# Shonihari

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**Week 12 (10) 4/7**

Treatment of common pathologies: **"Kanmushi-sho"** (Irascibility bugs syndrome) and ADHD.

## ADHD
## Its Understanding and Appropriate Shonihari Treatments

**ADHD Understanding & Treating Appropriately**

1. No set definition on ADHD (Developmental Disorder) exists.
2. Developmental disorders: hard to list symptoms -> hard to define
3. Some definitions used as **international standards**:
   a. Two definitions
      i. **ICD-10 (1994)**
      ii. **DSM-IV (1994) DSM-IV-TR (2000) DSM-V (2013)**

**Classification of the Disease**

1. **ICD-10**: International Disease Classification of ADHD by **WHO**
   a. Psychological developmental disorders (F80-F89)
   b. Behavioral and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)
2. **DSM-IV**: Classification by American Psychiatric Association (APA)
   a. Part of disorders usually first diagnosed in infant, childhood, or adolescence

**DSM-IV-TR Diagnostic Criteria**

1. The following **inattention** and **hyperactivity-impulsivity** symptoms are present more often and significantly than the degree seen in others at the same age and developmental stage.
   a. **Inattention** (fails to give attention to the activities, difficulty sustaining attention, often loses things necessary to the task, difficulty organizing tasks and activities)
   b. **Hyperactivity-impulsivity** (difficulty to remain seated, difficulty playing or engaging in leisure activities quietly, often has difficulty awaiting turn and interrupts or intrudes on others)
2. More than one symptoms are recognized **before** the age **7 years old**
3. Some impairment from the symptoms is **present in two or more settings** (such as at home and at school).
4. There must be clear evidence of **clinically significant impairment** in social, academic, or occupational functioning.

5. The symptoms do **not** occur exclusively during the course of a **pervasive developmental disorder, schizophrenia, or other psychotic disorders**

**DSM-5 (2013) Criteria (Revised from DSM-IV)**

1. Moved into the category of **developmental neuropsychiatric disorders** (congenital cerebro-neurological developmental abnormality) and out of the category in which destructive behavioral disorders and oppositional defiant disorders are classified in.
2. Same classification as **Japanese Developmental Disabilities Supporting Law** (2005) use.
3. Several of the individual's ADHD symptoms must be present prior to **the age 12**, compared to 7 years as the age of onset in DSM-IV
4. ADHD can be diagnosed in conjunction with autism (**comorbidity and/or complications with autism**)
5. **Abolished** classification of **3 sub-types**:
   a. **Predominantly inattention** type
   b. **Predominantly hyperactive-impulsive** type
   c. **Mixed** type
6. Evaluate the **severity with 3 degrees**:
   a. Mild, moderate, and severe

**DSM-IV**

1. Critiques by **Allen Frances** (American psychiatrist who chaired to compile DSM-IV)
   *a. "The **expanding boundary of psychiatry** is causing **a diagnostic inflation** that is swallowing up normality and that the over-treatment of the 'worried well'."*
   b. **Threefold increase** of the number of children diagnosed with attention deficit disorders since DSM-IV was published.
   c. Reasons:
      i. **Pharmaceuticals** made pediatricians, pediatric psychiatrists, parents and teachers believe that ADHD had been under-diagnosed.

ii. many children who had been considered "normal" before the introduction of DSM-IV were diagnosed as having ADHD

d. Many children who have simply a unique personality and are not "sick" or "abnormal" were **over-diagnosed** as having ADHD and thus were **over-treated** with medications in the U.S.

2. **Relative-age Effect** (Research in Canada)
   a. **Younger children**: more likely to be **inappropriately diagnosed** with ADHD & treated with prescription medication than their older peers in the same grade.
   *e.g.) Children born in August are the youngest in class. They tend to appear more "**immature**' due to their age & could be considered "abnormal."*

**Symptoms of ADHD**

1. Hyperactive
2. Impulsive
3. Attention deficit
4. Other problems
   a. Difficulty making friends
   b. Often having comorbidity with Learning disability
   c. Tend to cause problems at home

**Disorders that tend to have Comorbidity with ADHD**

1. Autism
2. Obsessive compulsive disorder (OCD)
3. Tourette Syndrome
4. Tic
5. Oppositional defiant disorder (ODD)
6. Disobedience
7. Conduct disorder
8. Attachment disorder
9. Depression
10. Anxiety disorder
11. Drug and/or alcohol abuse

**Misdiagnosis**

1. Possible Misdiagnosis of ADHD is pointed out in the U.S.
   *"Of out of 450,000 children diagnosed with ADHD, 100,000 are possibly **misdiagnosed** or **inappropriately diagnosed** as a ADHD in the U.S."*

**Incidence & Prevalence of ADHD**

1. Varies depending on the criteria & standard
   a. **1-5%** of children are affected **in the world**:
   b. **3-5%** when diagnosed via **ICD-10 criteria**
   c. **0.5%** when diagnosed via **DSM-IV**
2. Other factors: Gender
   a. More significantly seen in boys:
   This could be because boys tend to play rough and their problems tend to be more easily seen than in girls.

