

Ashi Points in Clinical Practice

Abstract

The use of ashi points constitutes the most practical approach to clinical acupuncture, particularly in terms of the treatment of musculoskeletal pain and dysfunction. In this article the author documents the historical context of the use of ashi points, before describing the associated basic theory and their use in clinical practice.

Introduction

Although Ma Danyang's Heavenly Star Points are the easiest method of bringing acupuncture theory into clinical practice (see *The Journal of Chinese Medicine*, issue 98, February 2012), the most practical approach to acupuncture in a clinical situation involves the use of ashi points. However, their apparent simplicity of use often means they are discarded by practitioners in favour of treatment based on complex channel and point theory. A story illustrates this point: Twenty years ago a fellow intern in Beijing asked our acupuncture teacher why he did not include distal needling or make use of ying-spring or shu-stream points during treatment. The teacher answered, 'If something gets into your eye, get it out of your eye', in order to remind us not to lose sight of the problem being treated due to overthinking the theory. That this comment came from an acupuncturist who had previously lived as a Buddhist monk on Mount Wutai - praying, sweeping and treating the suffering - who was then forced to live in a pig-sty as part of his re-education during the Cultural Revolution, and finally ended up working in a hospital outpatient clinic in the middle of Beijing, made this admonition to remember that theory results from clinical experience - and not the other way around - all the more poignant.

Within Chinese medicine, treating the location of discomfort or pain without addressing its underlying causes is regarded as giving a 'branch' treatment instead of fixing the 'root' cause of the condition. Because ashi acupuncture frequently involves needling directly into discovered areas of pain, it is easy to mistakenly believe it falls under the heading of a branch rather than a root treatment. As will be seen below, treating the obvious location of pain without looking at the patient holistically - known in Chinese as 'treating the head when the head hurts, treating the foot when the foot hurts' (頭痛醫頭, 腳痛醫腳) - is not how authentic ashi acupuncture is actually practised. Ashi acupuncture involves treating areas causing with pain and dysfunction that are usually unknown to the patient, and which actually constitute the root cause of their physical pain or dysfunction. Adopting ashi acupuncture as the primary treatment method when treating physical pain, numbness, tingling or burning

due to inhibited circulation or nerve impingement, as well as a range of motion issues, is critical to clinical success.

The *Nei Jing Ling Shu* (Inner Classic Divine Pivot) Chapter *Xie Qi Zang Fu Bing Xing Pian* (Chapter on Illnesses of the Zangfu and Pernicious Qi 靈樞 邪氣臟腑病形篇) clearly states the criteria that should be used to judge the standard of a physician:

上工十全九: Superior practitioners, of ten [patients] nine are cured.

中工十全七: Medium [i.e. standard/common] practitioners, of ten, seven are cured.

下工十全六: Inferior practitioners, of ten, six are cured.

The *Nan Jing* (Classic of Difficulties 難經) quotes this in the 13th Difficulty, thereby reaffirming it as the accepted standard for medical practitioners. Major texts from each successive dynasty have since included a commentary on these standards, which have not changed or lessened through time or author. These are tough standards by which to judge oneself. I would personally be thrilled to be ranked along with the lowest of practitioners as described in the *Nei Jing*. However, the complexity of my clients, the weakness of Chinese medicine at this particular time in history, the poor quality of herbs available, the restricted or outlawed use of some ingredients or needling methods, the lack of effort or compliance on the part of patients, and the distractions of my own life, mean that an efficacy rate even of over 50 per cent remains elusive. However, if we narrow the field down to physical injury and rehabilitation, I can confidently state that the majority of my patients will experience extraordinary improvement or cure, and that almost all will experience tangible benefit from seeing me. This is not arrogance, nor a result of any secret techniques passed on by my teachers, but merely the result of the clinical teaching I received that puts ashi work at the core of all injury treatment.

