical family treatment method in the Osaka area around 350 years ago. It takes little imagination to understand that the practitioners of that time would

Fig. 2.2 Collection of modern and historical tools from Hidetaro Mori's collection at the Harikyu Museum, Osaka. (Courtesy of Mori H, Nagano H. *Harikyu Museum. Museum of Traditional Medicine.* Vol 2. Osaka, Japan: Morinomiya Iryougakuen Publishing; 2003. Special thanks to the editor Ms. Oda and to Hitoshi Yamashita for his assistance.)

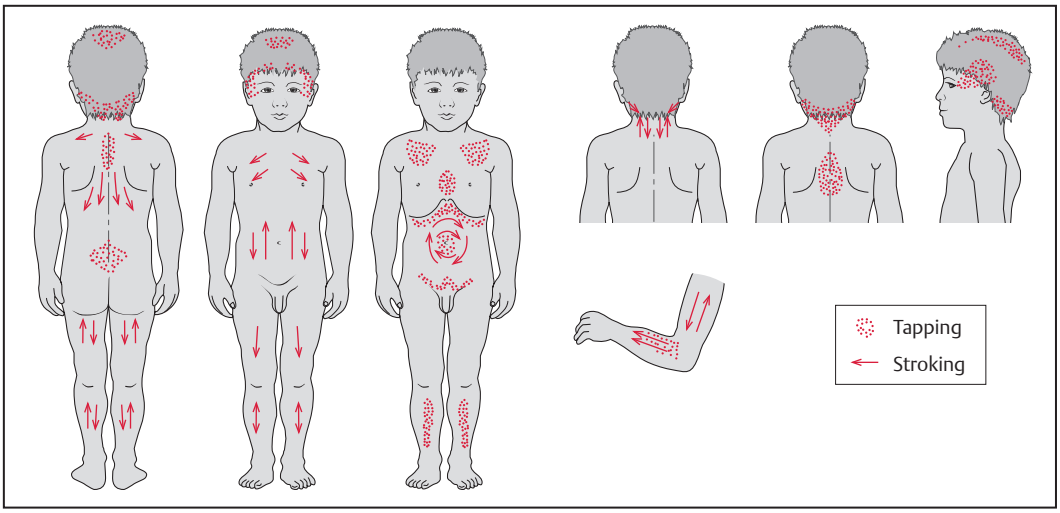

Fig. 2.3 The basic treatment map from Yoneyama and Mori (1964). Apply tapping techniques where there are dots and stroking techniques where there are arrows.

have had the same or greater problems than we have today, trying to insert needles into emotional, frightened, unhappy, resistant, restless, moving children. I say *greater* problems because needle technology was not at all as it is today; the needles available in the 1600s were significantly thicker and had a rougher surface than what is available now. Nobody enjoys treating children when they are crying, screaming, and resisting treatment. Thus, it is easy to understand why the developers of *shonishin* would have sought a different approach; one that would be more comfortable for the child and less stressful for the parents. The motivations for developing the system are clear.

Given this kind of motivation it is still necessary to understand how this approach developed by briefly discussing historical trends within the larger context of Traditional East Asian Medicine (TEAM). The term *TEAM* refers to all those therapies and approaches that arose in East Asia and were strongly influenced by the early Chinese medicine *qi*-based theory of systematic correspondence. It thus includes diverse practices, such as herbal medicine, acupuncture, moxibustion, cupping, bloodletting, and massage (Birch and Felt 1999). TEAM started in China and evolved there into many different strands and approaches. After spreading to neighboring countries, such as Japan, Korea, and Vietnam, adaptations and new interpretations emerged from those countries. Today TEAM embraces the multitude of practice styles and treatment approaches that can be found throughout China, Taiwan, Japan, Korea, and their offshoots outside Asia, such as in Europe, the United States, and Australasia (Birch and Felt 1999). The commonly used system of traditional Chinese medicine (TCM) is a subset of the larger field of TEAM, representing a unique and broad combination of historical and modern methods and ideas.