**ADHD as an Evolutional Process as a Species**

**Interpretation of ADHD**

1. Not disorders
2. **Unique personalities** manifested in the process of **evolution**
3. Difficulty to grasp the characteristics & causes of ADHD
   a. Requires appropriate understanding and support.
   b. However, it's hard to determine objectively the causes of the problems related to ADHD:
      i. True disabilities (i.e. ADHD)? or
      ii. Simply lack of their life experience (lack of life and people handling skills)?

**ADHDs as Little Geniuses**

**Uniqueness or Disorders?**

1. Some think that many of the people who were historically called "geniuses" such as great people, artists, inventors may have had ADHD.
   e.g. Winston Churchill, John F. Kennedy
2. Some concern that the treatment of ADHD with medication may **improve** the children's **social adaptability**, **but** it may **ruin their uniqueness**.

**New Interpretation of ADHD: "Quick Adaptation" Type**

**Advantages of the Characteristics of ADHD 1**

In the Journal of the American Academy of Child & Adolescent Psychiatry (December 1997 issue), **Peter Jonson** (Psychiatrist) described the children with ADHD as:

1. **Always alert** (excessively sensitive): can collect and integrate information by using all the five senses at the same time
2. **Quickly judge** things **visually**
3. **Promptly take actions**: quickly attack prey and/or flee from enemies, if necessary
4. **Hyperactive**: advantageous in capturing food, or making quick decisions, such as moving to a milder place during a drastic seasonal change or of the ice age quickly enough.

**New Interpretation of ADHD: "Quick Action" Type**

**Advantages of the Characteristics of ADHD 2**

**Quick Action Type (an ADHD Type) v.s. Challenging the Environment Type ("normal" type)**

1. **Quick Action Type**: advantageous under physically challenging conditions.
   a. Quickly move somewhere else to avoid the problems
   b. Can cope with quick changes.
2. **Challenging the Environment Type**: tends to take time & think before taking an action.
3. **Changes of required traits as a species**
   a. Old times when our environment was hard or quickly changing: Quick Action Type had more advantages
   b. Now, our environment became safe and stable: Challenging the Environment Type has more advantages
      Our environment doesn't require quick actions.
      Instead, our society requires abilities to:
      **a. Analyze and solve problems**
      **b. Be patient**
         **i. Control impulsiveness**
         **ii. Control hyperactivity**
   -> Disadvantageous for people with ADHD

**ADHD and Diversity of Behaviors**

**What is the Appropriate Range of Normal Behaviors?**

**Diversity as a species**

1. If we allow us, as human beings, to be **diverse**, likewise we should allow **various behavioral patterns** of people
2. Expanding range of criteria of ADHD:
   a. Does NOT allow **diversity of behavioral patterns**
   **b.** Can cause **Over-diagnoses**
   c. Could cause **over-treatment**
   d. Could **interfere with healthy growth** of children who are labeled as a ADHD

**Concerns about Medication**

**Possibility of Over prescription**

1. **Increasing number** of children are **on medication**
2. Some object to the use of **CNS stimulants**
3. Some object to the use of **Ritalin**:
   a. Overprescribed especially in the U.S.
   b. Takes away **creativity and intelligence** from children who are diagnosed with ADHD, but are actually healthy.

