

Pediatric *Ashi*-Point Care: Helping Children Explore Therapeutic Discomfort

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ABSTRACT

Background: *Ashi*-point theory dates back at least 2100 years. Successful *Ashi*-point treatment can be complex, might necessitate many visits to educate pediatric patients about the therapeutic process, and might involve many treatment modalities. The treatment setting provides an opportunity to perform needleless treatment and to introduce acupuncture. Introduction to acupuncture can, in and of itself, be both diagnostic and therapeutic.

Case: *Objective:* The aim of this case study was to explore the factors that led to a successful *Ashi*-point treatment in a 7-year-old female and to determine the role that acupuncture played in her diagnosis and treatment. *Design and Patient:* This retrospective case study was performed to evaluate three treatment sessions in succession; each was 6 weeks apart. The child was treated in a private clinic. Her chief complaint was headache, characterized by superior periorbital eye pain, which alternated sides but occurred predominantly on the right side. *Intervention:* The treatment for this child's condition involved general holistic management, *tui'na*, myofascial trigger-point therapy techniques, attempts to introduce acupuncture, and education about her treatment.

Results: The patient's headache was relieved by manual techniques applied to relieve the *Ashi*-point pain that was present, originating in the upper trapezius and rhomboid muscles. Attempts to introduce acupuncture were varied but yielded important clinical data.

Conclusions: Manual methods may be sufficient to treat *Ashi*-points, but acupuncture is known to be effective for this, and the treatment setting enables the opportunity to introduce acupuncture to children. Introduction of acupuncture, even conceptually, may be informative in and of itself, and it can provide valuable insights into a patient's condition.

Key Words: Acupuncture, Acupressure, Integrative Physiology, Musculoskeletal Pain, Pain Management, Trigger Point, Children, Myofascial Trigger Point Therapy, *Ashi* Point

INTRODUCTION

ASHI-POINT THEORY dates back at least 2100 years. It is conceptualized in the *Nèi Jīng Líng Shū*,^{1,2} an Early Han Dynasty (220 BC–0) Chinese medical document. It has been said that every hands-on medical system begins with the discovery of *Ashi* points, and the methodology of care that subsequently develops represents systemized attempts to relieve these “painful spots” as they are translated.² As cultures discover *Ashi* points and seek ways to relieve them,

and as cultures realize the value of needle-based therapy in this endeavor, history repeats itself as acupuncture is rediscovered and proponents of other health systems seek to understand how to conceptualize and incorporate this ancient method.³

Acupuncture has been clinically observed for millennia to be a system that is ideal for treating *Ashi* points, and, indeed, a primary purpose of the *Líng Shū*, Chapter 13 is to describe how to use the therapeutic needle most effectively to ensure success in “painful-point” treatment. *Líng Shū* treatments

are somewhat complex at times, and involve more than the isolated use of the filiform needle. Musculotendinous *Ashi* points are understood to be areas of energetic (Qi) consolidation, with subsequent locking down of the Yin of the region, inhibition of the proper healthy flow of Qi and Blood through the tissue, and disruption of the use of the associated channel(s).⁴ The biomedical translation of this is that areas of fascia and muscle are contracted dysfunctionally, and, hence, circulation is impaired, as is the use of the region for various movements.

Ashi points are, by definition, painful points, and humans and other animals instinctively guard painful body regions. *Ashi*-point treatment is, in most circumstances, somewhat intense as well, and, hence, the ability to tolerate *Ashi*-point treatment varies from patient to patient. In addition, many factors determine how quickly and deeply the practitioner might work. *Ashi*-point treatment may be more challenging in children, as many children have not developed the ability to allow painful procedures to be performed without guarding, even with the promise of pain relief. Hands-on work is often sufficient for *Ashi*-point relief but acupuncture is a prized treatment method.⁵⁻⁷ Applying *Ashi*-point treatment methods in children adds many levels of complexity, as the ability of the child to allow treatment of *Ashi* points is far more variable than that of an adult. One reason for these challenges in the child is that successful *Ashi*-point treatment is ultimately linked to a pleasure response characterized frequently as “relief,” and knowledge of this destination motivates the adult to endure temporary discomforts for the positive outcome.

