Introduction to Traditional Japanese Acupuncture (Meridian Therapy)

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Preface
The purpose of this paper is to introduce the theory and practice of Meridian Therapy, which is Traditional Japanese Acupuncture. Probably most people in the West have studied the theory and practice of Traditional Chinese Medicine, and practice accordingly. Not many have been exposed to or actually observed the clinical practice of Japanese style Meridian Therapy, except for those who have attended seminars given by the Toyo Hari Association or those who have read Denmei Shudo’s Introduction to Meridian Therapy and attended his workshops. In order to make this paper easy to understand for the uninstructed, I will cover the following topics:

I. Features of Traditional Japanese Acupuncture - a comparison with Chinese acupuncture
II. The History of Traditional Japanese Acupuncture - the context in which the theories and practice of Traditional Japanese Acupuncture developed
III. Theoretical Foundations of Traditional Japanese Acupuncture
IV. Diagnostic Approach and Practice
V. Treatment Approach and Practice

Due to limited space, only the essence of these topics can be presented. For a more thorough presentation refer to “Traditional Japanese Acupuncture (Essentials of Meridian Therapy)” compiled by the Japan Meridian Therapy Association, which is scheduled for publication in English. As to the practice of these techniques, we expect there will be opportunities to hold seminars in the U.S. In any case, I will present these topics in a way that the reader might visualize the actual situation in clinical practice.

I. Features of Traditional Japanese Acupuncture

Both Meridian Therapy and Chinese acupuncture are the same in that the diagnostic and treatment system are based on medical classics such as Suwen, Lingshu, and Nanjing. Oriental medicine is founded on function rather than form, and Meridian Therapy and Chinese acupuncture are both based on Yin-Yang and the five phases and the existence of meridians. The following features distinguish Traditional Japanese Acupuncture from Chinese acupuncture:

1. Equipment
Japanese acupuncture needles are shorter, thinner, and far more flexible than Chinese acupuncture needles. This is because painless insertion is important in Japanese acupuncture and delicate needle techniques are emphasized. For example, for conditions caused by chilling or external cold, there is a technique called contact needling where the needle is not inserted but just touches the skin. In cases of heat, it is common in Japanese acupuncture to change the needling technique according to whether the heat is internal or on the surface. The most important thing is that thin and flexible needles make it easier to feel the arrival of Qi.

The most obvious difference is the use of insertion tubes. The insertion tube is used to insert the needle painlessly and accurately into acupuncture points. It was invented in the Edo Period by Sugiyama Waichi. There are a few practitioners in Japan who insert needles without a tube, but the vast majority use tubes.

When it comes to moxibustion, stick moxa is seldom used in Japan. Direct moxibustion is used instead. The purpose is to add heat, and not to burn, so when direct moxibustion is used ointments such as shiunkou are applied on the skin first. The size of the cone is small (half-rice grain size, being most common) and the cone of moxa is often extinguished before it finishes burning so that only the heat is felt. There is no burn. Also indirect moxibustion using a buffer like ginger or garlic, and moxa needle (with moxa placed on the handle of the needle) is popular.

2. Needling Techniques
Those who have visited China and observed acupuncture treatments there know that in China the needle is inserted deeply and importance is attached to a strong needle sensation known as Deqi. In Traditional Japanese Acupuncture the depth of insertion varies according to the practitioner and the condition of the patient, but the depth is around 1 cm, even for deep insertion, and for shallow insertion, the skin is just barely penetrated (1 to 2 mm), and there is contact needling where the needle is not inserted at all. The reason for this may be that in China research on the meridians began with studying sensitive people (those who felt radiating needle sensations), and also they may have a greater number of people engaged in physical labor. Practitioners of Traditional Japanese Acupuncture consider the existence of meridians to be a given, even without the phenomenon of radiating needle sensations. The emphasis in treatment is to regulate Qi and the consensus from a long history of clinical experience is that Qi flows close to the surface of the body. Furthermore, since the 1960’s Japan has achieved a high level of economic growth and the nature of work has changed from heavy physical labor to mental work in offices. Also household tasks have become less physically demanding with the profusion of household appliances. Thus the disease trend in Japan has shifted to primarily deficient conditions. In other words, treatments in Traditional Japanese Acupuncture are designed around regulating Qi (which in turn regulates Blood and Fluids). Painless and light acupuncture stimulation is considered best for deficient conditions.