**Underdiagnoses & Under treatment**

It is critical for the parents and other adults involved:

1. To appropriately **understand** the disorders
2. To appropriately **support** the children

**Lack of understanding** can cause

   a. Delay of finding children's behavioral problems
   **b. Delay of appropriate treatments**
   c. **Secondary psychological & emotional disorders:**
      i. Bully
      ii. Juvenile delinquency
      iii. Refusal to go to school
      iv. Recluse
      v. Rebellious behavior

**Skepticism against Overmedication**

**1. Is ADHD really underdiagnosed?**

**2. Is Ritalin really overprescribed?**
   a. Prevalence of ADHD (in U.S.): **3-5%** of the children
   b. Rate of prescription (in U.S.): **1-2%**
      i. (3-5%) - (1-2%) = **2-3%**
      ii. **2-3%** of children diagnosed with ADHD are **not** on medication

**3. Is the medication working?**
   a. This fact may tell us:
      i. Some on medication may need higher dose of prescription
      ii. Some on medication may **NOT** need the medication

**Affect of Labeling - Good or Bad?**

**Labeling is good**

1. Labeling makes it easy to support the children with ADHD
2. **Russell Barkley** (clinical psychologist) says:
   a. Labeling has quite a few pitfalls BUT,
   b. **Accurate labeling** makes it possible for the children:
      i. To **access various avenues of support**
      ii. To **be understood** better by people around them

**Labeling is bad.**

Labeling may lead the children to where they are anticipated to be.

1. **Tom Hartmann** (writer and journalist) says:
   a. It's cruel to label any child with a brain disorder

**Labeling is bad.**

**Self-fulfilling Prophecy**

1. **Thomas Armstrong** (psychologist & educator):
   a. Self-fulfilling Prophecy: a prediction that directly or indirectly causes itself to become true, by the very

terms of the prophecy itself, due to positive feedback between belief and behavior.
   b. Labeling may work as self-fulling prophecy
   c. Criticizes the behavioral therapy that the children with ADHD access
   d. Propose raising the children based on the personality and environment of each child.

**ADHD & Support Systems**

***Yoiku* (raising & educating) by all household members**

1. Help from living family members has is significant regarding both physical and psychological support.
2. It may be hard for the parents to accept this support at the beginning
   a. Sense of guilt
   b. Don't want to be thought of as being irresponsible
3. Appropriate diagnosis & treatments change family members' negative view:
   a. To the children: ADHD can be treated.
   b. To the parents: ADHD is not their faults.

**Organizations, Groups, & Communities**

1. If surrounding people, such as a soccer coach, and other sport instructors, understand ADHD better,
   a. They can support and help the children with ADHD develop their abilities and build fruitful relationship with their friends
   b. It can give the children great opportunities to have confidence and self-respect

**Central Nervous System (CNS) Stimulant Medication**

1. In the U.S.,
   a. CNS stimulants are largely used. Many students are prescribed the stimulants and end up being sent to the school nurse
   b. However, psychologists and other related professionals are reluctant to use the stimulants.
2. Concerns about the effects of stimulants on babies and toddlers
3. Caution must be used for the use.

**CNS Stimulant Medication**

**Ritalin**

1. Use of CNS stimulants in the U.S.
   a. Dramatic increase in the prescription
   b. Some report that 5-10% of the class are on the medication
2. Ritalin (Methylphenidate, MPH):
   a. A CNS stimulant used in the treatment of ADHD, and narcolepsy.
   b. Similar to amphetamine
   c. Also used for Chronic Fatigue Syndromes (CFS)

**Use in Japan**

1. Major prescribed CNS stimulant medications
2. Ritalin [R] (Ritalin [R] 439740 and Concerta [R] (Concerta [R] 4657942)
3. Ritalin [R] is used for narcolepsy
4. Concerta [R] is used for ADHD
5. Was limited to those 18 years old and younger
6. In December 20, 2013, extended its application to patients older than age 18 years.

| ADHD | Type | Dosage | Side effects |
|---|---|---|---|
| **Ritalin Methylphenidate** | **CNS Stimulant** | ***5-60mg*** | **Insomnia, lack of appetite, tic** |
| **Dexamphetamine** | **CNS Stimulant** | ***5-20mg*** | **Insomnia, lack of appetite, tic** |
| **Tricyclic Antidepressants** | **Antidepressant** | **Max 5mmg/1kg of the weight per day** | **Thirst, constipation, crams** |

**Medication Used for ADHD**

**Efficacy**

1. Increase the ability to control hyperactivity and compulsiveness and increase the duration of attention
2. Decrease many problems related to ADHD, decrease defiance, increase the ability to follow instructions, and thus decrease problems
3. Reduce forgetfulness, can sometimes dramatically improve the academic performances: quality of work, reading, and writing.
4. Become cheerful, motivated and confident since they know they are not giving their loved one's troubles

**Overcome the negative effects caused by ADHD**

1. Dramatic improvement is temporary
2. Recognize the negative effects that have been caused by ADHD
3. Recognize the abilities that should have been acquired in terms of predicted age-related development
4. Learn and obtain these abilities
5. Repair the current relationship with the family members and reestablish a new relationship with them
6. Manage intake of the medication
7. Regular intake of the medication at the set dosage each time

8. Consideration of how the child feels about the medication

**Dosage**

How much dosage is required for a child?

