LEPROSY REHABILITATION IN JAPAN

SHIGETAKA TAKASHIMA, M.D.

*Nagashima Aiseien
National Leprosarium*

As the Japanese government faithfully enforced segregation policy from 1907, the patients were not allowed to be discharged and their freedom to go out of the sanatorium was severely restricted. Although compulsory segregation is now abolished and rehabilitation encouraged, the patient himself does not wish to be discharged, nor is our society ready to get him back.

Here lies the difficulty about rehabilitation.

I. Emotional Problems in Restoration of Leprosy Patients

A joint study was made on the factors interfering with the rehabilitation of patients institutionalized in the eleven national leprosaria in our country. Takadate (8) summarized the results and reported them to the third Pan-Pacific Congress. In our opinion, there are the following reasons for the patients being reluctant to be rehabilitated:

1. The feeling on the part of the patients that they have been persecuted by society through leprosy administration policy and antipathy against it, which give them the idea that they are entitled to lifelong protection.
2. The blind belief that leprosy is incurable and that the permanent sequelae of leprosy mean leprosy itself.
3. The delusion of persecution owing to social prejudices against leprosy.
4. The sense of being alienated from society and inferiority feelings.
5. Loss of the family through long-standing segregation. Anxiety about getting jobs. Anxiety and apathy in relation to social life.
6. Attachment to married life in the sanatorium and dependency on other aspects of institutional life.

These are the elements that seem to be combined more or less in forming the mental condition of the patients. It may be called institutionalism. Many of the patients seem to be used to an easy way of life and to have fallen in a state of mental atrophy (Kamiya: (5), Takahashi: (9)).

On the other hand, there is on the part of society an ineradicable fear at the sight of the deformities caused by leprosy, which are taken for leprosy itself, so that people in general wish to have the patients segregated just as they have been since 1907.

Here arises the need for new activities in the sanatorium for the restoration of leprosy patients.

II. Activities in the Sanatorium in Connection with Leprosy Rehabilitation

In Aiseien, the patients are divided in three groups: the group needing medical

treatment, the group needing protective care and that forming a colony. Rehabilitation is being promoted as a major problem common to all three groups.

1) Medical Rehabilitation.

The therapeutic effects of DDS, such as the disappearance of the bacilli, healing of the leprosy lesions, and the stabilization of symptoms, have made it possible for the patients to benefit from the progress of reconstructive surgery.

a) Orthopedic Surgery. In Japan, Iwahara conducted surgery on the paralytic drop-foot for the first time in 1947 (Tomita (10)). Ikeda started reconstructive surgery of deformities from the spring of 1953. Stimulated by Brand's surgery (1), Tsuge (11) has conducted more than 200 cases of surgical operations of the hand at Oku-Komyoen and Nagashima Aiseien since 1957. A Society of Orthopedic Surgery was organized in 1963 (Chairman: K. Hamano (3)) and the surgeons of all the sanatoria are getting together to discuss the different ways of applying reconstructive surgery to deformities of the hand and foot and mutually demonstrating the techniques.

In the surgery of the hand, there are corrective operations for the loss of opposition of the thumb (Yabe (12)), the claw hand and the radial nerve paralysis in that of the foot; there are treatments for trophic ulcers and operations of arthrodesis for the drop-foot. (Hashizume (4)).

b) Plastic Surgery. There being a great number of severe cases owing to long-standing institutionalization, the need for plastic surgery furthered its development.

Planting of the eyebrow has been actively carried out since 1954 and studies are made of operations for facial paralysis, lagophthalmus and rhinoplastics (Narita (6)).

c) Physical Therapy. For the prevention and cure of the deformities, it is indispensable that the patients should be taught how to protect their hands and feet and how to organize their daily lives and surroundings.

Accordingly the roles of the physical therapist and occupational therapist are highly important.

Many of the deformities in leprosy are aggravated by injuries due to sensory disturbances or by suppuration due to indifference to burns and mistaken treatment of these.

They can, however, be prevented as secondary disturbances. It is only through education that the patients' attention can be directed to the prevention of deformities and that they can be made more willing to get treatment for them. It was because we did not make sufficient efforts in this respect that the patients got many deformities left, which made them lose their will to be rehabilitated.

2) Protective Measures for the Disabled Patients.