3. Diagnosis
The use of the Four Examinations of looking, listening, questioning, and palpation to decide the Pattern is the same in both Japan and China. In Traditional Japanese Acupuncture, however, within the palpation exam, pulse diagnosis is given special emphasis. These techniques will be discussed in detail later, but in Meridian Therapy health or disease is decided by the presence of Meridian imbalances. The basic assumption is that all diseases begin with a deficiency of Jing (Yin Qi) in a Zang. Various internal, external, or miscellaneous factors enter the picture and the Qi, Blood, and/or Fluids of the Zang become deficient to cause a particular pathological condition (what is called a Deficiency Pattern). Diseases actually manifest from the heat and cold generated by these conditions (deficiencies), which then spread to other organs and meridians.

Based on this view of disease, one can use pulse diagnosis to determine which Zang is deficient (Basic Pattern such as Kidney Deficiency), the pathological condition (Yang Excess, Yin Deficiency, etc.), and the relationship between the symptoms and the pathological condition (understanding of symptomology in terms of meridian pathology). Within pulse diagnosis, six position pulse diagnosis (comparison of pulse strengths at the deep level) is used to determine which Zang is deficient. Pulse quality diagnosis is used to decide the Deficiency
Pattern. To understand the symptomology, the comparison of pulse qualities in individual pulse positions is used. Let me give an example of how these aspects of pulse diagnosis might be applied clinically.

Let’s say we have a patient who has pain in the right shoulder from knitting too much. She tried to ignore the pain at first, but movement in the shoulder became very difficult and now it is painful even while sleeping at night. This is a case of so called frozen shoulder. Six position pulse diagnosis reveals a weakness in the left middle and distal positions at the deep level, while the right distal position is strong at both the deep and superficial levels. Pulse quality of individual positions shows a sunken and wiry pulse at the left middle and distal positions, and the right distal position is sunken, wiry, and also bounding. The result of this pulse diagnosis indicates a Liver Deficiency from the weakness in the left middle and distal positions, and the pulse quality at these positions indicates that it is primarily a deficiency of Fluids. Thus, it can be deduced that the deficiency of Fluids in the Liver and the deficiency of Blood caused by stress in the shoulders led to a condition of Yin Deficiency. This generated Deficient Heat in the interior and the heat spread to the Lung and Large Intestine meridians as palpated at the right distal position. Judging from the pulse quality at this position, (probably because a large amount of heat was generated by the Liver over a long period) Excess Heat stagnated in these meridians to cause frozen shoulder on the right shoulder. Thus, the symptoms are explained in this way through pulse diagnosis.

In the differential diagnosis of TCM, various data from the Four Examinations (questioning, tongue diagnosis, pulse diagnosis, etc.) are assembled as necessary for each case to understand the pathological condition. In Traditional Japanese Acupuncture the Four Examinations are used to understand the outline of the disease, and pulse diagnosis is used to grasp the specifics of the pathological condition. Pulse diagnosis in Chinese medicine, as far as I know, does not include the comparison of strength in the six positions or the comparison of pulse qualities in individual positions. Without these one cannot ascertain specifically from pulse diagnosis which Zangfu and meridians are affected.

In Traditional Japanese Acupuncture, in essence, pulse diagnosis is viewed as being the best way to detect changes in the meridians and to learn about the pathological condition of the Zangfu and meridians. This emphasis on pulse diagnosis is consistent with the classics since numerous texts on pulse diagnosis have been compiled starting with the Nanjing and Pulse Classic.