1. 5mg as a unit. Prescribe in 5mg increments.
2. Start with a small dose and gradually increase it.
3. Find the dose which is most effective with the least side effects
4. Maximum dosage: 60mg per 24 hours. Usually most children don't need this much amount.

**Duration of Intake**

How long should the child need to take the medication?

1. Most children can overcome the problems related to ADHD as they grow older or at least they become better at controlling the symptoms and obtain the skills to overcome them.
2. For a small child, it sometimes takes a few years until s/he can deal with his or her problems.
3. Regularly evaluate
4. Once a year, stop the medication for 1-2 weeks.
5. Observe how the child is doing without the medication
6. Evaluate the effect of the medication and
7. Determine the dosage of the medication
8. Controlling the dosage of the medication must be done regularly with the assistance of their doctors and teachers.

**Prognosis of Children with ADHD**

1. **About 50%** of the children diagnosed with ADHD become able to lead **a "normal" life** at the beginning of their adult years.
2. The **rest 50%** live with the hardship related to ADHD for the rest of their lives.
3. **30 - 80%** of the children diagnosed with hyperactivity have the symptoms even after reaching the adult age.

**ADHD & Education**

1. ADHD and the secondary symptoms can cause other problems such as depression and conduct disorder.
2. These symptoms affect their behaviors and learning performance.
   a. 90% have poor abilities
   b. 90% doesn't reach set goals
   c. 20% are not good at reading
   d. 60% have serious problems in writing
   e. 30% drop out school (in the U.S.)
   f. Only 4% obtain undergraduate degrees. (<-> Average rate of the total population is 25%) (in U.S.)

**Children doesn't fit for Mass Education**

For teachers who use mainstream techniques, children with ADHD are the "hardest to deal with."

**"I didn't do anything wrong..."**

"I didn't do anything wrong, but I am scolded, ignored, ridiculed. I lost my confidence."

Children with ADHD try to find a way to supplement their "lack of attention" and adopt socially.

**Understanding the Disorders**

What can we do for them?

1. Understand their feelings
2. Acknowledge their efforts
3. If they make a mistake, explain how to correct it
   a. Until they will gain their confidence gradually
4. First step is
   a. To understand ADHD
   b. To grasp the situation where the children are & how they are feeling

**Cope with the challenges in the Developmental Stages**

1. If the children can clear the goals of each developmental stages, they can go together with their peers and in certain areas, they may show their special talents.
2. Possibility of "Quick-action Genius Type"
3. If others don't treat them with understanding about how they are feeling, they will have more inferiority complex and low self-esteem, and tend to become irritable.

**Adults with ADHD**

**Research by Dengler and others (1976)**

1. 31-66% of adults who had ADHD in their childhood still have the symptoms.
2. If the children are diagnosed with ADHD at an early age, and have appropriate treatments and supports, they have less hardship in their childhood and may be able to develop their potentially unique talents.

**Criteria for Adult ADHD**

1. Prerequisite: **ADHD symptoms seen in their childhood**
2. Consistent kinesthetic hyperactivity
3. Obvious attention deficit, inattention and forgetfulness
4. Meet at least **two** or more of the following criteria (DSM-IV):
   a. Emotional instability
   b. Inability to complete tasks
   c. Temperamental problems: irritability, easily get angry, explode emotionally
   d. Impulsiveness
   e. Low tolerance of stress
5. Some of the criteria are not appropriate to apply for adult ADHD

**Clinical Statistical Report from the CULIA KI Clinic**

**Period**:

**3 years 7 months (01/01/2008 - 07/31/2011)**

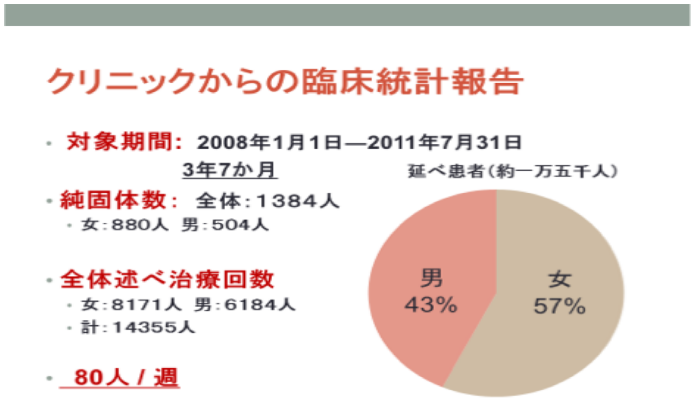
**Number**: Total:1384

Female: 880 (57%), Male: 504 (43%)