Disability in daily life is brought about by deformities or amputation of the upper and lower extremities, blindness, difficulty in hearing as well as combined diseases such as tuberculosis, psychoses, apoplexy and senility. It is therefore necessary to evaluate the degree of disability and make a goal setting accordingly in order to take measures of physical therapy and reconstructive surgery as much as possible and to promote ADL by providing supplementary aids and by improving the living conditions. The

Table A. Evaluation of Disability in Leprosy
(Committee on Evaluation of Disability. Ministry of Welfare. 1963)

	ADL	Points	Normal	Somehow able to do	Needing a little help	Not able to at all
				1	3	6
1	Eating	4	0	4	12	24
2	Walking	10	0	10 Aged, lame	30 Blind, using clutches	To be carried on stretcher or wheel chair
3	Squeezing a towel	2	0	2 By pressing the towel	6 Much water left	12 Not able at all
4	Putting clothes on and off	3	0	3 First button handled	9 No buttoning at all	18 Not able at all
5	Putting the bedding in and out of the shelves	6	0	6 Only the lower shelf handled	18 Not able	36 Not able at all
6	Fleeing in an emergency	5	0	5	15 Deaf and dumb Artificial legs	30 Blind and using clutches; psychosis
7	Arranging personal affairs	8	0	8 Slow, inexact	24 Not able	48
8	Taking bath	7	0	7	Lagophthalmus 21 Unable to go in and out	42
9	Reading and writing	1	0	1 Disability of the hand	3 Disturbance of the sight	6 Totally blind socially blind
10	Cleaning the room	9	0	9	27	54
	Total	55	0	55	165	330

Table B. Evaluation of Disability of Patients at Aiseien
(As of December 31, 1965)

Group	Numerical assessment	No. of Patients	Percentage
Highly severe	330-264	55	3.6
Severe	263-179	191	12.7
Medium	178-102	171	11.3
Light	101- 51	386	25.6
Other cases	50- 0	70	4.6
No disability		617	40.9
Not investigated		19	1.3
Total		1, 509	100.0

Ministry of Welfare organized in 1961 a Committee for the Evaluation of Disability (2), which selected a minimum of ten items in ADL that seem to be most rational for evaluating the degree of disability of an individual. These items are given the value of one to ten points according to the rate of metabolic energy involved in each movement, so that the degree of disability may be evaluated numerically.

Thus it was made possible to distinguish the degree of disability into highly severe, severe, medium, light and others according to a definite standard of numerical values (1963). This enables us to conduct group education and assistance in ADL more effectively and more rationally.

Table A shows the main points of this plan and Table B the classification of patients at Aiseien.

According to the latter Table, there are in Aiseien 55 (3.6%) highly severe cases and 191 (12.7%) severe cases. Almost all the blind cases are ranked above the severe categories. In Aiseien at present, the disabled cases down to the medium category are placed in protective wards, where they are helped to recover ADL under the leadership of the head nurses. The highly severe and severe cases have, however, strong dependent tendencies, show mental atrophy and do not understand the true meaning of rehabilitation. We are having the cooperation of the psychiatrist and psychologist in connection with them.

3) Colony.

As of March 21, 1966, 437 (29.3%) patients among 1489 were engaged in different kinds of jobs in the sanatorium. These patients are negative without any deformities or with very little deformity.

Of these 437 patients, 24 formed a stock-raising group and are raising 450 pigs and 1000 hens. Another group of 25 patients are keeping a shop. Among those working in the sanatorium, there are 140 patients helping the medical work, 39 engaged in, transportation, 34 in carpentry and repairs, 21 in hairdressing, 17 in sewing, 92 in cleaning and arranging the surroundings, 81 in helping at the office and 23 in other kinds of work. Besides, vocational training centers are being built in various sanatoria; for instance, a factory for manufacturing Tatami (rice mats used in Japanese houses) as a sheltered workshop at Aiseien, a factory for making staplers at Zenshoen, and Tohoku Farm at Shinseien through the help of the Japanese Leprosy Foundation.

Though the wages are low within the colony, the patients do not want to return to society. In order to stimulate their will to rehabilitation, we are organizing bus tours, travels to home districts and visits to head-temples of various Buddhist denominations in order to familiarize them with society at large.