4. Treatment According to Pattern

Diagnosis in Meridian Therapy is used to decide the Pattern. This is to determine
A. which Zang is deficient,
B. the pathological condition (five conditions such as Yang Excess External Heat) or whether there is a heat or cold condition,
C. which Zangfu and meridians are affected by the spreading of heat or cold.

The reason for this diagnostic process is to decide the treatment plan. In other words, when the Pattern is decided, of course the meridians to be treated are decided (even when the Zangfu are affected, the meridians are treated to affect them), and it becomes clear which points are to be treated, and in what way (depth and insertion technique).

This process of diagnosis leading into treatment is called treatment according to Pattern.

Details of this approach will be presented in the next article covering basic principles, treatment, and actual practice (section III to V). For now, I will use this approach to analyze the case of the patient with shoulder pain mentioned above.

The problem originated with deficiency in the Jing of the Liver (Liver Deficiency) which caused a deficiency in Fluids and Blood of the Liver that generated Deficient Heat (Yin Deficient Internal Heat Pattern). This heat spread to the Lung and Large Intestine meridians and pain appeared in the right shoulder, along the path of these meridians. This Pattern is known as Liver Deficiency Heat Pattern. (The heat or cold generated by a deficiency can spread to almost any meridian, so these are not included in the name of the pattern.)

The treatment for Liver Deficiency would be to apply the first principle of the 69th chapter of the Nanjing, in other words, the Liver and Kidney are the meridians to be treated (the wood phase and its son, the water phase). And because it is a Heat Pattern (in this case a Yin Deficient Internal Heat Pattern), the points used should be fire and water phase points, which remove heat (water points cool the body, and fire points serve to treat heat in the body). The treatment points would therefore be LV8 and KI10 (water points) and LV2 and KI2 (fire points). Instead of fire points, wood phase points, which basically have the same function, can be used.

As for depth of needling, since it is a case of Internal Heat from Yin Deficiency, it should be slightly deep, or 3 to 5mm. Since it is heat caused by a deficiency, the technique is tonification. For the Lung and Large Intestine meridians where the heat has lodged, since it is localized Excess Heat, dispersion is applied. The points should be Xi Cleft points, or LU6 and LI7.

The above approach of treating heat or cold that originates from a deficiency of Jing in a Zang (treating the root of the disease), is what is meant by root treatment. Once the Pattern, including the meridians affected by the heat and cold, are determined, the treatment is decided as a matter of course. Furthermore, when the symptom of pain in the right shoulder is not resolved by the above Root Treatment, reactive points are palpated in the local area: the right shoulder. Painful local points primarily on the Lung and Large Intestine meridians are therefore needled. Since this is a localized manifestation of Excess Heat, the needling technique would be mostly dispersion. Applying tonification and dispersion to local areas with symptoms, according to excess or deficient manifestations, is known as branch treatment or symptomatic treatment. A complete treatment consists of both root and branch treatment.

From the above explanation on the features of Traditional Japanese Acupuncture, it should be clear why it is called Meridian Therapy. It is because theoretically and clinically both the diagnosis and treatment is aimed at the meridians, not acupuncture points. The treatment is done on acupuncture points, but these are chosen by deciding the meridian to be treated and applying specific principles of point selection. Points are not used simply because they are special effect points or because of special properties (or the function of points as in Chinese acupuncture).

I will discuss the history of acupuncture in Japan to explain how a unique form of Traditional Japanese Acupuncture called Meridian Therapy developed in Japan.

II. The History of Japanese Acupuncture

Oriental Medicine (Chinese Medicine) arrived in Japan around 560 A.D. along with Buddhism. Since that time to just before the Meiji Period, when Japan modernized, Oriental medicine was central to medicine in Japan and developed in unique ways to suit the conditions in Japan. Once the Meiji Period arrived, however, under the slogan of “prosperous country, strong soldiers,” the government reorganized the medical system based on a Western medical model. They even attempted to ban Oriental medicine altogether as a relic from the past which was useless for public health or military
medicine. Nevertheless, among the Oriental medical practices, massage and acupuncture were preserved as professions for the blind, who had few other career options. This basic policy has continued to this day without much change and it has been the cause of much confusion within the profession.