Many children (depending on age, maturity, parental input, prior experience, constitutional state, and inherent aptitude) have not yet developed the capacity to inhibit their defensive responses in the treatment setting, despite assurances that the work is for their benefit, and that they will “feel better when it is done.” This represents both a lack of development in brain regions involved in executive function, such as the frontal lobe and its projections, and inherent lack of experience to reinforce the logic of such an assertion.⁸ The child is said, for these and other reasons, to be relatively Yin Deficient, which leads to unanchorable Yang defensiveness.

Adding acupuncture, even conceptually (i.e., the knowledge that someone will be sticking a needle intentionally into the body “soon”), into this treatment scenario alarms the pediatric patient further in many cases. Practitioners frequently see the Qi scatter or the Liver Yang rise at even the conceptual introduction of the acupuncture needle. Hands-on work is often, but not always, sufficient for *Ashi*-point relief, and the treatment setting provides an opportunity to both do hands-on treatment and introduce acupuncture. How the child responds to the introduction of acupuncture can be both diagnostic and therapeutic.

The rationale for introducing acupuncture in general includes that, in many cases, acupuncture is observed to

hasten resolution of *Ashi*-point conditions; if the patient can tolerate acupuncture, the chances of achieving a quicker cure are believed to be potentially greater. Acupuncture also enables simultaneous treatment of many body regions, which can extend the effects that are achievable in a single treatment session. In addition, acupuncture is understood to treat many other ailments, so the ability to utilize this treatment method for individual health maintenance and restoration may be of other inherent value. In a family who prizes acupuncture use as part of their healthcare, introduction of the system is often desired early for the children.

This article presents a retrospective case study evaluating three treatment sessions, in succession, each 6 weeks apart, for a single child in a private clinic. The child’s chief complaint was headache, characterized by superior periorbital eye pain, which alternated sides but was predominantly on the right side. A qualitative exploration of the factors leading to successful intervention is presented as well as an exploration of how the process of introducing treatment may lead to valuable clinical insights.

CASE

When A.B. was brought for treatment, she was a 7-year-old, Caucasian female of American birth and of upper-middle class social status. She appeared to have above-average intelligence. Her family was highly educated and utilized acupuncture and other integrative care methods regularly for the health and care of all family members. The child was a clinic patient for ~7 months, during which time, she received treatment with bodywork, Western supplements, and Chinese herbal remedies for *Xiao Chuan* or wheezing disorders and for chronic cough (*Ke Sou*). She had successful resolution of these conditions. She also presented for treatment of headache. The headache was characterized by dull pain in the superior periorbital region of the forehead. It was stronger on the right but occurred on both sides intermittently. The child was unable to discern factors that exacerbated or relieved the pain, and there were no secondary signs consistent with migraine. A preliminary workup had been performed by the primary medical team to rule out serious conditions.

The child had a medical history that was significant for mild torticollis on the right side, and her mother believed that she still saw signs of imbalances on occasion. The child was learning to play the banjo but did not play violin or flute, which are more intensively associated with dysfunction of the musculature of the shoulder region. She denied carrying a heavy bag or backpack and was on summer vacation during the second of the reported treatment periods. She was generally extremely spirited and dynamic, and was classified as a Heart or Fire type personality in Chinese medicine. She gesticulated dramatically when speaking, using her whole body expressively. Her pulse was equivocal in meaning because of her age, and her tongue was pale pink

with a thin white coat. The resting tone in her shoulders was elevated, with a “shoulders in the ears” appearance. She shrugged frequently and strongly when expressing indecision and defensiveness.

On physical examination, tender spots were found particularly in the upper trapezius muscles bilaterally and the rhomboid muscles bilaterally. The right side was more affected than the left side, both in frequency of problem occurrence in general, and in intensity of pain at the time of the examination. Pressing on the spots led to a strong recoil response initially. The child could not tolerate sustained pressure long enough to discern if it exacerbated her eye pain.

During the first of the three visits, this child was unable to remain still for treatment. She shrieked at pressure on the spots and pulled away from the physician’s hands. She did not cry, but protested loudly without becoming angry. Her method of recoil included nervous laughing and giggling, which was indicative of Heart Qi Timidity.