History

Ashi needling is not complicated. In fact, the discovery that injuries improve after massaging a particularly painful spot likely constitutes one of the first and most

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fundamental discoveries of every medical system on the planet. It is an experience that every human who has tried to help others suffering from pain must have experienced. The first record of using such painful spots as treatment

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points in the Chinese literature is in *Ling Shu's* chapter *Jing Jin Di Shi San* (Thirteenth Writing: Sinew Channels 經筋第十三): 'It is [the point of] pain that defines an [acupuncture] point (以痛為腧).' The term *ashi* - literally 'Ah yes!' - was first coined by Sun Simiao in his Tang Dynasty *Qian Jin Yao Fang* (Thousand Ducat Formulas): 'In terms of the method of *ashi*, in speaking of a person who has a condition of pain, when squeezing, if there is a spot inside [we] do not ask if it is a [recognised] acupuncture point, because [we] located a painful spot and they said, "Ah yes!". Needling and moxibustion [the points] have proven effective in the past, thus they are called *ashi* points.' (《千金要方》: 有阿是之法, 言人有病痛, 即令捏其上, 若里當其處, 不問孔穴, 即得便成痛處, 即云阿是。灸刺借驗, 故云阿是穴也。)

Ashi points today

Ashi points can be found in various contexts today. In the West, Janet Travell's pioneering work on what she terms 'trigger points' has found its way into Western acupuncture and the professions of sports massage, chiropractic and physical therapy. In modern China Professor Lu Dinghou of the Beijing Physical Education University has tried to scientifically prove the efficacy of *ashi* work by intentionally injuring his own thigh, then needling the injury whilst monitoring the healing process through repeated biopsy (see Lu, 2000). Japanese *shiatsu* (*dian xue* 點穴 in Chinese) treatments often find the practitioner leaning deep into tender knots in the muscles that light up entire pathways of pain; Thai massage, Swedish deep tissue massage - the styles of treatment and countries of origin that make use of *ashi* points are endless. Yet, despite such widespread usage across so many cultures, the application of *ashi* points as part of a cohesive treatment strategy is limited. Thus *ashi* work does not seem to generate results that surpass the lowest ranking of a physician as described in the *Nei Jing* above. This is likely due either to practitioners only searching for *ashi* points based on the Western Trigger Point charts, which do not provide a broad enough understanding of the connections across the body, or a lack of clinical understanding of what needling sensation to generate when *ashi* points are actually discovered during treatment.

Basic theory

The most fundamental concept to grasp regarding *ashi* work is that the place where a patient feels pain is rarely the actual source of that pain. This concept is true elsewhere in

Chinese medicine: if a patient has red patches on their skin, the causative pathology is most likely not in the skin itself but the presence of heat in the blood; likewise if a patient has a painful back, the pain is likely coming from an injury to the tendomuscular channels (*jingjin*, also commonly known as sinew channels) that lead to the back (usually inferior to the pain). There are exceptions, of course, such as if the patient's skin is burned or the back is bruised in a fall (to continue the examples above). Therefore, whilst acknowledging that there are many reasons why one may experience pain, this article will focus on what in my experience is the most common - which I call 'pathways of pain'. The treatment of these pathways involves *ashi* points as the focus of treatment.

Pathways of pain

A pathway of pain is a line connecting two places in the body affected by an injury: the first being an area of stagnation, and the second being the location where pain is perceived. The first point - the *ashi* point - is usually unknown to the patient. The second point - the location of the pain - is where the patient tends to point when asked about their injury. The true injury is at the *ashi* point, which physically tightens part of the tendomuscular channel, or manifests as knot at a specific location along its pathway. In both situations the overall length of the tendomuscular channel is shortened. This creates a pull that is not a normal tension-vector of healthy body movement - put plainly, the injured tendo-muscle pulls on the skeletal system in an abnormal way. This causes pain to be perceived elsewhere, usually where the tendomuscular channel passes through or connects to a joint of the skeletal system, which is compressed or pulled out of place. The pathway of pain is the direct - but unknown - connection between the *ashi* point and the perceived injury/pain.