In any case, the practice of acupuncture and moxibustion was allowed to continue and, in order to integrate it with medical policy based on Western medicine, the government authorized reinterpretation and systematization of acupuncture and moxibustion, under Western anatomy and physiology. As a result, meridians were discounted as unscientific, and the principles of Yin-Yang and five phases were also discarded, and instead local treatment and special effect point treatment became prominent. Under these circumstances, not just Kampo herbology (which was banned) but acupuncture and moxibustion which was preserved also followed a path of decline. This trend continued until the early Showa Period. In 1939 a group of young acupuncturists started a group to revive acupuncture and moxibustion as a vital part of traditional Oriental culture. This group called “Shinjin Yayoi Kai,” was formed by students of Yanagiya Sorei, Okabe Sodo and Inoue Keiri, and later Takeyama Shinichrou. The aim of this group, under the slogan “return to the Classics,” was to reestablish the theory and practice of acupuncture and moxibustion based on classical principles. In order to do this, they studied and discussed the Classics day and night from around 1932. They tested the various treatment methods presented in the Classics and finally, in 1941, they came up with a treatment system they called Meridian Therapy.

Of course, Meridian Therapy follows the Classics in its theory on diagnosis and treatment because it was created in this way, and pulse diagnosis and treatment by tonification and dispersion is emphasized. Also, in this period, there were still a handful of practitioners who continued to practice a traditional style handed down from the Edo Period, and these old acupuncturists were a great help in reestablishing traditional acupuncture. Several years later, the “Shinjin Yayoi Kai” was reorganized to promote traditional acupuncture under the name of Meridian Therapy.

By 1945, the end of World War Two, Meridian Therapy had rapidly spread throughout Japan to become the dominant style of acupuncture. Late in 1945, however, the occupation government of the United States (GHQ), under the authority of General McArther, banned acupuncture and moxibustion under the perception that these practices were barbaric and unsanitary. Thus, once again the acupuncture profession was confronted with a grave crisis. Acupuncturists all over Japan organized and petitioned the GHQ and the Ministry of Health and Welfare. Thus the right to continue practicing acupuncture and moxibustion was gained on the conditions that hygienic standards including asepsis would be improved and scientific research would be further pursued.

In terms of legislation, the laws pertaining to Oriental medicine today are a direct reflection of the above mentioned historical developments. Physicians, after undergoing six years of education after graduation from high school and passing the national examination, receive all rights to diagnose and treat patients. They can practice Oriental medicine even if they have received no special training on Kampo herbology or acupuncture. In recent years 100% of the cost of Kampo herbs have become reimbursable by the national health insurance system, but the amount paid is the same whether the herbs are prescribed by a diagnosis using the traditional four examinations or they are dispensed based on a Western diagnosis with no knowledge of Oriental medicine. In other words, the government policies of the Meiji Period have been maintained in that the autonomy of Oriental medicine in relation to Western medicine is not recognized at all.

Acupuncturists, on the other hand, after graduating from high school and receiving three years of training in an acupuncture school, or four years in an acupuncture college, must pass a national examination. (There is no difference in the license whether one receives a college degree or not). Then they receive a license as practitioners of “quasi-medical practices,” and have the right to open an independent practice. Because they are not medical doctors, however, they cannot diagnose a patient, and they are limited to the practice of acupuncture and moxibustion, and are not allowed to prescribe herbs which have always been part of Oriental medicine. There are six scientifically recognized conditions for which acupuncture is effective, that the government accepts, including cervical brachialgia and arthritis. A special insurance coverage called “convalescence fee” is applied for these conditions. This is completely different from the insurance coverage for care provided by a medical doctor, and there is a strict condition that diagnosis and treatment

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Despite this biased policy of the government against Oriental medicine, acupuncture and moxibustion are very popular among the Japanese. Many people still want to receive treatments even if they have to pay out of pocket. According to a survey conducted by the Metropolitan Government of Tokyo, as many as 75% said they felt that acupuncture treatments should also be covered by insurance. Let us now return to the subject of Traditional Japanese Acupuncture.