This first treatment session focused on working with the child to breathe and stay in place as her *Ashi* points were massaged gently. *Tui’na* techniques including *Tui* (pushing), *Na* (pulling), *An* (rapid and rhythmical pressing), *Nie* (kneading), *Moa* (rubbing), and *Pai* (tapping) were used as tolerated.⁹ The parent was shown how to begin working on the area, and the child was referred to a licensed massage therapist (LMT) for more specific and generalized work between visits. The feedback technique shown to the parent was learned by the physician from study of the myofascial trigger point therapy (MTPT) style of care. This included giving a number from 0 to 10 for the pain-scale rating and allowing pressure on the point to drop from a higher number to a lower one to indicate resolution of discomfort. Acupuncture was discussed during this visit but the child was averse to it. Needle insertion was demonstrated on the physician by the physician but was not attempted on the child.

Discussion of acupuncture for the next visit was initiated. The parent revealed an input style that allowed the child to self-govern her own decision entirely about receipt of acupuncture, but the parent supported the idea strongly and verbally that this would be the right choice. The parent did not offer a reward for acupuncture but reinforced the idea that doing acupuncture helps your body “be well.”

By the second visit, the family had been performing the home-massage treatment. The child was well-rested, in a good mood, and able to tolerate treatment well. She gave reasonable accounting of numerical pain-scale ratings during the treatment, and was better at tolerating the work. She was still “squirmy” and dynamic but was much more able to receive therapy and self-regulate. She had also had one massage visit with the LMT between sessions, and that had been a positive experience. Work on breathing and staying still was deepened. Her mother reported decreased frequency of headache complaints of this child. Acupuncture was introduced and demonstrated to the child again, and she

was able to tolerate brief needling at LI 11 (*Qu Chi*; “Pool at the Bend”) on the right side. Acupuncture was performed using a 1-cun, Seirin red needle (No. 1/0.16/40 gauge) with a guide tube and in-and-out insertion. The intent was predominantly demonstrative. The patient noted no pain, and she indicated a willingness to try acupuncture again with more needles during the next visit.

At her third visit, the child was exhausted. She had been off of her regular schedule because of a school holiday and family travel. Home massage had not been performed. She was generally pleasant but had lower energy than usual. She complained of the typical, right-sided, predominant supraorbital headache at the start of the visit. *Tui’na* was performed again, although the child was unable to provide a reliable pain rating, giving all pressure either a 10 or 0 on the scale. Nonetheless, she tolerated a 20-minute session and fell asleep a number of times during the work. Her headache resolved by the end of the treatment. Her shoulders had been up and contracted at the onset of the visit and were relaxed at the end. There was initially a palpable *Ashi* point in the upper trapezius muscle on the right, the side of the active headache, which resolved by the end of the treatment.

Prior to doing the largest part of the hands-on work during this third visit, an attempt was made to introduce acupuncture again. The patient indicated that she was very fearful of this and was unable to hold herself still for even a repeat experience with LI 11 on the right. Interestingly, her response to an approach with the filament was to squeeze her arms together tightly and shrug her shoulders forcefully to her ears. She was undecided about whether or not to allow the treatment and also was guarding. Ultimately, she allowed very brief insertion of a filament at LI 11 on the left side, but felt uncomfortable with the concept of this and could not let the needle remain in place, although she admitted that she was not experiencing any pain. Because of the inability to move on to the use of acupuncture for the *Ashi*-point treatment, only manual work was performed. The family was instructed again in doing the home treatments, and the child was shown a self-care technique to massage her own muscles when they became tight.

RESULTS

The patient’s headache was relieved by manual techniques applied to relieve *Ashi*-point pain that was found originating in the upper trapezius and rhomboid muscles. Attempts to introduce acupuncture were variable, but provided important clinical data on how emotional responses and physical posturing unique to this child might account for the development of the syndrome presenting. The patient’s exuberant physical posturing, used to express fear of receiving acupuncture, put her into physical positions that would be predicted to cause and/or exacerbate *Ashi* points in

the trapezius and rhomboid muscles. The patient had improvement in her ability to tolerate uncomfortable treatment methods over the course of the three visits, but this was significantly affected by her mental state and general level of fatigue.

