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U. S. NAVAL TECHNICAL MISSION TO JAPAN
CARE OF FLEET POST OFFICE
SAN FRANCISCO, CALIFORNIA

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10 December 1945

RESTRICTED

From: Chief, Naval Technical Mission to Japan.
To : Chief of Naval Operations.

Subject: Target Report - Neuropsychiatry in the Japanese Armed Forces.

Reference: (a) "Intelligence Targets Japan" (DNI) of 4 Sept. 1945.

1. Subject report, covering Supplementary Questionnaire "D" of Fascicle M-1 of reference (a), is submitted herewith.

2. The report was prepared by Comdr. P.B. Ayres, (MC) USNR, assisted by Lieut. P.E. Arioli, (MC) USNR, Lt.(jg) F. Gilbert, USNR. and Lt.(jg) W. Hendrickson, USNR.

C. G. GRIMES
Captain, USN

30632

NEUROPSYCHIATRY IN THE JAPANESE ARMED FORCES

"INTELLIGENCE TARGETS JAPAN" (DNI) OF 4 SEPT. 1945

FASCICLE M-1, SUPPLEMENTARY QUESTIONNAIRE "D"

DECEMBER 1945

U.S. NAVAL TECHNICAL MISSION TO JAPAN

SUMMARY

MEDICAL TARGETS

NEUROPSYCHIATRY IN THE JAPANESE ARMED FORCES

An honest summation of the status of psychiatry in the Japanese armed forces, the adequacy of the psychiatric program and the results achieved in therapy of psychiatric disorders would indicate that the subject might well be passed over.

The medical personnel in the Japanese Army and Navy recognize psychiatry as an important field and one with which they are all too unfamiliar. Painfully few psychiatrists were available, for example the six civilian specialists drafted into the Navy comprised the entire trained staff. Internists were appointed as ward officers for mental wards. No psychiatric hospitals existed in the Navy, although two were organized for the Army, while patients were usually cared for in psychiatric wards in general or base hospitals.

Treatment of such cases was more on the organic than functional basis, with very little rapport being established between physician and patient.

Interrogations concerning the number and type of N.P. cases have repeatedly been answered by the reply "very few" or "less than 1%" and that "hysteria" is the common type of difficulty.

An exhaustive interrogation was prepared by the Surgeon's Office, GHQ, USAFPAC, and a copy with its reply is enclosed.

Civilian psychiatry is more advanced in JAPAN than the military, and a few physicians trained abroad have a good knowledge of the field of psychiatry as of 1939. The war-time isolation of the country, lack of exchange of scientific journals, restrictions on travel, etc. and the bending of every energy of the Japanese government to the war effort have resulted in the arrest, if not in the retardation, of the progress of this branch of medicine.

TABLE OF CONTENTS

REFERENCES

A. Names of Japanese Personnel Who Assisted In Gathering and Locating Equipment and Documents:

None.

B. Japanese Personnel Interrogated:

1. Lt. Comdr. SUZUKI, (MC) IJN, Neurologist, YOKOSUKA Naval Hospital.

2. Comdr. I. YONEKAWA, (MC) IJN, Neurologist, TOKYO Naval Hospital.

3. Y. UCHIMURA, Chief, MATSUZAWA Psychopathic Hospital, TOKYO; Consultant to the Japanese Army and Navy Medical Bureaus.

4. T. MURAMATSU, Assistant Psychiatrist, MATSUZAWA Psychopathic Hospital, TOKYO (Trained in BOSTON and MUNICH).

5. K. SUWA, Col., (MC) IJA, CO, KONODAI (Army) Government Insane Hospital.

6. All medical personnel (internists and neurologists) listed in Target Report M-01, Reference "B".

C. Reports of Other Investigating Committees:

1. See the report on "The Brain Research Institute of the TOKYO Imperial University," by Lt. Col. MOORE, MC, and Lt. Col. H. A. CATTON, Chief Surgeon's Office - To be found in the files of GHQ, AFPAC, filed under "Reports on the Activities of the Committee for the Technical and Scientific Investigation of Japanese Activities in Medical Sciences."