Historically in Japan, medical texts were written in Chinese; thus literate medical practitioners in Japan read Chinese source texts for information about medical practice. When *shonishin* was developed (17th century) there were many texts and traditions of medical practice available to a literate practitioner. The first specialized pediatric texts in China and thus in Japan were, however, exclusively herbal medicine texts (Gu 1989). Given the fear that can be encountered using acupuncture on children, it is not surprising that the trend in China might have been toward using herbal medicines rather than acupuncture in pediatrics. This is not to imply that acupuncture, moxibustion, massage, and other such methods were not also used, but the dominant trend in Chinese pediatric treatments has been herbal medicine. The evidence for this is found in many modern TCM

texts on pediatrics (Cao, Su, and Cao 1990). We can imagine that those who developed *shonishin* were not much influenced by these pediatric herbal texts: but why?

Before the sixth century, Japan was isolated and had little knowledge of China. After embracing Chinese ways, the Japanese of the day began a wholesale import of everything Chinese. The first medical texts were brought to Japan in 562 CE by Chiso (or Zhi Cong in Chinese), a Korean Buddhist monk (Birch and Felt 1999). At the time of this first appearance, Japanese practitioners were content to study and copy what these older Chinese traditions could teach them. Because the first medical texts from China were, by and large, acupuncture related or herbal medicine related rather than a combination of both, (though some early texts did combine them), it seems clear that the Japanese at that time began imitating this older tradition. From early on, acupuncture and moxibustion were taught and learned separately from herbal medicine (which one can say is a kind of homage to the ancients, who for the most part worked the same way). The first Imperial Colleges established in 702 CE taught acupuncture and herbal medicine separately in 7-year programs (Birch and Felt 1999, p. 23). This tendency for separation thus became the tradition.

Most acupuncturists in Japan have worked very little with herbal medicine, if at all, and vice versa. Although there were sections in earlier Chinese texts dealing with pediatric care, such as Sun Simiao's *Bei Ji Qian Jin Yao Fang (Thousand Golden Essential Prescriptions)* (ca. 652 CE), the first text devoted to pediatric treatment was the herbal text *Lu Cong Jing* (*The Fontanel Classic*) of the mid-10th century (Gu 1989). Additionally, the primary pediatric texts were dominantly herbal medicine texts, including the important and very influential *Xiao Er Yao Zheng Zhi Jue* (*The Correct Execution of Pediatric Medicinals and Patterns*) of 1107 (Gu 1989). Given these facts, it is highly probable that the literature specializing in pediatrics from China would have provided no assistance to those who developed the *shonishin* system. Not only because its treatment methods were inaccessible, but also because the diagnostic methods and the theories of physiology and pathology needed for safe and effective herbal prescription would likely have had little utility as well. For example, tongue diagnosis developed within the domain of herbal medicine practices, and to this day, many acupuncturists in Japan do not use tongue inspection because it is thought of as being a tool used by herbal medicine practitioners.

Are there other ideas in the acupuncture-related literature that could provide a basis for treating children? After reading various texts and sources over the years I believe that the answer to this question is yes. I have found several ideas and descriptions that may well have provided the ideas and precedents influential for those who developed *shonishin.* Although it is not possible to provide a definitive answer to this question, the information described following here represents a potential, or at least a partial, explanation. To answer this question, my speculations are based on small pieces of evidence found in various sources.

First, the *Huang Di Nei Jing Ling Shu* (*The Yellow Emperor's Inner Classic Spiritual Pivot*, originally called the *Zhen Jing* [鍼經] or *Needle Classic*), specifically Chapter 1, describes nine kinds of needles, only one of which is the regular thin filiform needle widely used today (**Fig. 2.4**).[1] Of these nine needle, two were explicitly described as round-headed "needles" that were to be pressed onto the body or rubbed along the surface of the body (the book *Japanese Acupuncture: A Clinical Guide* by Birch and Ida 1998, pp. 39–57, summarizes the historical descriptions from the *Ling Shu* and some modern ideas about the nine needles and how to use them).