DISCUSSION

Wan Quan, a pediatric specialist in the Ming Dynasty, advocated a number of naturopathic-type practices for the care of children, as well as providing strategies for pediatric care. Among these strategies was the concept of “training to resist Cold.”¹⁰ To understand this guideline better, it is important to note that the character for Cold (*Leng*) can be translated also as “lonely,” “strange,” “sudden,” “unknown,” “lacking sympathy,” and other similar terms.^{11,12} Hence, “training to resist Cold” really encompasses the need to introduce foreign, alarming, and strange procedures and concepts to children gradually and on a repeated basis, so that, at their own pace, they can become accustomed to these procedures.

Few things are stranger to children than accepting painful treatment to feel better, or allowing the insertion of needles to induce relaxation. These concepts and practices must be introduced gradually and reinforced repeatedly. Ultimately, it is this practitioner’s experience that many children will become acclimated to deeper tissue bodywork and acupuncture over time. In this case, the patient did well acclimating to *tui’na*, but she requires more time before accepting acupuncture. Her inability to tolerate acupuncture treatment at the third visit was not related to any actual pain experienced, but rather it was a conceptual objection that was heightened by her fatigue. This underscores the primacy of emotion and perception in the experiences of both bodywork and acupuncture.

This patient was also tired, was out of her routine, and had no compulsion or reward-incentive from her parent to accept the treatment. The patient was not using any type of “screen distraction” (viewing device), which is a powerful distractor used by parents for many children within the practice. (Screen distractors, displaying content valued by children, are, by far, the most successful distractors seen in this practice. These may even, in the opinion of this practitioner, detract from some of the child’s experience, as they lower the threshold for receipt of care to a level that requires very little effort on the part of the child.)

The patient’s physical posturing responses to the “threat” of acupuncture were diagnostically significant. As mentioned, the patient contracted her upper trapezius muscles tightly and forcibly when she was faced with a threat (i.e., she shrugged her shoulders forcibly in an upward direction). She was ambivalent, so her muscles relaxed and contracted repeatedly, but she also maintained a fundamentally defensive posture. *Ashi* points develop along channels for many

reasons; these include dysfunctional posturing caused by an emotional imbalance. This is one mechanism by which emotional intemperance is translated into illness, as predicted in the *Huang Di Nei Jing Su Wen*.¹³ Indecision is associated with the Gall Bladder system and meridian, and overall affects the *Shao Yang*. Defending the exterior, particularly the back and neck, is a task of *Tai Yang*, and causes Qi to accumulate in the Urinary Bladder and Small Intestine meridians.

This patient engaged in posturing that involved both the *Tai Yang* and *Shao Yang* channels; this posturing would lead to pathologic accumulation easily in both of these meridians. In Chinese channel theory, this would be anticipated to lead to pain syndromes along the course of, especially, the primary channels and/or musculotendinous regions of these systems. The region of the forehead just superior to the eye falls along both these regions.¹⁴ Habitual posturing would reinforce the Stagnation of energy and lead to more entrenched symptom patterns. Part of engendering a true cure would be to help the patient realize how her physical posturing is leading to the symptom pattern, and also to explore times when that posturing occurs.

This child was in no real danger at the office visit; she knew this. Yet, her physical response, partly a result of her temperament, was quite extreme. It is highly likely that she assumes these postures on a regular basis, both in play and when she is feeling truly threatened. In this case, no other signs indicating catastrophic trauma were present, although considering this is always part of a complete treatment protocol.¹⁵ The family was instructed to observe the patient’s posturing patterns at home and in other settings, to learn when the postures occurred and to explore their contributions to the clinical headache syndrome further.

One of the unique additions MTPT has made to the Western cannon of knowledge is the description of referred pain patterns associated with trigger points. The patient in this case had a pain-referral pattern consistent with dysfunction of the fascia in either the upper trapezius muscle or the sternocleidomastoid (SCM).¹⁶ The SCM showed no tenderness on palpation, thus, it was ruled less likely to be a cause of the referred pain pattern. True practice of MTPT involves an exploration of “perpetuating factors” that lead to the preservation of trigger points. These are understood to be often behaviorally based and are believed to be the result of stereotyped movements and habitual patterns taken by patients over time. These factors may also include mechanical, chemical, nutritional, psychologic, and traumatic causes.¹⁷ Treating a patient without exploring perpetuating factors is a form of malpractice, as no cure would be anticipated from treatment so long as these exacerbating forces remain unchecked. The patient would simply be coming back for repeated treatment that would induce temporary relief in a painful area, only for it to be inflamed again by the same underlying cause. This would keep the patient in treatment in an unethical fashion.