LIST OF ENCLOSURES

(A) Japanese Military Psychiatry

Interview with Lt. Col. SUWA by Lt. Col. H. A. CATTON, AUS

(B) Questionnaire

"Syllabus on Japanese Military Psychiatry" (with answers obtained as explained in Enclosure "C")

(C) Japanese Naval Psychiatry

(Answers to questions contained in Enclosure "B")

(D) Japanese Army Psychiatry

INTRODUCTION

The lack of adequate diagnosis, therapy and institutional care afforded the mentally deranged in JAPAN has been reported frequently enough to be common knowledge. As in many other fields a few qualified specialists are faced with a gigantic problem, discouraging in its magnitude, in the relatively primitive attitude of the people to the problem, and in the lack of funds and facilities to better the situation.

The indoctrinated, disciplined and repressed individual typified by the average Japanese might have been expected to react to combat situations with the brutality and excesses that he sometimes showed. At the same time, mankind being basically the same, psychologically, the world over, having taken the "conditioning" of the Japanese into consideration, it was to be expected that he would be affected by the same emotional, nervous and fatigue factors as the occidental.

Our experience with "combat fatigue," "operational fatigue," "front-line therapy" and the mass of psycho-neurotic cases, developing due to war-time conditions and strains among troops, gave a reasonable indication of what to expect among the combat troops of any other nation. Here again, the effort has been made to discover whether any "new or good thing" in diagnosis and therapy had been developed by the Japanese medical services, in view of what was bound to be one of the common, disabling conditions arising in their personnel in service. The following reports merely serve to confirm the facts, that psychiatric problems were frequently unrecognized or ignored, that therapy was inadequate, and that psychiatry in the Japanese Army and Naval Medical Corps is in its tender years.

THE REPORT

1. The incidence of nervous breakdown among Japanese service personnel was variously reported by those in charge of the P.N. wards, but all agreed it was less than 1%. The statistical department of the Naval Medical Bureau furnished the following table.

"Mental Breakdown"

Year	Incidence per 1000
1940	0.09%
1941	0.22%
1942	0.52%

The statistics for the last three years are not clear. Actually, even the Medical Bureau has no accurate figures on which to base a table. The reporting of cases from various hospitals at home and abroad was irregular. Diagnoses were usually covered under an organic heading especially in psycho-somatic complaints, and it is apparently impossible to obtain reliable figures on which to base any conclusions.

2. Nervousness and fear in combat seem to have been treated more by severe reprimand from the line officers than by sympathetic therapy from the medical officer. Mild sedatives, such as the barbiturates, were used at the discretion of the medical officer. Some psycho-therapy was attempted at regimental hospitals in the field, where rest for recuperation was the usual advice of the M.O. in charge. Shock (electric) therapy machines were available for treatment in these hospitals, and all "nervous" patients were carefully examined for evidences of malingering. This statement refutes the contention of the Japanese personnel interrogated, that there was "very little nervous trouble in the troops." It has been ascertained that, following the end of the GUADALCANAL campaign, and with the stepping-up of our air raids on RABAUL, preparatory to the northward advance, there developed such a general degree of "nervousness" in the military personnel stationed in that base as to require a civilian psychiatric consultant to be brought down from JAPAN.

3. The percentage of service personnel invalided that are disabled because of nervous conditions is reported by the Japanese Naval Medical Bureau as follows:

Year	Incidence per 100 patients
1940	3.11
1941	3.92
1942	3.93

Again the years 1943-1945 cannot be listed as the same fragmentary reports only are available, have been destroyed, or are too humiliating to be divulged. The comment is made, however, that "we are sure the percent has been increasing."

One of the neurologists in charge of the P.N. ward in the YOKOSUKA hospital stated that in his opinion 6% to 7% of the invalided were suffering nervous conditions.

4. From all available information it is evident that no new methods were developed for the treatment of nervous conditions in combat.

5. The techniques for the selection of officers and enlisted men were mainly intelligence tests. These were measures of the degree of education, more than psychological screening tests. The tests devised for the Air Corps personnel were the only selection tests as we understand the term. They are referenced under Target Report M-06.

6. The incidence of organic neurological disorders was again given by all contacted, and by the Medical Bureau Statistical Department as "much less than 1%." This seemed to satisfy the naval medical authorities, and from the coincidence of this figure with that for "mental breakdown," it seems fair to assume that only organic lesions were actually reported as nervous disease.