**Cumulative Number of Treatments**:

Female: 8171, Male: 6184

Total: 14355




**Number of Children Visited**

**Children (Age 1-12)**

24% of the total patients visited

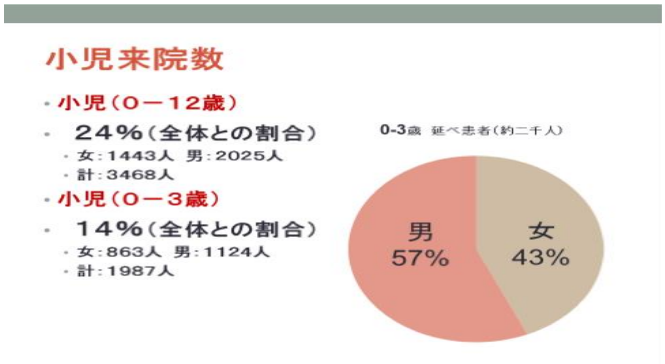
Female: 1443, Male: 2025

Total: 3468

**Children (Age 0-3)**

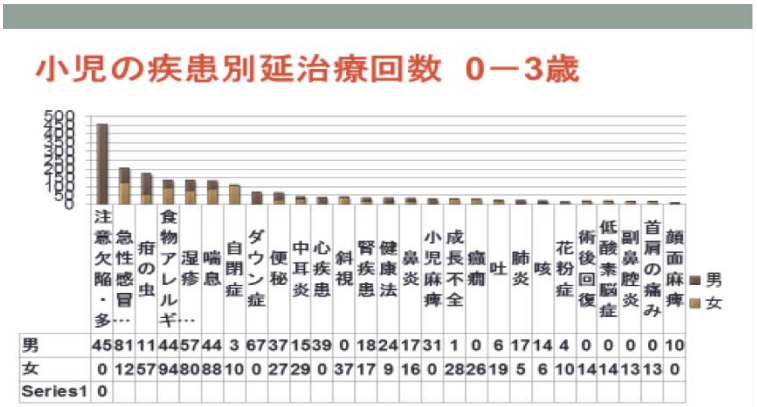
14% of the total patients visited

Female: 863 (43%), Male: 1124 (57%) Total: 1987




**Number of Clinic Visits for Pediatrics (Age: 0 - 3)**

**Breakdown of Reason for the visit**




| Top row from left to right | | |
|---|---|---|
| 1. Attention deficit<br>2. Flu<br>3. *Kan no mushi*<br>4. Food allergy<br>5. Eczema<br>6. Asthma<br>7. Autism<br>8. Down syndrome<br>9. Constipation<br>10. Otitis media<br>11. Cardiovascular problem | 12. Strabismus (squint)<br>13. Renal problems<br>14. How to maintain health<br>15. Nasal inflammation<br>16. Polio<br>17. Multidevelopment<br>18. Temper<br>19. Vomiting<br>20. Pneumonia | 21. Cough<br>22. Hey fever<br>23. Recovery from surgery<br>24. hypoxic ischemic encephalopathy<br>25. Sinusitis<br>26. Shoulder pain<br>27. Facial paralysis<br><br>Brown Square: Male<br>Yellow Square: Female |

## Clinical Record in CULIA KI CLINIC

**Visiting Rate & Ratio between ADHD & Other Developmental Disorders**

| Total # of Clinic Visits | 3468 | Ratio |
|---|---|---|
| Total # of visits for Developmental Disorders (DD) | 1038 | Developmental Disorders/Total Visits 29.9% |
| DD Breakdown | Number of Visit | Disorder/Total Visit of DDs |
| ADHD | 600 | 57.8% |
| Autism | 119 | 11.5% |
| Down Syndrome | 67 | 6.5% |
| Under-development (Physically) | 47 | 4.5% |
| Seizure | 27 | 2.6% |
| Tic Syndrome | 4 | 0.4% |
| Kan no Mushi | 174 | 16.8% |