This does not mean that the patient's perceived injury is not real - it does actually hurt at the place indicated by the patient. In fact, it is not uncommon for the *ashi* injury to cause physical damage further down the pathway due to the shortening of the tendomuscular line. But if one treats the injury at this location without discovering the actual cause further down the pathway and using this to release the contracted tendomuscular channel, then either the results of treatment will be poor, or the injury will improve temporarily but remain a recurring problem for the patient. As a clinical example, take the common case of a patient who has 'thrown out' their lower back. The injury seems to be in the lower back - as the person is unable to straighten up or put any weight on the lower spine - but the most common cause of this problem is actually not in the lumbar vertebrae or muscles of the back, but in the tendomuscular pathways in the anterior aspect of the thigh somewhere between the anterior superior iliac spine (ASIS) and the knee. Palpation of the anterior thighs will reveal *ashi* points that are often unexpected for the patient.

These unacknowledged, old injuries are actually what set off the acute injury of the lower back. In such a case if the practitioner only treats the lower back, although the person may slowly recover over a week or so, the back will remain vulnerable to being 'thrown out' on a regular basis. If the practitioner treats the ashi points in the thigh (and usually it is not necessary to needle the back at all) the patient is often walking normally the next day, and in the future will not need to suffer with a chronic 'bad back'.

Ashi points

By virtue of their name, ashi points are identified through pain on palpation. However, this pain must be differentiated from other points that hurt when pressed. An ashi point produces an unexpected 'wince-pain' for the patient. It is a pain that is:

- 1) Unexpected in intensity
- 2) Instant (it does not build gradually with pressure), and usually causes weakness/flaccidity of the muscles of the patient's entire body, instead of a desire to tighten and resist the application of pressure by the practitioner.

When palpating for ashi points, it is necessary to educate patients to differentiate between two types of pain: 'injury pain' and 'expected pain'. Injury pain refers to the ashi pain sensation described above, whereas expected pain refers to the discomfort that results from having a finger or thumb pressed deeply anywhere into the body, regardless of whether there is an injury present. It is important to be able to differentiate between these two types of pain in order to minimise the number of needles required to treat the problem (see below).

To illustrate by way of a clinical example, take the case of the person described above who has 'thrown out' their back: they may report that their injury happened unexpectedly, perhaps while bending over the sink to brush their teeth or when they tried pick up their child - they collapse to the floor, unable to stand and are unable to take any weight whatsoever on their back. On further questioning we ascertain that the patient had cleared out their garage the previous weekend, or perhaps recently joined a gym and started running and lifting weights. During palpation we discover that the front of both thighs have ashi points, but that the right side is dramatically more 'injury painful' than the left. The root injury in this case is therefore in the right thigh, and was caused by the previous physical exertion that was either excessive, or that was not followed up by appropriate stretching and care. The tendomuscular channel in this case tightened and stasis manifested along the pathway of pain, which then pulled on a lower vertebra of the spine where it attaches. The vertebrae now had an unfamiliar force-vector, and were being pulled in a direction that they are not designed to go. Then, when the patient bent over the sink or picked up their child the

additional weight added to this vector was enough to pull the vertebrae from its accepted range of movement into a place of injury. The result is the 'thrown out' back, but the actual cause was the force-vector from the ashi point

An ashi point produces an unexpected 'wince-pain' for the patient.

along the pathway of pain. This sub-acute tension, added to the tension from a normally acceptable source (leaning forward or picking up a heavy object) combine to create an injury. If we then treat the ashi point, the tendomuscular channel relaxes and infuses with proper flow, the sub-acute pathological force vector is removed, and the vertebrae can return to and operate in their normal range of motion.