The following table again is incomplete, unsatisfactory and shares the error common to the previous two.

Year	Epilepsy	Neuritis	Brain Injury
1940	56	11	68
1941	80	20	107
1942	127	41	112

This was reported to be the number of cases for the whole Japanese Navy in the years reported. "Headache" was not recognized as a diagnosis and was not reported either by the patient or the medical officer. Neurosyphilis figures were not obtainable. The "Army Committee for the Survey of Japanese Medical Sciences Report" may again be referenced. Certain Japanese records and documents were destroyed, hence the error due to the effort of memory in reproducing this figure, added to the inaccuracy of the original figure, makes an estimate of no value.

7. Electroencephalography was not utilized in screening, and no hospitals were equipped with equipment for such examinations. This technique was known to the Japanese Navy Medical Corps but was regarded as of value chiefly in research. The aero-medical research laboratories used such recordings.

In this connection there has been described the following apparatus, which was reported to be available in Imperial University hospitals and was devised to measure the degree of nervousness of an individual;

a. A negative lead is attached to the palm and a positive lead is attached to the wrist of the same hand, a volt meter and battery being in the circuit. Since brain waves which originate in the thalamus travel through the sympathetic system, the impulses will arrive first at wrist and then at the palm and produce sweat which acts as a conductor for the current generated. The amount of sweating varies the current which is recorded on the voltmeter and indicates the degree of nervousness of the individual.

8. The disciplinary infractions such as AWOL, drunkenness, assault, etc. seem to have been regarded and handled very much as in our service. However, it may be noted that no Japanese ship had a brig; deprivation of pay, apart from reduction in rank, was not authorized; and no decrease in food allowance could be ordered for punishment of an offender.

9. Deviations in sexual behavior were reported by all concerned to have been so exceedingly small in number that no records were kept of such. The general opinion was that it was found in less than 1% of the naval personnel. No statistics can be obtained, nor can any more accurate a summation of the situation be obtained from line or medical officers.

10. The Japanese Navy had a policy of rotation of personnel, and limitation in length of service for given areas, depending on the nature of the duty. Two years sea duty was the maximum to be expected, and rotation of duty from ship to ship, and area to area, was standard operating procedure. The personnel from one Naval District or base, were as much as possible kept aboard fleet units from that base.

11. All sources deny that any deliberate psychological preparation was given to troops before a "Banzai" attack. The following is quoted from the reply of a Japanese naval medical officer: "The charge depends on the loyalty, the hope of not disgracing the honor of his own Corps and his family. It is the same with suicide pilots. All the pilots want to be selected as suicide pilots. The success of the charge of their predecessors inspires them."

It was gathered that there may have been impromptu exhortations from unit commanders, and there was reported definitely a "mutual exhortation" which started between unit members and increased to the point of mob hysteria. This was a spontaneous affair and not maneuvered by the commanding officers, who merely explained the tactical situation and placed the challenge before the men.

ENCLOSURE (A)

JAPANESE MILITARY PSYCHIATRY

Interview With Lt. Col. SUWA, (MC) IJA,
by Lt. Col. H. A. CATTON, MC AUS
Chief Surgeon's Office GHQ AFPAC
(Advance Echelon)

15 October 1945

Subject: Japanese Military Psychiatry.

To: Chairman, Committee on Japanese Medical Sciences.

1. Visited Japanese Army Medical School. Was informed that there was no longer a psychiatrist on the staff although there had been one during the war. From questioning various other Japanese medical officers it appeared that not very much instruction in psychiatry was given to the average Japanese Army Surgeon. However, they all said that war neuroses occured in their armed forces during the war and that such conditions were quite common in conscripted personnel but rare in volunteers and officers. No records or statistics were available as to incidence of these conditions.

2. No N.P. patients kept at hospital of Army Medical School. Such cases treated at KONODAI Government Insane Hospital. This is about five miles away. CO is Col. Keisaburo SUWA, medical officer of Japanese Army. Col. SUWA spoke no English and was interviewed through an interpreter. He seemed to have a fairly good grasp of the principles of modern psychiatry and to be familiar with the work of the American and Eurpean psychiatrists up to about five years ago. He had a number of statistical records, graphs, etc. showing incidence of various conditions, response to treatment, etc. There was nothing of any special or unusual interest in any of this material. Copies are available in my files.