The *yuanzhen* (Japanese *enshin*) was described as having a round head and was to be used by rubbing on the body—**Fig. 2.5** shows a modern form of the *enshin* from Japan; **Fig. 2.6** shows a historical image from East Asia of the *yuanzhen.* In each case one can see a similar image of the *yuanzhen* or *enshin* as having a rounded end. Likewise, the *shizhen* (Japanese *teishin*)

[1] See the illustrations on page 40 of *Japanese Acupuncture* (Birch and Ida 1998) for various interpretations of what these nine needles look like.

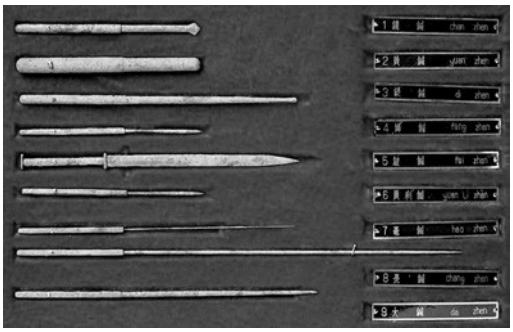

Fig. 2.4 The "nine needles" of the *Ling Shu*. From Hidetaro Mori's collection at the Harikyu Museum, Osaka. The filiform needle is number 7, third from bottom. (Courtesy of Mori H, Nagano H. *Harikyu Museum. Museum of Traditional Medicine.* Vol 2. Osaka, Japan: Morinomiya Iryougakuen Publishing; 2003. Special thanks to the editor Ms. Oda and to Hitoshi Yamashita for his assistance.)

Fig. 2.5 Modern form of the *enshin* from Japan.

Fig. 2.6 Historical form of the *enshin* (*yuanzhen*). (See also different images in Birch and Ida 1998, p. 40.)

was described as a thicker needle with a rounded point, reminiscent of a millet seed, used for pressing the body surface. **Fig. 2.7** shows two modern *teishin* from Japan and **Fig. 2.8** a different historical image.

Another of the nine needles, the *chanzhen* (Japanese *zanshin*—literally the "arrow-headed needle") was described as having a sharp edge and was used for lightly cutting the skin (much like a paper cut). It does not penetrate the body; rather, it breaks the skin only. **Fig. 2.9** shows the arrow-headed point of the *chanzhen*. Although this instrument was intended originally to break the skin, various modern forms of it are used for

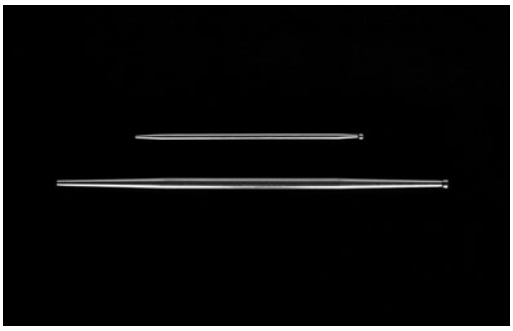

Fig. 2.7 Modern forms of the *teishin* from Japan.

Fig. 2.8 Historical form of the *teishin* (here called *dizhen*). (See also different images in Birch and Ida 1998, p. 40.)

Fig. 2.9 Historical form of the *zanshin* (*chanzhen*). (See also different images in Birch and Ida 1998, p. 40.)

rubbing or scratching on the skin surface rather than breaking it. Today the *zanshin* has taken on a variety of forms in Japan. **Fig. 2.10** shows a typical shape for the *zanshin*, and **Fig. 2.11** shows a conically shaped version.