Although the actual physiological mechanics involved are certainly more complicated than this description, this is the basic premise for ashi work in the clinic. To take another illustrative example, the tendo-muscles around Shousanli (手三里) L.I.-10 can be injured due to repetitive grasping of the hand, or falling on the hand and wrist. The tendomuscular line tightens and contracts, shortening the connection down through the wrist and into the fingers. This means that the normal spacing of the bones in the wrist is shortened and their range of movement inhibited. A pathway of pain is created, pinching the nerves and/or limiting blood flow to create tingling, numbness, pain or burning in the wrist or hand. The additional force-vectors created may not be enough to create constant pain, in which case the person may only experience pain when lifting an object or rotating in a specific direction. As in the example of back-pain above, directly treating the wrist, fingers or knuckles will provide slow and/or temporary relief, whereas releasing the contraction at the ashi point in the area of Shousanli L.I.-10 will relax the pathway so that the pain disappears permanently within 24 to 72 hours.

Although ashi points can be created by physical trauma – an obvious movement in the gym, sports field or workplace - ashi points are more commonly generated without the individual realising what is happening, such as by overusing or overtaxing specific muscles and tendons. Although there are many variables that dictate whether an ashi point is created, there are a few things practitioners should bear in mind when questioning patients:

1. Non-routine exercise that uses unfamiliar muscles is often not a problem for larger weight-bearing muscle groups, but smaller ones are easily damaged, even though the patient may think this unlikely or is already very physically fit.
2. Use of a particular muscle over a greater length of time than normal, or using the muscle to hold a specific posture for a greater length of time than normal can cause ashi points. Classic examples are spending all day

moving house, or skiing with the knees bent and the body in one fixed position all day.

3. Using a muscle for the same motion over several days in a row so that by the third day the force is being applied to a muscle that is already fatigued from overuse on days one and two. That is to say, if the patient had stopped using that muscle after the first or second day, an ashī injury would not have formed, but on day three the stress of use was too much for the fatigued muscle and an ashī point was created.
4. The most important factor of all, however, is not how a muscle is used, but the rest state (or lack of) that happens afterwards. According to the research conducted by Professor Lu Dinghou and documented in his *Muscle Injuries and Pains Involving Back and Limbs* (Lu, 2000) a muscle that has been overused needs fresh blood as it goes through the 24, 48 and then 72 hour marks of cellular breakdown, reparation and rest. We experience this as muscular soreness, and it is why we are often more sore on the second or third days after exercise than on day one. When a patient with an overworked muscle goes to sleep at night their heart rate drops, pushing a minimal amount of blood through the body at the time when the muscles most need plenty of blood to repair and recover. Starved of the extra blood required, they tighten and knot. The back-pain patient described earlier, for example, may sleep in a foetal position with their legs pulled up, in which case the tendomuscular channels of the thigh tighten in this shortened position, creating even more of a pull when they reach for the toothpaste or pick up their child the next morning.

It is also important to be aware that when ashī points are created in the manner described above, they may not cause an immediate problem. Instead, they shrink in size and harden, waiting until either they are re-aggravated into a larger injury, more ashī points are added along the same pathway of pain, or an excessive movement causes injury long after the original shortening of the tendo-muscle. Most patients fall into this category, and have no memory of how they developed the ashī points located by the practitioner.

The 'onion effect'

It is rare that an injury results in the creation of only one ashī point. For instance, if you catch yourself with your hand as you fall to the floor, multiple muscles/tendomuscular lines will likely be strained or jolted. The sudden tensing during the fall and jolt upon impact will also likely shoot up into the scapula, shoulder, spine and neck. If on the way down you also bounce on your hip - but do not notice due to the greater pain in the wrist - additional unknown ashī points will be created in the lower back, buttock etc. If a practitioner was to treat every single ashī point in such a case, the patient would end up covered in needles and their qi might become exhausted. This is why it is essential

to identify the most important ashī point – the epicentre - of the pathway of pain. I describe this to my patients as the 'onion effect', a metaphor that also serves to remind practitioners that the tendomuscular channels are three-dimensional, and that ashī points can develop at a variety of depths. Either the practitioner must treat every single ashī point at all depths over several treatments to see success, or look for the epicentre point that will cause the lesser ashī points to resolve. If one is able to identify and treat the main ashī points, then within one to three days many of the lesser points disappear as qi and blood flow down the tendomuscular pathways with less obstruction and thus greater force, softening and dispersing minor blockages of qi and blood. Instead of treating every layer of the onion before reaching its core, we look for the centre so that the outer, less important layers take care of themselves. If one only treats the minor blockages, the flow created by their release is not enough to break through the obstruction and heal the larger ones. It is therefore critical to needle the most important ashī points, not only to obtain the most effective results for the patient, but to lessen the number of needles used (see below).