3. The KONODAI Government Insane Hospital is described as follows:

a. The hospital is of the wooden barracks type, not unlike our cantonment hospitals. Fairly clean but plumbing very primitive. Bed capacity 1000, of which 300 are temporarily being used for non-psychiatric cases (medical and surgical).

b. Patients are all male personnel of the Japanese Army. The hospital is primarily for psychotics but they have about 20% war neuroses. Also 4.5% of their cases are psychopathic personalities. The incidence of paresis is 10% as against 20% in Japanese civilian mental hospitals. 42% are schizophrenia and 3.5% manic depressive. The remainder are brain injury cases, toxic psychoses and organic neurological cases such as tabes doresalis.

c. Treatment. Insulin has been used in the past but was dicontinued during the war. They had an electric shock machine but this was taken away for the material for war use. Cardiazol is used for shock therapy of the functional psychoses. They deny having many fractures with this treatment but do not take routine x-rays before and after. There is apparently very little psychotherapy carried on. They claim to do a certain amount of occupational therapy but all the patients were sitting around doing nothing. There were extensive vegetable gardens which are cared for by the patients. Col. SUWA said they did not discharge any patient who was not completely cured. He reported 57% cures of dementia praecox of which 40.7% were partial and 16.3% complete. These statements as to partial and complete cures were not consistent with his statement that he only discharged completely cured cases. He admitted their follow up system was poor and that they usually never knew what happened to the majority of cases discharged.

ENCLOSURE (A), continued

d. Personnel. The hospital normally had 24 medical officers but this has been cut to less than half. There are about 100 graduate nurses and 100 attendants.

e. Wards. Doors kept locked except for psychoneurotics. Many glass partitions but patients do not seem to break glass. Mechanical restraint not used. No violent cases seen and Col. SUWA said it was his impression that Japanese psychotics were in general less apt to be violent and disturbed than ours. He felt this was due to the more passive and submissive personalities of the orientals. Wards had no furniture, patients sat or lay on floor.

f. There was a civilian psychiatrist in charge of the psychological testing. He was familiar with the US Army alpha tests from the last war and with other standard psychometric tests. A number of samples of their test forms are in my files.

g. Research. The only research of any interest was on war neuroses. This material is now being translated.

ENCLOSURE (B)

SYLLABUS ON JAPANESE MILITARY PSYCHIATRY
(See Enclosure "C" for Answers)

HEADQUARTERS
UNITED STATES ARMY FORCES WESTERN PACIFIC
OFFICE OF THE CHIEF SURGEON

GSMD 730

APO 707
25 Sept. 1945

SUBJECT: Syllabus: Study of Japanese Military Psychiatry.

To: Chief Surgeon, GHQ, AFPAC, APO 500.

1. Psychiatry in selection, training, and conservation of manpower.

a. Psychological testing for screening and classification. Psychiatric induction standards. Limited service for men with psychiatric disability?

b. Policy towards psychiatric disorders apperaring during training, or in combat: hospitalization, reassignment, discharge-(what criteria are used?). Methods of handling: psychoses, psychosomatic complaints, anxiety states and hysterias, epilepsy, psychopaths (to what extent are procedures disciplinary, to what extent medical?).

c. Do psychiatrists advise command on personnel policy, on training methods?

d. Officer selection. Use of personality tests; psychologically slanted field performance assignments; standards of education, intelligence, personality; use of psychiatric interview and evaluation of past history.

e. Officer training. Indoctrination of ideals of self-discipline and of principles of care of men. Officer-enlisted man relationship: Development of personal initiative, devotion to leadership, group sense, on the part of men.

2. Treatment of psychiatric disorders.

a. Study of problems of the individual; methods of reassurance; reassignment.

b. Facilities in general hospitals; special psychiatric hospitals; special training programs for men with psychiatric disabilities.

c. Are psychotics treated in Army or in civilian facilities? What methods are used? Are recovered psychotics retained in service; assigned to limited duties; discharged from service?

3. Training of psychiatrists for military service.

a. Orientation on structure and organization of the military; problems of individual adjustment in training, field living, and combat; war aims; enemy psychology.

b. Opportunity to live with troops and share their experiences; to study at first hand leadership and training methods; to assist in the development of morale-building procedures.