I stated earlier that Meridian Therapy was established in 1941. I will now explain how Meridian Therapy has come down to this day and has changed in terms of theory and clinical practice. Japan, after the war, shifted toward chronic and deficient conditions, such as complaints of general malaise. Along with this shift, Meridian Therapy shifted toward retaining needles and tonification techniques. In terms of diagnosis the emphasis was placed on finding deficiencies in the deep level of the pulse with six position pulse diagnosis. For treatment, the principle in the 69th chapter of the Nanjing, especially tonification using the mother-son generating cycle came to be emphasized. In case of Liver Deficiency, for example, since this is a deficiency in the wood phase, the mother phase or the Kidney meridian is treated using water phase points (LV8 and KI10). In this way, the root treatment was standardized for each of the Primary Patterns. This was done in order to simplify teaching and to make it easy for people to practice. Also, this approach was suited to patients who generally had cold and deficient conditions. Thus the theory and practice of Meridian Therapy came to serve the general need to tonify deficiency, and dispersing excess became secondary. About a decade ago, however, criticism started to arise over such a simple and standardized approach.

One issue was whether the same root treatment could be applied for any condition as long as the patient was Liver Deficient. Even in cases of Liver Deficiency, some patients have insomnia while others have low back pain, and some patients are robust while others are thin and weak. So there is a difference in symptoms as well as constitution. Naturally, there were differences between the standard approach of Meridian Therapy and what practitioners actually did in their clinic. Another issue was establishing a theoretical framework connecting symptoms with pathological conditions and explaining the real nature of the disease. Unless we did this, we would have difficulty explaining what was being done in practice and preserving this system for future generations.

For example, let us say a patient with insomnia who has constant stomach problems with heartburn and diarrhea is found to be Liver Deficient. To say that all this was caused simply by deficiency of Liver function does not explain very much, and the principle and methodology for treating these symptoms cannot be deduced. It therefore became necessary to deepen our understanding of traditional pathology and develop a system which better connected diagnosis and treatment.

Therefore, as mentioned earlier, the Meridian Therapy Association agreed upon a theory of symptomatology and pathology and integrated this with the treatment principle of Primary Patterns. Based on this common understanding, we have reconstructed a di-
agnostic and treatment system of Meridian Therapy as follows:

A. Four Examinations with emphasis on pulse diagnosis.
B. Understanding of symptomology and pathology.
C. Deciding the Pattern.
D. Treatment appropriate to the pathology and symptomology.

One thing must be emphasized again. Once the Pattern is decided, such as Liver Deficiency Heat Pattern, this does not mean the treatment will be the same in every case. It can even be said that the treatment will be different for every single person. This is, because, even for the same diagnosis of Liver Deficiency Heat, sometimes the heat is due to internal heat from Yin Deficiency or excess heat on the body surface from Yang Excess. The heat generated in these ways sometimes spreads through other meridians and organs, and it can spread almost anywhere. There are even cases where heat which started out as Deficiency Heat changing to Excess Heat at the site it spread to, as will be described in section 3.

It is obvious, if one has any clinical experience, that the various symptoms patients have are related to the meridians and organs where cold or heat has spread. Therefore, when treatment of the affected meridians and organs does not give good results, it is often because treatment has not been given for the root cause of the disease. Once a person masters Japanese pulse diagnosis, it becomes easier to grasp where the root of the disease lies and where it is spreading to cause the symptoms. This makes it possible to provide the appropriate root treatment. Also, even among cases of deficient heat, there are varying degrees and the point selection and depth of insertion must be adjusted according to the degree. I would like to outline the features of conventional and reconstructed Meridian Therapy once more to clarify.