It is interesting to observe how Chinese channel theory correlates mind–body–posture connections that can elegantly and simply explain the mysteries behind the development of trigger points or *Ashi* points. In this case, one sees the engagement of the defensive muscles of the *Tai Yang* channel in response to a perceived threat. The *Tai Yang* governs protection of the exterior. This includes especially recruitment of the musculature protecting the neck, including notably the upper trapezius muscles.¹⁸ This expressive posturing leads to Qi Stagnation in the involved channel, leading to pain pathology. This underscores the elegance of the Chinese channel system and exemplifies the clinical applicability of this knowledge to the present day.

Forms of therapy, such as trigger-point therapy would meld very easily with Chinese channel theory, although the full channel system (not only the primary channels) must be considered to see the overlap. In this case, the Chinese *Ashi*-point theory and MTPT were parallel and largely indistinguishable from one another. Chinese theory examines pain patterns predictably radiating along channels, while MTPT theory looks at known associations of trigger points with characteristic pain referral patterns. These are the same clinical phenomena with different frameworks for organizing the findings. This physician would argue that the Chinese system is more expansive and inclusive than the existing Western system, although the MTPT system states the information more concisely.

CONCLUSIONS

Ashi-point pain is a clinically frequent condition in all age groups.^{19–21} This case is an example of the application of *Ashi*-point theory and *Ashi*-point treatment for a child. This way of evaluation and treatment, a classical Chinese precursor of MTPT, led to the efficient diagnosis of a headache pain pattern caused by channel Stagnation and associated *Ashi*-point dysfunction. Treatment applied over time, with care taken to help the child gradually accept the therapy, led to improvement in symptom frequency overall and resolution of an acute headache during an individual session. Attempts at introducing acupuncture led to posturing patterns revealing behavioral tendencies that could underlie what MTPT practitioners would call perpetuating factors, and these are framed neatly within the Chinese physiologic paradigm. Working patiently with the child over time, educating the parent on home treatment, and exploring the perpetuating factors for the patient's Qi Stagnation and subsequent *Ashi*-point development enabled proper management and helped avoid overtreatment with pharmaceuticals that would have only masked the patient's pain without addressing underlying causes. There is still work to do in the longer-term with this patient, but significant gains have been made.

If this patient learns to accept acupuncture as a modality, treatment in the office might be streamlined even further,

though, if self-care is maintained and postural dysfunctions are eliminated, there will be no need for any supplemental care. The child might gain developmental benefits from this overall process, benefits that are quite distinct from the clearing of the headache but which also make it more likely that the headache will be suppressed. This physician's research indicates that children who learn to accept acupuncture successfully may gain a great sense of empowerment and accomplishment as well as an increased ability to control internal impulses and endure dissonant sensory input. Thus, the ability to learn to receive acupuncture may be of its own inherent value.

Further research is needed to determine how best to approach *Ashi*-point care in the pediatric population. Rubrics that would enable rapid and accurate diagnosis of *Ashi* points and their referred pain patterns, as well as assessments of perpetuating factors leading to channel Stagnation, would help identify pain presentations more quickly and accurately—presentations that could be treated appropriately and safely with manual therapies, needle-based work, and lifestyle modification. This would help minimize expensive workups and the use of pharmaceuticals, thereby leading to less costly and safer management. This approach would also treat the root of the pain rather than settling for only symptomatic relief, and might, secondarily, help children develop valuable understanding of how to tolerate uncomfortable treatments that lead to better health. Determining how to help children best accept the often strong sensations associated with *Ashi*-point treatments is also a domain in need of study. Cross-referencing treatment techniques and observed pain patterns among the fields of *tui'na*, acupuncture theory, and MTPT would likely yield great gains for pain management in children and adults alike.

AUTHOR DISCLOSURE STATEMENT

There are no conflicts of interest to disclose.

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