ENCLOSURE (B), continued

c. Continued opportunities for consultation among each other, exchange of experiences, and formulation of psychiatric policy to meet military need.

4. Psychological warfare organization.

a. Analysis of enemy psychology and propaganda.

b. Methods of dissemination of information. Does this information reach the troops?

c. Counter propaganda.

d. Is the advice of psychiatrists or psychologists obtained in any of these procedures? Who is responsible for propaganda analysis and counter propaganda?

5. Psychiatric orientation of medical and line officer.

a. Appraisal of premedical and medical training through visits to medical school - interviews with deans and professors of psychiatry and medicine.

Interne and resident training
Status of psychiatry in medicine
Teaching emphasis on psychoses or psychoneuroses
Psychiatry as a basic medical science
Psychiatry as a specialty
Utilization of recent advances in psychiatry
Liaison with internal medicine
Psychosomatic medicine
Trends in psychotherapy - psychoanalyses
Group therapy
Utilization of special therapy - shock - narcosynthese, hypnosis, occupational - recreational, etc.
Psychiatric clinic organization
Psychiatric hospital organization
Facilities for post graduate and graduate teaching - didactic and clinics, etc.
Mental hygiene and prevention
Relationship to psychiology
Sociology and anthropology
Teaching and indoctrination of military psychiatry, etc.

b. What military training does the medical officer receive? What opportunities does he have for identification with the military? What is his status in respect to command? What command responsibilities does he have? Does he receive further professional training? Is there any method of rotation between field and hospital? How is he oriented on psychiatric policy in his unit? What opportunities does he have for psychiatric consultation on individual problems? Is he trained to do psychiatric history - taking and interviewing? Does he receive special training in military psychiatric problems? What professional liaison exists between field medical officer and hospital?

c. Are line officers given any systematic instruction on the recognition of behavior deviation of psychiatric importance? On the principles of personal management in relation to manpower conservation? On psychiatric implications in training methods? On principles of mental conditioning for combat? On evaluation of anxiety reactions in combat?

6. Liaison with tactical groups.

a. Psychiatrists in armies, corps, or divisions; as consultants in higher command echelons; in training camps, replacement depots, with service units.

b. What opportunities, if any, are psychiatrists given to influence personnel and training policies at various echelons, from top to bottom?

c. Attitude of command towards psychiatric contributions?

7. Liaison with general medicine and specialties.

a. Are psychiatrists included in T/O of various types of hospitals? Note in detail. Are they brought in for consultation on demand? Extent of psychiatric military literature. Attitude of other doctors towards the work of the psychiatrist.

8. Efficiency of neuropsychiatric organization.

a. What is the general organization of psychiatric work in the military service (chart)? Is there a representative in the equivalent of our Surgeon General's Office? Psychiatric consultant to War and Navy Ministries? Policy on utilization of psychiatrists. Protection of professional duties. Chain of responsibility of individual psychiatrists. Supervision of work of psychiatrists. Special studies and reports. Channeling of psychiatric recommendations; how much attention is paid to them?

b. What changes in psychiatric policy and organization have taken place during the course of the war? What changes in utilization of psychiatric personnel? Question key military and civilian persons on their opinion as to effectiveness of psychiatry in the services.

c. Relation of psychiatry to G1, G3 and civilian and military propaganda organs.

9. Motivations, cultural patterns, morale and relationship to Japanese ideologies.

a. Effects of child training and education in molding of character structure and attitudes. Study of Japanese character structure. (Invite anthropoligist to work with team.) Methods of bowel training, weaning; restrictions, rewards and punishments; libidinal satisfactions, attitudes towards mother, father, siblings; siblings rivalry; handling of behavior problems in children, etc.

b. Summary of information on Japanese cultural standards, ideologies and educational methods.

c. Morale in the armed forces.

(1) Officer-men relationship.
(2) Promotion and furlough policies.
(3) Complaints; penalties; awards and decorations.
(4) Orientation.
(5) Home ties: attitudes of family towards military service; care of dependents; legal advice; mail.
(6) Leisure-time activities: Athletics, entertainment, and recreation; artistic, musical, and hobby opportunities; books

and libraries; liquor and cigarettes; motion picutres; newspaper; radio.