From this one can easily see a clear precedent for the idea of using hand-held instruments (interestingly called *zhen* [鍼], "needles") that could be used for rubbing, pressing, or scratching on the body surface, rather than penetrating the body (like the needles we commonly use today). It therefore seems likely that those who developed *shonishin* were influenced by these old ideas about needle types and needle methods and started experimenting with different constructions and surface stimulation applications.

What about the acupuncture points? Why is it that much of the therapy is targeted to regions of the body rather than the usual acupuncture points (as we tend to find in the treatment of adults)? Here it is easy to speculate, so I shall keep it short and simple. There is a very clear statement in the *Huang Di Nei Jing* (*Ling Shu,* Chapter 10) about how *qi* does not start moving and circulating in the *jing mai,* or channels (meridians),

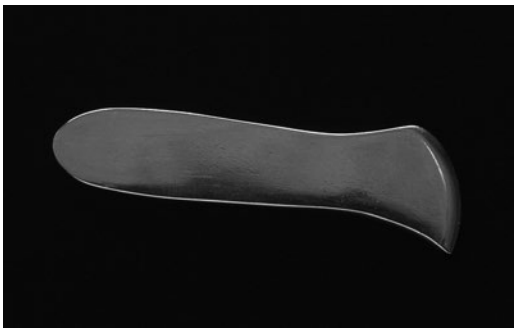

Fig. 2.10 Modern form of the *zanshin*-like instrument.

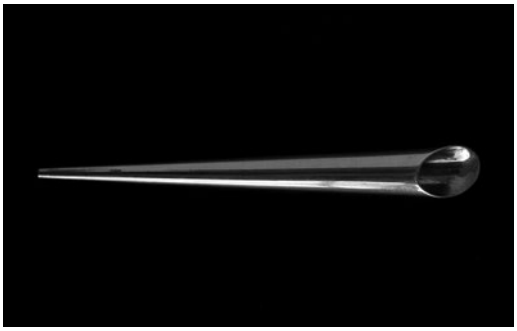

Fig. 2.11 Modern conically shaped form of the *zanshin*.

until after birth. *Ling Shu,* Chapter 10, describes the development thus:

> *The Yellow Emperor said "[after] the person's conception, the jing is first composed. The jing composes the brain and bone marrow. The bones become the stem [the spinal column forms?]. The vessels become the ying [nourishment]. The muscles become firm. The flesh becomes [like a] wall. The jing is hard, and then the hair and body hair grow. [After labor when the] gu [grains] come into the stomach, the vessel-meridian pathways are [all] connected, the blood and qi [begin to] move."*

This, of course, makes sense when one is familiar with historical ideas about the circulation of *qi.* One of the most important early ideas in acupuncture that has remained influential is that the *qi* circulates through the 12 *jing mai* or channels in a continuous circuit. It is propelled through the *jing mai* by breathing, moving 3 *cun* with each inhalation and 3 *cun* with each exhalation (*Ling Shu,* Chapter 15, and *Nan Jing* [*Classic of Difficulties*], Chapter 1, are quite clear on this point [Matsumoto and Birch 1988, pp. 77–78]; see also Birch 2014, pp. 188–190). The lungs were seen as a kind of pump for the *qi* as a parallel to the heart as a pump for the blood. Since the *jing mai* have thus not yet started circulating the *qi* before birth—this circulation beginning only with the first breath after birth—one can imagine that this is not yet a well-developed system and could reasonably be thought of as being different from that found in an adult. Thus, in a newborn, the *jing mai* can be thought to be in an immature state. Further, we know that each *jing mai* was described as having intimate relationships with at least two internal organs, often being "branches" of those organs (Matsumoto and Birch 1988, p. 50). At birth, several of these organs have functioned little as well and exhibit considerable changes over the next few years as the child grows and matures. Thus the evidence about acupuncture points shows that they were not mentioned before the system of *jing mai* or channels had been described (Birch 2014). Rather, they were first described at the same time that the theory of *qi* circulation in the channels was proposed, and they are related to the movements of the *qi*, rather than to the underlying anatomical structures. Based on this, one can easily imagine that the acupoints start forming out of the developing *jing mai* or channel system. *Ling Shu*, Chapter 1, describes the nature of the acupoints thus: "At the articulations within the body there are 365 points of communication . . . 'articulations' refers to where the divine *ch'i* [sic] travels freely and moves outward and inward, not to skin, flesh, sinews, and bones." The translator of this passage, Nathan Sivin, continues: "A modern Westerner expects these points of communication, where the physician's needles can affect the circulation, to be places in tissue, but here we find them related instead to processes" (Sivin 1987, p. 51).