Intensity of treatment and preparing the patient

Using the minimum number of needles is very important because ashī work can be an intense experience for the patient. Generally speaking, the greater the injury, the more intense the treatment will be. This intensity of sensation is interpreted by the patient as pain, and must be gauged carefully against the overall strength of their qi. Pain depletes qi and can leave a patient exhausted and traumatised, or even in a state of shock. Having the skill to locate and effectively treat the most important ashī points to create a cascade of release throughout an entire pathway of pain, whilst also considering the patient's pain threshold and the appropriateness of treatment intensity is the key to success with a wide variety of patients of every age, gender and health status. If one does not grasp these two concepts, then one will either quickly stop using this style of ashī work due to the belief that it is 'too strong' for patients, or end up with a very narrow client-base that fit a treatment application that is not based upon understanding the qi of each individual. I always prepare first-time patients for this kind of treatment by stressing that this particular technique does not represent the whole of Chinese medicine, but is one specific treatment method within the vast field of acupuncture. I explain that the more physically intense the treatment is, then the less severe the actual condition is (and vice versa), pointing out that if the patient were coming for treatment with late stage cancer, then the needling experience would feel warm, floating and relaxing, but because they have come with a physical injury but are otherwise in good health, the experience will be strong and intense. Equally, however, I explain that the

results should be noticeable in 24 to 48 hours, and the total number of treatments needed will be few. I also prepare them for treatment by telling them that although they will need to be strong enough to endure the intensity required to achieve efficacy, being a hero is not helpful either. I explain that if the sensation is so strong that they stretch away from it, or find their whole body stretching out to spread the sensation, it means we are on the right side of the threshold envelope; on the other hand, if the intensity makes them tighten or 'lock down', literally gritting their teeth, then we are on the wrong side of the threshold envelope. Greater intensity does not imply better results. The goal is to release the pathway that has led to the injury. If the intensity is too great and the patient tightens, then the pathway becomes more blocked and there will be less efficacy from the needling. There is an ideal line of intensity that should be approached, but not crossed, during treatment in order to achieve the best possible result.

I also try to give my patients a vocabulary for the sensations they can expect to experience: muscle jumping and twitching (fasciculation), throbbing, electricity, sensation spreading out all around the point of insertion like a spider's web, aching, travelling up or down in lines from the needle, rushes of temperature, etc. I explain that there are a few sensations that are undesirable, such as needle-sharp, stabbing, burning or stinging-hot sensations. These would mean that I have penetrated a blood vessel, which while not particularly dangerous, provides no therapeutic value. I try to encourage the patient to keep breathing during treatment, but without hyperventilating. Occasionally a patient will hold their breath during a particularly intense moment, and although I do not try to stop this, I make sure that they do not continue to hold their breath after the moment has passed. I have also found it very helpful to encourage patients to sing or shout out as the intensity increases, which greatly diminishes their perception of the sensation as pain.

Treatment

Trapping the ashi point

While the actual needling of ashi points is not complicated, the maturity and strength to do effective ashi needling can be hard to cultivate, due to the nature of the sensation experienced by the patient. During any acupuncture treatment the 'other' hand (without the needle) is always more important, and in ashi needling constitutes the difference between success and failure. Once the ashi point has been identified, the tendo-muscle must be trapped and held in place to be successfully needled. I routinely use three basic trapping techniques to isolate the ashi point in order to keep it from shifting during treatment. These are the pinching technique, the 'backstop' technique and the flattening technique:

1. The pinching technique involves trapping the ashi point

between the thumb and index finger, or the thumb and index/middle fingers. The fingers start either side of

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the ashi point and push down and towards each other to pinch and raise the point. Sun Simiao describes this technique as nie (捏). The ashi point is locked between the fingers so that the needle will not miss or slide off the line. This technique is ideal for larger fleshy areas such as the thighs, forearms, Jianjing (肩井穴) GB-21 region, etc.