It would be appropriate as a kind of occupational therapy if patients could be employed in administrative work. The hindrance to organizing such a system of employment lies in the fact that the individuals belonging to the colony are legally treated as leprosy patients. As this hindrance is based on the present Leprosy Prevention Law, it is desirable that this should be amended immediately. (Omura (7)).

Summary

In the days before chemotherapy, leprosy was believed to be an incurable disease. Consequently segregation ended only with the patients' death.

Now that leprosy has become curable, our present Leprosy Prevention Law needs to be amended, but prejudices against leprosy hinder it.

To improve this state of affairs, we must further promote education of the general public about leprosy, obtain more effective drugs and make still greater progress in reconstructive surgery.

We should like to add that restoration is not synonymous with driving the patients out of the sanatorium, just as institutionalization and segregation were not synonymous with lifelong exile in the past.

To promote leprosy rehabilitation smoothly will be the final achievement crowning leprosy work in Japan.

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日本に於ける癩のリハビリテーション〔抄録〕

高 島 重 孝

(長 島 愛 生 園)

(受付 1967年 6月15日)

日本の癩予防法(1907年)では、患者の隔離は徹底的であり、患者は退所の自由はなく、また外出にも厳重な制限があった。現在では強制収容は、廢止され、社会復帰は推進されて居る。しかしながら長期入園者の大部分は、退所を希望せず、社会は彼等を受け入れる体制を整えては居ない。ここに癩の Restoration に関する問題がある。

1. 癩の Restoration を阻む社会的情緒に就いて

長期間の隔離生活は、社会への疎外感を深め、患者は強度の Hospitalism に陥り、そのなかには、Mental atrophy に陥って居るものもある。

他方社会の側に於ては、癩に基因する変形或は2次的の後遺症を、癩病そのものとして恐怖し、或は嫌悪して、患者の隔離を継続することを希望し、受入れ体制は不充分である。

II. 癩養療所に於ける、癩の Rehabilitation に就いての努力

愛生園に於いては、入園者を3群に別け、要治癩療法群、要生活介補群、及 Colony として、この3群の共通の課題として、Rehabilitation を推進して居る。

1. Medical Rehabilitation

DDS による治癩効果は、更生医学の適応を可能とした。整形外科及形成外科は最近長足の進歩をした。之を助けるものは、物理療法の進歩である。

2. ADL の回復、生活介補群

1961年度より、癩患者の不自由度を計数的に評価し、不自由者を、特重、重、中、軽その他の5群に分類し、之等不自由者の ADL の回復のために、生活介補は、婦長の指導のもとに、職員による世話を開始した。

愛生園では、特重及重の大部分は、新装の不自由舎に収容、職員の世話が、曲りなりに始められた。盲人群は

大部分重症に格付けられ、其の他の群のなかに、高齢者が格付けられる。之の不自由者の群のなかには、高度の Mental Atrophy に陥って居るものが多いが、重症にランクされる盲人連中には、徹底したせい、意欲的な活動をするグループがある。

3. Colony 入園者 1489 名中 437 名(29.3%)は、Colony と呼ぶべき生活を、園内で送り、患者自治会により、運営されて居る患者慰安会の作業及び、色々の園内の作業に従事し、若干の賃金の支給を受けて居る。近頃 Restoration を目標として、愛生園では、回復者のために庇護授産所として、畳表製造工場を作った。全生園にはホチキス工場が出来、新生園には回復者農園が出来て居る。

之の回復者は、長年月菌陰性で、症状も固定したものであるから、これ等が職員或は助手として、園内管理作業に従事出来ることが希望されるが、癩予防法は之を妨害して居る。

この法律の一部改正は、希望されて居るが伝統的園内秩序保持のためと、社会的偏見のため、早期の改正は認めないのが現状である。癩が治癒可能の疾病と認められた今日では、患者の偏見及び社会情緒の改善のために、取敢えず、超慢性の感染症の予防のために、罹患者の隔離は、その罹病者の死亡をもって終るといような、前時代的の法律は改正すべきである。

又、Restoration の体制が出来、更生医学が発達をしたとしても、患者自身の Mental Atrophy が回復しない限り、Rehabilitation は、円満に遂行出来ないであろう。

従来の隔離政策が、終身徒刑と誤認され、近年の解放運動が、患者追放運動(療養所からの)と誤解されることがあるとすれば洵に心外である。これ等の言説は、相互不信感の根強い人々の臆測にすぎないものと思うものである。