It is very easy to continue speculating here, but the point I am trying to make is that it is not unreasonable to think of the channels and their acupoints as being in less-well-developed states in babies and small children, and that at some time in the child's development they reach a state of development that makes them similar to

those found in adults. There are other ideas and sources that support this idea. Li Shizhen is famous as the author of the seminal herbal medicine text, the *Ben Cao Gang Mu* (*Materia Medica*). He also wrote a small treatise on the extraordinary vessels, the *Qi Jing Ba Mai Gao* (*The Eight Extraordinary Vessels Examined*), ca. 1578. This places the text as predating the development of *shonishin,* but it is important for us here because Li Shizhen was a considerable scholar of older ideas. This text has been translated by Charles Chace and Miki Shima (2010). Of interest here is a short passage in a discussion on the origin of the extraordinary vessels. A Japanese colleague drew my attention to this passage as evidence for the immature state of the channels in babies and children and thus a theoretical reason that could have contributed to the development of *shonishin* (Kurita, personal communication, 1989). My crude translation of this passage renders it thus: "All people have these eight vessels. They belong to the *yin shen. They close and do not open.* Only the [Daoist] adepts can push them open with their *yang qi.* Therefore [by this means] they are able to grasp the *dao*" (Anon 1970; Wang 1990). Chace's more refined translation does not contradict the interpretation my colleague explained to me: "All people have these eight vessels but they all remain hidden spirits because *they are closed and have not yet been opened.* Only divine transcendents can use the *yang qi* to surge through and open them so that they are able to attain the way" (Chace and Shima 2010, p. 110). I have italicized the relevant line. *The eight extraordinary vessels are closed in adults.* My Japanese colleague speculated that, since before birth the 12 *jing mai* are similarly not functioning or are closed, instead, something else—the extraordinary vessels—had the function of helping regulate *qi* movement in utero. After birth the 12 *jing mai* start to function, and then, gradually, as they mature, they take over and replace the functioning of the extraordinary vessels. At a certain point (in most people) the extraordinary vessels would become closed while the 12 *jing mai* would take over the function of helping regulate *qi* movements in the body.

I am not saying this is correct, but rather that important historical ideas and passages have been interpreted as showing precedents to the notion that the channels and their acupoints are immature at birth and thus temporarily of a different nature until they reach a more mature state. Nor should the reader interpret that I am suggesting or supporting the use of the extraordinary vessels as a specialized treatment in pediatric conditions. First, there is almost no literature supporting this (i.e., there is little or no published experience of this idea). Second, Li Shizhen's notions and treatments of the extraordinary vessels differ greatly from the typical ones learned in the study of acupuncture using the eight treatment points (Chace and Shima 2010).

The foregoing ideas can be seen as purely abstract and speculative, but I describe them because they account for clinical experience treating children and seeing some of the different responses between children and adults. With adults it can be very important to be right on the point for the treatment to work. However, with babies and small children, it is usually enough to be at least in the right area using the right techniques timed appropriately. In this sense, I feel that acupuncture points in babies and small children are more likely to be very open spheres of influence rather than sharply defined loci.

It may well have been this kind of straightforward thinking about the nature of the acupoints, channels, and *qi* movements, coupled with experiments using different-shaped hand-held instruments found to have different effects, that guided those who developed *shonishin.* In the end we will probably never know, but this seems reasonable given the historical evidence and precedents.