2. The 'backstop' technique involves putting the thumb or fingers behind one side of the ashi point and its associated pathway like a backstop. The ashi point is then needled at an angle towards the backstop so that it does not drop away from the needle. This is ideal for areas with less room and flesh to trap, or for locations close to bones – for example needling ashi points down the Bladder channel on the back, on the scapula, or next to the elbow joint. It is also used in the opposite situation, where there is too much flesh, such as in the buttock/hip or abdominal regions.
3. The flattening technique involves using the whole hand to press down on a large area that includes the tendomuscular pathway and the ashi point. The needle is then inserted perpendicularly into the ashi point next to the hand, so that the pressure prevents the point from slipping away to either side or moving below the needle. This technique is useful for various areas, but is the least accurate of the three methods.

These are not the only ways to trap tendomuscular lines and ashi points, and different trapping techniques are often used together during a treatment. The object is to isolate and trap the ashi point rather than to apply a formalised technique, so however one achieves this effectively is acceptable.

The other important role of the supporting hand is to keep the area being treated from moving. The patient may flinch or try to move the limb due to the intensity of the sensation, and it is critical for their safety and the success of the treatment that the practitioner does not allow this to happen. The strength and weight of the supporting hand has to be such that the patient and the area are anchored to the treatment table without causing pain or making the patient feel trapped. This can be achieved in a multitude of ways and often involves including other points of contact with the patient's body that the patient is unaware of, for instance the heel of the hand, the forearm, the other fingers of the supporting hand, and the wrist and forearm of the needling hand can and should be used at the appropriate locations and moments. The importance of remaining

aware of this aspect of treatment cannot be overstated. While infrequent, the unexpected flailing of a limb will happen, creating a potential needle-stick injury for the patient or practitioner. With regards to being caught by surprise, the late Dr. Xie Peiqi used to say, 'Treat every cat like a tiger, and you will never be surprised.'

Ashi needling

During ashi needling the needle must be inserted and then held with confidence. Although this should go without saying, it is the main reason why ashi needling is ineffective for many practitioners. If the insertion is poor and the needle held weakly, this creates skin/nerve pain at the 'heaven' (superficial) level for the patient that has no connection to the therapeutic sensation generated when the ashi point is needled correctly. Alternatively, needling to rearrange both hands after insertion - instead of being able to keep the ashi point trapped with one hand and executing an insertion and needle manipulation with the other - frequently results in missing the ashi point altogether. One's insertion should not affect or change what has already been set up and locked down with the supporting hand.

There are three basic methods that can be used to treat an ashi point:

1. Needle shallowly to stimulate the most superficial layer of the point and cause a fasciculation to fire repeatedly.
2. Needle into the middle of the point to create a single 'deep' fasciculation followed by achiness.
3. Needle through the point to create a deep throb and achiness that covers a wider region than just the point itself in order to encourage the flow of qi and blood to the area.

Each of these three methods has its application within ashi treatment, and one should use whichever is best for the situation at hand. This usually involves using combinations of the methods or all three during a treatment session, or even at the same point. What is critical is that one makes a conscious decision and remains aware of the location of the tip of needle while the patient is giving feedback on sensation. None of the techniques are wrong or right, they are just more or less appropriate for each situation. The only thing that can be considered wrong during needling is to be unaware of what one is doing - and therefore why things are happening (or not) for the patient.