Conventional Meridian Therapy
1. Existence of meridians affirmed.
2. Based on view that all diseases manifest as an imbalance in the meridians.
3. Meridian imbalances are understood in terms of deficiency and excess which is determined by palpation, especially six position pulse diagnosis.
4. The Primary Patterns are deficiency Patterns. These are the four Patterns of Liver Deficiency, Kidney Deficiency, Spleen Deficiency, and Lung Deficiency.
5. Treatment is separated into root treatment and branch treatment, and both of these are applied in the same treatment and are of equal importance.
6. The basic treatment principle is to tonify deficiency and to disperse excess.
7. Root treatment is primarily tonification, in which needles are inserted shallowly barely penetrating the skin and they may be retained. Point selection is standardized based on the 69th chapter of the Nanjing.

Reconstructed Meridian Therapy
Items (1) and (2) are the same.
3. It is insufficient to only understand meridian imbalances in terms of deficiency and excess among the meridians. Thus the concept of deficiency and excess of Yin and Yang (five pathological conditions mentioned earlier) was incorporated. First one determines how the imbalance occurred (Yin Deficiency, Yang Deficiency, Yin Excess, Yang Excess, or Yin Repletion). Then one knows which pathological condition has been produced (deficient heat inside, excess heat inside, cold on the outside, etc.). Thus the imbalance is understood in terms of deficiency or excess and cold or heat in the meridians. Further, when the heat or cold spreads to other meridians and organs, this understanding of pathology is used to explain the various symptoms which arise, as a result. Thus the pathological condition of the patient is grasped more fully. Different types of pulse diagnosis are employed in this process: Six position pulse diagnosis is used to determine which Yin meridians are the cause, pulse quality diagnosis is used to understand the pathological condition, and pulse quality in individual positions is used to explain the symptomology.
4. The Basic Patterns are the original four Primary Patterns with differentiation of cold and heat conditions. There are eight Basic Patterns such as Liver Deficiency Cold Pattern and Liver Deficiency Heat Pattern. The name of the Basic Pattern does not reflect the distribution of cold or heat in the meridian. The interpretation of the symptomology involved in deciding the Pattern, however, would of course indicate certain meridians. In other words, the Basic Pattern is just a general category and each one of them includes a variety of manifestations.
5. The separation into root treatment and branch treatment basically remains the same as in conventional Meridian Therapy but, because of a broader understanding of pathology and the incorporation of this into the Patterns, the scope of root treatment has been expanded.
6. In terms of basic treatment principle, the addition of the concepts of cold and heat has modified the conventional techniques of tonification and dispersion. Thus a general rule for the depth of insertion has been designated as follows:
- Tonification with deep insertion for Yin deficiency.
- Tonification with shallow insertion for Yang deficiency.
- Dispersion with deep insertion for Yin excess.
- Dispersion with shallow insertion for Yang excess.
- Tonification with deep insertion for Yin reactive excess (cold invading from exterior).
7. The emphasis is on tonification, but the following principles are applied:
- Depth of insertion and tonification or dispersion is decided by deficiency or excess of Yin and Yang as listed above.
- Simple insertion or retaining needles is decided by heat or cold. Needles are retained for cold conditions. In cases of heat, dispersion with simple insertion is used for excess heat and needles are retained for deficient heat (although not as long as for cold conditions).
- Point selection is based on deficiency and excess of meridians and whether it is a cold condition or a heat condition. In general for cold conditions Luo Connecting points and the earth points are used. In cases of excess heat, Xi Clift points or son points (based on the 69th chapter) are used. In cases of deficient heat, the water or wood points are used.

The above principles are general rules, and it goes without saying that the point selection and needle technique is ultimately decided by the pathological condition and findings of each patient.

(To be continued)

Translated by Stephen Brown

Somei Okabe, MD. graduated from Showa Medical College in 1963 and received his Doctorate in Radiology in 1963. He became a professor at Showa Medical College in 1971. Then became Head of the Acupuncture Department of the Oriental Medical Research Unit of Kitasato University in 1973. He left his position in 1984 to devote himself to Meridian Therapy and the operation of his own clinic. He became the President of the Japan Meridian Therapy Association in July of the same year. And he also established and became the Director of the Acupuncture and Meridian Therapy Institute in 1986.