There is one other historical influence on the development of *shonishin* that is relevant, at least for a part of its practice. In modern *shonishin* practice we still find the diagnosis and treatment of *kanmushisho*, related primarily to behavioral problems. What is this and where does it come from? There is an interesting history related to the development of diagnostic categories for children in China and ideas in Japan about normal development and problems before modern concepts of physiology had penetrated Eastern thinking, and the fusion of these two traditions.

Kanmushisho (疳虫証) or *Kannomushisho* (疳の虫証)[2]

The term *kanmushisho* or *kannomushisho* refers to a class of problems that manifest in childhood. The term comes out of a historical period when the concepts of different medical traditions were fused in the development of medical practices.

The term *mushi* (虫) refers to a kind of worm or insect that was thought to inhabit the body. There were thought to be many different *mushi* in the body, which influenced both normal and abnormal physical and mental functioning. An example of the "liver *mushi*" (肝虫) is seen in **Fig. 2.12**.[3]

The *mushi* concept comes from Japanese history several centuries ago, and had both lay and medical uses. Many older societies have had different concepts about entities inside the body that influence health and disease. Pictures of some of these *mushi* give them the appearance of different parasites, but others are more anthropomorphic; thus we cannot say they were based on observing parasites in the body. The text *Shin Bun Sho* (*The Book to Understand Acupuncture* [針聞書]) from the 17th century explains their use in a medical context, but they had lay uses as well, and various rites or ceremonies conducted by Buddhist monks were developed, some of which can still be found today.[4]

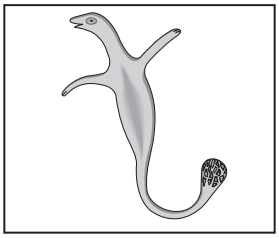

Fig. 2.12 Redrawing of the *kan no kanmushi* (liver *mushi*).

The term *kan* (疳) comes from the Chinese medicine tradition: the Chinese term is *gan*. It refers to a disease of childhood characterized by "emaciation, dry hair, heat effusion of varying degrees, abdominal distention with visible superficial veins, yellow face and emaciated flesh, and loss of essence-spirit vitality" (Wiseman and Feng 1997, p. 236–237). There are as many as 22 different *gan* associated with the internal organs and other structures and symptoms (Wiseman and Feng 1998), such as "spleen *gan*," "liver *gan*," "lung *gan*," and so on. Each has a different manifestation.[5] The concept of *gan* developed within the Chinese medicine tradition and came to be useful in pediatrics. As this tradition was absorbed into Japanese medical practices, it encountered the concept of *mushi*, which was in vogue at the time. The term *kan no mushi* (疳の虫) represents a fusion of these two different concepts of disease. At first there were several concepts in this fusion tradition, but the term *kan no mushi sho* (疳の虫証) is the only one that has survived and come down to us today. The term *sho* (証) means pattern.

The term *kannomushisho* has therefore come to mean the pattern of *kannomushi* disturbance. It is particularly associated with behavioral problems in children. In the infant the *kannomushisho* manifests as irritability, crying, screaming, and poor sleep. In the toddler the child has poor sleep, irritability, angry outbursts, and tantrums. In the older child the behavioral problems manifest usually as hyperactivity, but can also be the distracted child who has poor concentration at school. Shimizu describes his belief that in Japan the term *kan* came to represent children's diseases in a more general sense, and that the term *kanmushi* took on both a medical sense referring to earlier stages and more easily responding medical problems, as well as a lay understanding about stages of normal development in children. Hence, *shonishin* has also been used as a tool to assist in normal development of the child by

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[2] Thanks to Sayo Igaya for her assistance with this section. Ms. Igaya conducted research to investigate *kannomushisho* for her thesis as a student at the Toyo Shinkyu Senmon Gakko acupuncture school in Tokyo and offered invaluable help with this section.