In Western-influenced ashi work there is a belief that fasciculation is critical to success, and that the point must be needled until fasciculation happens. Although fasciculation is often desirable and indeed what the patient needs, the success of treatment should not be judged by whether or not it occurs. There are eight basic sensations to look for when ashi needling, each of which affects the qi of the point, pathway and patient differently. To believe that one type of response is the necessary component for success in every

situation means only being successful when that situation happens to present itself. During ashi work the practitioner should neither become attached to making the muscles fasciculate, nor be satisfied if the patient feels nothing. This is tangible work that treats tangible injuries, and therefore it must be felt tangibly in one of the eight ways outlined below:

1. A sensation of awareness or awakening at a location other than where the patient is being needled: the practitioner and patient are often pleased or surprised at the 'magic of acupuncture' when this happens, particularly if the location of the sensation is unexpected, far away from the injury, and apparently unrelated to it. While this certainly occurs during ashi treatment, and is often felt in the area perceived to be injured, be aware that this can give false information. A distal sensation can be due to the proper awakening of the channel, but it can also be a result of the patient involuntarily tensing, shifting or holding themselves in awkward ways, causing them to become aware of other areas of their body.
2. A 'spiderweb' sensation from the epicentre of the ashi point outwards in all directions: this is useful, especially when treating the upper back, shoulders, scapula or anywhere else where there are a large number of tendomuscles connecting, overlapping or intertwining. In this way, successfully needling an ashi point can awaken and reinvigorate the qi and blood throughout a number of lesser ashi points, particularly those that are small but very painful or hard upon palpation.
3. A sensation of electricity up or down a specific pathway can be very important in certain situations. Not only does this fully awaken the qi along the pathway, but it is also the most important tool in chasing secondary stagnation - i.e. cold or damp blockage, wei or bi syndromes that happen opportunistically due to the injury - out of the pathway. However, an electric sensation by itself without also creating throbbing, achiness or fasciculation is unlikely to cure the problem and may only provide temporary relief that then disappears after a few days.
4. Throbbing at the point means that the flow of blood has been increased in the area. This can be very important in large muscles and thicker parts of the tendomuscular channels, or when the ashi point is a small lump within a specific layer of a tendo-muscle, but is not affecting all of its layers. This needle sensation is often then retained for a few minutes by further stimulation in order to maximise circulation in the area.
5. A sensation of fullness is always a good sign, and often the best strategy when dealing with patients who require gentle treatment. However, with stronger patients or when treating serious injuries, eliciting a sensation of fullness is rarely successful by itself.
6. A sensation of heaviness, like fullness, is always a good sign but again is rarely enough with stronger patients or with serious injuries. The most important result of

heaviness is that it means that the area is no longer stuck in a holding pattern of tension and resistance, but has relaxed to a place where healthy qi and blood flow is possible.

7. Achiness, like fullness and heaviness, indicates a low level of qi and blood flow that is important in terms of healing weaker patients, but rarely enough for stronger ones. The greatest function of achiness is that it forces the body and mind to acknowledge a particular area, and thus begin repairs.
8. Fasciculation is frequently the most important treatment method in ashi work. The twitch and spasm of the muscle literally pushes and courses the qi and blood through the point and pathway. While it is tempting for the practitioner to see fasciculation as a validation of correct needling, I again caution against the belief that it is necessary to achieve at every insertion and with every patient. In a situation where bi or wei have settled in, fasciculating the ashi point without also producing electricity down the pathway often produces a painful treatment with low success. Acupuncture is Chinese medicine, and in Chinese medicine qi leads the blood. Fasciculation primarily addresses the blood aspect of an injury and physically lengthens the pathway to release the tension vectors involved, but does not necessarily address the numerous secondary problems that happen as a result of qi no longer flowing smoothly through the pathway. This illustrates the point that ashi needling must be included in the context of a correct Chinese medical diagnosis in order for treatment to be truly successful.

Point location

In terms of locating ashi points, one can either palpate the patient's whole body, keeping careful notes, or else consult published trigger point charts in order to choose needling locations. Both are useful but have their problems, and thus neither are recommended as primary methods of locating points. The former takes too much time and gives too much information that may have little to do with the patient's chief complaint. The latter encourages one to follow a theoretical map rather than work with the actual patient on the couch in front of you. The traditional Chinese guide to locate points is as follows:

1. If the problem is in the front, look in the back.
2. If the problem is in the back, look in the front.
3. If the problem is above, look below.
4. If the problem is below, look above.