(7) Handling the problem of sex deprivation.

(8) Who is responsible for morale?

10. Techniques of potential value to our occupational forces and G2.

a. Studies in Japanese psychological attitudes, reaction to defeat, acceptance of reality of occupation, attitudes towards occupation forces.

b. Analysis of educational system; recommendations for its alteration and control.

c. Analysis of psychological factors responsible for non-democratic thinking and behavior, and evaluation of methods of influencing future psychological attitudes and character structure.

d. Recommendations on type of orientation for occupation troops in understanding Japanese thinking and reactions.

e. Incidental to main project, observing special problems of occupational troops in adapting themselves to living in JAPAN, and planning psychiatric programs and policies to meet these special problems.

For the Chief Surgeon:

THOMAS W. MATTINGLY,
Colonel, Medical Corps,
Executive Officer.

ENCLOSURE (C)

JAPANESE NAVAL PSYCHIATRY

Office of the Chief Surgeon
(Advance Echelon)

APO 500
1 Nov. 1945

MEMORANDUM:

SYLLABUS, JAPANESE MILITARY PSYCHIATRY, TOKYO NAVAL HOSPITAL
(Answers to Questions in Enclosure "B")

On 30 October, 1945, a conference was held at the TOKYO Naval Hospital with the staff physicians, and I. YANEKAWA, Internist and Neurologist, Chief of Medicine. The interrogators were Lt. Commander P. B. AYRES, MC, and Sgt. TANI. Report follows:

1. a. The Navy had psychological tests for screening and classification, but developed and used chiefly for candidates for admission into the Air Corps. All "volunteer" applicants for the naval service were given a "mental examination." Limited service for men of psychiatric disability was ordered.

b. Psychiatric disorder appearing after acceptance into the Navy was treated by the local medical officer when possible. If symptoms became "aggravated," or evidences of psychoses appeared, the patients were hospitaled. In the field, they were sent to the nearest large naval base hospital (500-600 beds) i.e. at AMBORNA, BATAVIA, SINGAPORE, SURABAYA, MANILA, RABAUL, etc. Here, they were treated by the internist in the psychiatric ward, and returned to JAPAN when transportation was available, to one of the Naval Hospitals.

If recovery was considered adequate they were re-assigned to duty compatible with their ability, this being decided by the Medical Officer. Severe psychotics were sometimes sent to the University Medical School Psychiatrists for treatment. True psychotics were never re-assigned but discharged from the service. The Criteria used for hospitalization, re-assignment, or discharge were not fixed, but existed in each individual medical officers knowledge.

(1) Psychosomatic complaints were treated by:

(a) Explaining the condition to the patient.
(b) Use of palliatine druges, on the basis of treatment of an organic disability.
(c) Occupational therapy.
(d) Rest and recuperation.

(2) Anxiety states were similarly treated.

(3) Psychosis as described above.

(4) Hysterias - discharged from the service. (The incidence was so low the "treatment" was not standardized.) Procedures seem to have been frequently disciplinary in the field, particularly as regards the attitude of the line officers to the anxiety states and hysterias. (Note that the previous fine interrogations have brought out that the majority of psychoneurosis were "hysteria." Psychosomatic cases seem to have been included in this broad classification.)

c. Psychiatrists do not have any voice in advising the command or personal policy, or training methods.

d. No personality tests, as such for officer selection, existed. Field performance was not psych slanted. No psychiatric interview as such was routine. The examining medical officer estimated the units of education, intelligence, etc. from the "mental exam."

e. Self-discipline, being a supposedly already acquired characteristic of "true Japanese" was emphasized only by the line officers in reproof in addresses to junior officers.

The principles of the care of the men were similarly not recognized as such individually, but were acquired through experience, precept, and informed advice from older, more experienced men, and handed down. The psychiatrist had no part in this.

The officer-men relationship in the Navy was superior to that in the Army, since the unity of a unit on shipboard was more easily established due to close daily contact, and "cooperative action." The relationship was friendly and more of a family type. Personal initiative was encouraged, devotion to leadership was a "duty to be expected," and also to be merited by the conduct and bearing of the officers. Group sense was well developed aboard combat ships due to the environment and peculiarities of ship board life.