[3] For more examples see http://www.kyuhaku.com/pr/collection/collectionJnfo01–2.html; last accessed 14 October 2015.

[4] Ms. Igaya showed me a short video of a ceremony she witnessed and the intriguing effects of the ceremony.

[5] Reflecting Japanese uses and understanding of the concept of *gan* (Japanese *kan*), Shimizu (1975) describes how *kan* is commonly associated with bad mood, sleep problems, night crying, poor appetite, diarrhea, and cough, and the association of the five organ *kan* are listed as follows: "heart *kan*"—surprise *kan*; "liver *kan*"—wind *kan*; "lung *kan*"—*qi kan*; "spleen *kan*"—food *kan*; "kidney *kan*"— hasty *kan* (Shimizu 1975).

parents that followed this way of thinking (Shimizu 1975).[6]

Shonishin Today

In the modern period the practice of *shonishin* uses many tools. As we will see in Chapter 6, they can be largely classified around different stimulation techniques (tapping, rubbing, pressing, scratching), but they are also used based on personal experience and preferences. Each of us who practices *shonishin* has our preference for which instruments we commonly use. For the most part the instruments are made of metal, but there are precedents for the use of other tools, such as the claws of a mole (Yoneyama and Mori 1964, p. 15), and the plastic presterilized disposable *shonishin* tools that were created by Seirin. Some practitioners have had specific tools constructed, such as the *daishi hari* of Masanori Tanioka of Osaka (Tanioka 2001a, 2001b) (see **Fig. 2.13**). In this way, *shonishin* has exhibited changes over time, as new instruments are used. One of these developments began in the United States in the 1980s. It was here that I helped contribute to another new usage of *shonishin.*

Before World War II, there were several *shonishin* specialists, acupuncture practitioners who exclusively treated children with *shonishin.* Since the war, the relative number of such specialists has dropped considerably, and most acupuncturists who use *shonishin* do so as part of their practice (Shimizu 1975), some obviously more than others. In Japan the typical practitioners who use *shonishin* do so in their clinic, where they apply the treatment periodically on the child, who must return for additional treatments. Many practitioners in Japan tend to work from their home, living upstairs while working downstairs. Their clinics are often in or very near residential areas. As such, many of their patients will come from the local part of town where they live. In many clinics I visited in Japan, most patients lived nearby and walked to the clinic or arrived by a short ride. Thus a practitioner can ask the parent to bring the child back for daily treatment over the next few days, or regularly several times a week. This has been reinforced by the fact that in Japan many mothers stop going to work once they have children and are thus available to bring the child in for frequent treatments as needed.

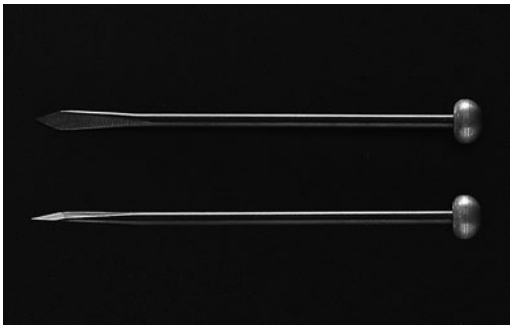

Fig. 2.13 Tanioka-family-style *daishi hari* instrument.

Working in Boston in the United States in the 1980s I encountered an entirely different set of circumstances. For many pediatric patients both parents were working, the child was in day care, and the family lived within driving distance of the clinic. Scheduling the child for treatment involved dealing with two or three people's schedules (four if you added mine). I found early on that most parents were simply unable to bring their children in for treatment more than once a week, and even that could create a burden that made continuing treatment difficult. Thus I was faced with the problem of not being able to treat frequently or regularly enough. As we will see in the following chapters, it is important to make the clinical setting as easy and emotionally calm as possible for the child in order for the treatment to be most effective. When parents are very stressed, trying to coordinate short clinic visits, it can create the opposite effect. Thus I had to consider how best to deal with the need for frequent treatment.