Practically speaking, these guidelines were created to remind the practitioner to look beyond the obvious or expected, rather than just treat the obvious location of injury or follow the affected channels to a distal point. However, true skill in point location within classical

Chinese medicine has always come from internship and experience, and the guidelines above are simply not sufficient to guide point location without having spent time palpating one's patients and watched someone who has skill in this area. A combination of traditional theory, internship and practical experience have always been the building blocks of good Chinese medicine, and there has never been a short-cut or 'chart' method of learning in all of

Body mimicry is the ability to mimic the posture, gait or pain area of a patient and then track its pathways through our own body.

its history. Even in modern TCM universities, the Chinese government's acupuncture textbooks have very poor renditions of the anatomical location of points, making self-study very difficult. Point location has always been taught directly in-person, through the medium of a body rather than a text. This is the reason that the culture which can paint the most incredibly detailed landscapes, birds and flowers chose to create anatomically unhelpful portraits of the channels from which to study acupuncture.

I personally spent years training with the late Dr. Xie Peiqi in the Yin Style Bagua tradition, which adds another dimension to ashi point location. Yin Style Bagua's training first focuses on self-awareness, particularly of the body and its internal mechanisms. The intensity and complexity of Yin Style Bagua internal cultivation (daoyin) practices build a structural awareness that is based on one principle: learn to awaken, develop and use as many of the smaller muscles as possible instead of building up individual large muscles. This is based on the belief that many things working in harmony create a result greater than the sum of its parts. This self-awareness is then applied to others to understand what is happening in their bodies. In terms of ashi work, this means developing skill in what I call 'body mimicry'.

Body mimicry is the ability to mimic the posture, gait or pain area of a patient and then track its pathways through our own body. Because I understand how things connect and work in my own body, by mimicking the patient and the pain they are experiencing I am able to feel and know where the ashi points are to be found and where they connect within the body. This ability is neither secret nor the exclusive province of Yin Style Bagua. Many practitioners already use this, or are able to adopt it instantly if they have a background of personal cultivation. It is also not unique to Eastern training methods, as I have come across Western somatic practitioners skilled in body mimicry.

The wider scope of ashi work

Nothing exists in a vacuum in Chinese medicine, and nor should ashi work only be used in physical injuries and ignored at other times. At a certain point, one should start seeing the conditions our patients have not in terms of

complex theory, but as a manifestation of qi. Like the six qi of wind, cold, summer-heat, damp, dryness and fire - when out of balance these same natural phenomena become known as pernicious influences. As qi moves through the channels and either adversely affects or is adversely affected by the organs, imbalances of excess or deficiency (or apparent excess or deficiency) are produced.

As familiarity with ashi treatment grows, it can move beyond the realm of only treating physically-injured patients. One begins to recognise that what I call 'pathways of pain' are actually 'pathways of improper qi flow', which returns us to the comment in the *Ling Shu*: 'It is [the point of] pain that defines an [acupuncture] point (以痛為腧)'. While the manifestation is usually pain (when applying ashi work in the context of orthopaedic-type treatment), it might also be wei syndrome, bi syndrome, burning joints, arthritis or anything else that reflects blockage of qi and stasis of blood. Not all diseases are due to a problem in the narrow pathway of the documented channels, nor respond well to treatments using what Sun Simiao describes as the 'recognised point (孔穴)'. This does not mean we should eschew the classic points in our treatment protocols, but it does remind us that ashi points can be discovered and provide success for people who have otherwise had no relief with treatment according to the documented points and channels. The cascade of illness that can happen from stagnation of qi or stasis of blood happening in an unexpected location can be life-altering for a patient, and the return to health as the blockage or stasis is dispersed by ashi needling can be equally life-altering. Learning to see ashi work not as a technique but as a way of working with the ease and disease related to qi and blood flow allows it to be used in both internal as well as external medical treatments.

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Reference

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