2. a. The treatment of psychiatric disorders was at the discretion of the Medical Officer in Charge, save in the large naval hospitals.

b. The Navy had no psychiatric hospitals as such. In all naval hospitals there was a psychiatric ward, or building. There were six psychiatrists, as such, in the Naval Medical Corps, who were called into the service after the beginning of the war. One psychiatrist was stationed in the six largest naval hospitals in JAPAN. In the other hospitals, the internist was in charge of the psychiatric wards. There was no special training program for men with psychiatric difficulties.

c. Psychotics were first treated in Navy Hospital psychiatric wards. If there was no improvement, they were sent to the University Hospital Psychiatric clinics, particularly from those naval installations where there was no psychiatric specialist. As stated, psychotics are discharged whether cured or not. The methods of treatment were as follows;

(1) Electric shock therapy 1-5 sic.

Chiefly for treatment of schizophrenia. Insulin, cardiogal and metrozal were not used in Naval Institutions.

(2) Education recondition.

The patient was told the mechanism of the production of his own difficulty.

(3) Occupational therapy.

This was on as practical a level as possible. In foul weather they were employed in carpenter shops, printing shops, in making sandals etc., indoors. During good weather they were chiefly employed in outdoor activities, such as gardening, farming, etc.

ENCLOSURE (C), continued

(4) Recreation.

Tennis, baseball, pingpong, chess, moving pictures, theatrical performances, reading, etc.

(5) Hydrotherapy.

Where indicated, continuous warm baths for sedation. Massage and peripheral stimulation, tourniquet about extremity for 10-15 minutes followed by massage. (BIER's passive hyperaemia?)

(6) Intra spinal injection of calcium phosphate 6.5%.

10 cc daily x 7 for one week with a week's interval of rest.

(7) Hypnosis.

(8) Psychoanalysis.

(Only by the six psychiatrists.)

3. a. There is no special orientation for psychiatrists regarding military service as to structure and organization, apart from that which they receive in the Naval Military School, where they are given a certain amount of training in organization and command functions. Subsequently, they gain some first hand knowledge from the older medical officers who have been in the field and who may pass on their experiences as to the problems of the men in combat, field conditions, etc. Medical officers per se, are not indoctrinated as to war aims nor as respects to enemy psychology, this being a function of the Propaganda Ministry.

b. The opportunity to live with troops in the field and share their experiences is gained only after assignment to such units. Morale building is not assigned to medical officers as a special function but is the duty of every naval officer.

c. There is no special psychiatric group society in the Naval Medical Bureau, and policy formulation and exchange of views has no recognized outlet, (save by individual contact) apart from the general medical conference held in the Bureau once annually.

4. There seems to have been no psychological warfare duties assigned to the medical officers as such, the proper ministry in the government being responsible for this function; hence, questions "a" to "d" are not valid.

5. a. There was no psychiatric orientation for medical and line officers. The training received in psychiatry above and beyond that which the medical school graduate would normally receive in the course of study before entering the naval service consisted of ten hours of lectures in the "junior course" at the Naval Medical School. This consisted of a course of lectures divided between diagnosis and treatment with a very limited amount of clinical demonstration.

Psychiatry is recognized as a basic science by naval medical personnel, and its importance was realized by a very few medical officers specializing in the field. Recent advances were reported in the various psychiatric journals both foreign and domestic, which were available in the library of the Naval Medical School. There was a very close liaison between the psychiatrists and the internists as well as with the various other departments, as it was recognized that psychiatric disabilities often played a great part both in the production of symptomatology and in effecting a rapid cure. Psychosomatic medicine was not recognized as such and frequently a provisional organic diagnosis was made on the sufferers of psychosomatic complaints until their course in hospital directed the physicians attention to his error. Group therapy seems to be utilized by the few true psychiatrists in the Naval Medical Service by gathering together those suffering similar disabilities and attempting to explain the basic nature of their trouble. Special therapy procedures have been mentioned in a previous question, as have the hospital and clinic organizations for psychiatric care. Since psychiatry as such was relatively new in the Naval Medical Service, no post-graduate course had yet been arranged for.