The solution first offered itself when a mother called me from New York. Her daughter was almost 3 years old and had a problem with cerebral palsy. She had been looking for acupuncture treatment for her child and was willing to fly to Boston. Not only did the travel distances and costs make regular treatments unfeasible, but I

[6] Wolfgang Michel, a medical historian writing in Thomas Wernicke's recent English language text on *shonishin*, gives useful additional information in an interesting historical overview of pediatric treatments in Japan (Wernicke 2014, pp.:12–30).

was about to leave for the summer for my first studies in Japan. My solution was to schedule to see the child, and to teach the parent an acceptable short form of the *shonishin* therapy to be performed daily at home. This was an immensely successful strategy (the case is reported in detail in Chapter 25, Case 1 Catherine). Then over the next few years, when I began seeing many 2- to 5-year-olds with ear infections (otitis media) that would recur upon completion of a round of antibiotics, I found I had to offer an alternative approach to allow for more frequent treatments. Weekly treatments were not frequent enough for this kind of recurrent problem. Thus I began routinely teaching parents to do some form of *shonishin* treatment, preferably daily, at home. With the success of these experiences, I have routinely taught home therapy as an additional component of *shonishin.* Many acupuncturists in Europe, the United States, and Australasia are familiar with this model. It is now being used by some practitioners in Japan as well. Home therapy approaches and rationales are covered in Chapter 8 and represent a very powerful addition to the whole *shonishin* treatment approach. My colleagues in Barcelona have written a book for parents about child care containing recommendations for home treatment. This includes simple *shonishin*-style treatments (Rodriguez and Anton 2008).

This concludes my very brief introduction to the history and development of *shonishin*. Much more can be said but the purpose of this book is to explain how to treat patients, thus I shift gears here and move to things of more clinical relevance.

Section II Treatment Principles and Tools of Treatment

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

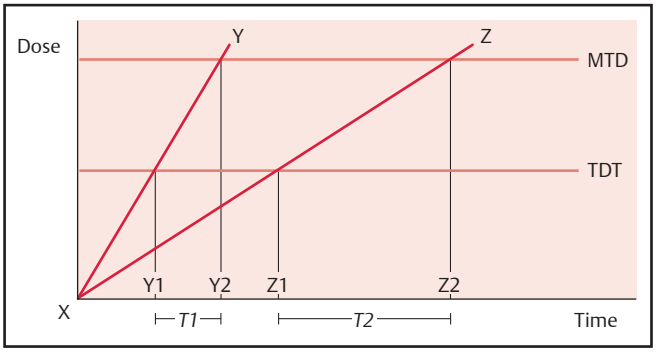

Fig. 4.1 Dose levels for normal sensitivity patient with different intensities of treatment (Y, Z). TDT, therapeutic dose threshold; MTD, maximum therapeutic dose.

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.

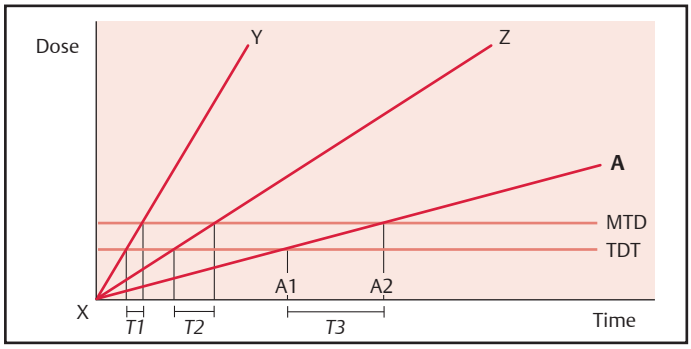

Fig. 4.2 Dose levels for the very sensitive patient (child) with different intensities of treatment (Y, Z, A). TDT, therapeutic dose threshold; MTD, maximum therapeutic dose.