### ADHD & Kan no Mushi

Kan no Mushi: considered a disease that pediatric acupuncture can effectively treat

1. ADHD is considered to be an expression of Kan no Mushi
2. Symptoms of ADHD are included within the symptoms of Kan no Mushi
3. Symptoms of ADHD:
   a. Hyperactivity
   b. Impulsiveness
   c. Attention deficit
4. Other related problems:
   a. Difficulty making friends
   b. Learning disability
   c. Causing problems at home

### Visiting Rate & Ratio between Pediatric Problems

### ADHD & Kan no Mushi Rates

Ratio of Visit due to Developmental Disorders in the total visits: 29.9%

* ADHD and Kan no Mushi are separated.
* ADHD: Severe cases. Patients are already on medication such as methylphenidate
* Kan no Mushi: Light to moderate cases. Patients were diagnosed with ADHD or similar disorders by a psychiatrist or psychologist, but are not yet on medication. They want to improve the symptoms with acupuncture without use of medication

### Severe ADHD

1. Severe ADHD cases: Diagnosed by a psychiatrist and prescribed medication
   a. Recommended to have acupuncture treatments regularly, too.
   b. Consider the treatments may be long term, 2-3 years.
   c. Also consider the possibility of having ADHD even after becoming adult (Adult ADHD) and how the child should live with ADHD as a family member, and how other family members can cope with it.

### Acupuncture (Shonihari) Treatment for ADHD

Already great masters have shown how to treat Kan no Mushi with acupuncture. These treatments can also treat ADHD and I am very grateful to the masters.

### Shonihari (Pediatric Acupuncture)

1. What should the family members do?
   a. Change their view of the child
      - From "the trouble maker" to a "Quick-response genius type," "star" of the family
2. What should Hari practitioners do?
   a. Should become "a genius who treats little geniuses"
   b. Become an even more bigger scale "Quick-response genius type" star acupuncturist
   c. Conduct super fun up-tempo treatments
   d. Consider the possibility of long term treatments:
      - Efforts to reduce family's financial burden and time spent:
        - Reduce frequency of the visit, introduce and instruct home-therapy
   e. Reconsider and further improve the level of Teishin Treatments and Sho in Keiraku Chiryo (Meridian Therapy)
   f. Consider the use of EV treatment and magnets
   g. Consider the use of peripheral acupuncture methods: gold press balls, press tags, and cupping
   h. Instruct the child and his/her family:
      - Dietary suggestions: adjustment from a "genius type" diet (fried/fatty foods) to a little more "regular" dietary habits.
      - Encourage the family to have more physical contact with the child

Common treatment Points for Blood stasis

## Lung Deficiency Liver Excess Pattern (Deficient type of Chp.75) Root Treatment Points:

**Tonify LU-5 and KI-7.** Disperse LR-2. Auxiliary Points for Specific Conditions: If the Heart pulse is excessive, tonify KI-2 and disperse either PC-4 or PC-8. **Disperse LR-8,** SP-10, and **SP-6** since the Liver excess is due to blood stasis. If there is a lot of deficient-type heat, tonify KI-10. LU-5 must be tonified if there is a lot of water ki. For Spleen and Stomach heat use a moxa-on-the-handle needle at SP-8, and disperse ST-36. If the etiological factor is pathogenic cold, disperse LR-4. If the etiological factor is abnormal eating, disperse LR-3. Root Treatment Supplementary Points: CV-17, CV-12, ST-25, LR-14, GB-24, CV-5, BL-13, BL-18, BL-19, BL-23, BL-25, BL-26

Common treatment Points for over intake of medication and foods

## Spleen Deficiency Liver Excess Pattern Root Treatment Points:

Tonify PC-7, PC-8, SP-2, and SP-3. For a Liver excess heat pattern, disperse GB-38, GB-36, TW-5, TW-3, and LR-2. For a Liver excess blood stasis pattern, disperse LR-8, SP-10, and SP-6. Auxiliary Points for Specific Conditions: If the etiological factor is abnormal eating, disperse LR-3. If it is pathogenic cold, disperse LR-4. If heat has spread to the Kidney and Bladder, disperse BL-40. If heat has spread to the Lung, use PC-5 and SP-5 as basic root treatment tonification points in place of the ones listed above in the root treatment points section. If there is Stomach excess, disperse ST-36, ST-37, or ST-39. Root Treatment Supplementary Points: LR-14, GB-24, CV-12, ST-25, BL-14, BL-17, BL-18, BL-19, BL-20, BL-21, BL-22