b. The naval medical officer received an indoctrination course of training, drill, command functions, etc., and is identified as being under the command of the senior officer present, as is the case with us. His own subordinates, and all personnel who come under his authority in regard to sanitary regulations and medical procedure. His command responsibilities, therefore, are similar to ours. A system existed whereby the naval medical officer after having graduated from the Naval Medical School and having served a tour of duty could receive post-graduate training in certain subjects in selected Imperial Medical Schools, such as, medicine, surgery, etc., which also might inclued medical research, either at the Naval Medical School or one of the Medical Research Sections of the Naval Technical Research Institute. The rotation policy fixed a maximum of two years of sea duty, supposedly alternated with an equivalent amount of time ashore. However, billets ashore being more numerous than those afloat, continuous shore duty for several more years was not unusual. Unit psychiatric policy seems to have been left entirely to the discretion of the local medical officer. The medical officer had no opportunity for psychiatric consultation on his individual problems, as the psychiatrists were only six in number and were stationed at the large naval hospitals. As noted, the medical officers total psychiatric training was contained in the ten hour lecture; hence, further questions under "b" are immaterial.

c. Line officers receive no systematic instruction as noted in this paragraph. Their only information was obtained from occasional informal lectures given them by their unit medical officers.

6. a. The level at which the psychiatrist was found is noted in answer 5b.

b. No opportunity was given psychiatrists to influence personnel and training policies.

c. The attitude of command to psychiatric contributions is said to have been "appreciative."

7. As noted, specialists for consultation were brought in from University Medical Schools, and patients were often transferred to such institutions for therapy. Psychiatric literature was exceedingly scarce as far as original contributions were concerned. The other specialists respected the psychiatrist's work but "did not understand" or "thought it a difficult subject."

8. a. There is no psychiatric representative in the Surgeon General's Office, nor was there a consultant to the Ministry of War and Navy. The policy of the use of psychiatrists was determined by the number available and their chain of responsibility was to their Senior Medical Officer, in common with the other ward chiefs in the hospital. There was no supervision of their work, save by the Senior Medical Officer, and what special medical reports and studies as were done will be found in the Naval Bulletin. Apparently very few psychiatrists' recommendations, if any, were made, requested, or acted on.

b. The changes in psychiatric policy were mainly the induction of six psychiatrists from civilian life into the Naval Medical Service, and the assignment of hospital wards to internists to fill a need felt during the war.

c. Cannot be answered in this report.

9. a. Cannot be answered in this report.

b. Cannot be answered in this report.

c. (1) The officer-men relationship was on a very good plane due to the nature of the naval service and was of the "fraternal" or "paternal" type.

(2) Promotions of enlisted personnel were by examination, and ten days to two weeks annual furlough was a regulation.

(3) Complaints were handled by the section leaders, taken up to competent authorities, and finally adjusted if valid. Penalties consisted of deprivation of privileges such as liberty, demotion, or confinement to quarters. Awards and decorations were made on the recommendation of unit commanders for meritorious conduct.

(4) Orientation is claimed to have been excellent due to the type of family life existing aboard ship.

(5) Home ties were kept close and families were proud to have their sons in the naval service. Dependents were cared for by an extra pay allowance for each dependent, and dependents hospitals were established where medical care was available at the cheapest possible rate. Every effort was made to insure mail service, although mail was usually collected and held at a ship's base and distributed when the ship reached port. Legal advice was available at local "Personal Affairs Offices."

(6) Recreational activities aboard ship included what athletics were available, moving pictures, ship's library, and a canteen service where tobacco and other necessities, and luxuries were availabe at fixed times. One "go" of sake could be purchased per man per day by personnel off duty, and a beer ration was sold on the same basis. Ashore, activities were similar, with other provisions for sports as allowed by fixed installations. Enlisted, NCO, and officer's Clubs were maintained. Moving pictures and theaters, since they were available from civilian sources, were not furnished.

(7) The problem of sex deprivation was handled ashore by permitting the use of inspected houses of prostitution, etc. No women were allowed aboard ships in port, save for trips of inspection during daylight hours. (Homosexuality, as a problem in the navy, is denied.)

(8) No Chaplain as such was carried aboard, and the burial ceremonies, when required, were conducted by a crew member who in civilian life had been a priest.

10. Naturally, this information cannot be obtained by interrogation.

11. All discharged service personnel requiring further attention of a medical nature, as well as having other disabilities, are cared for by the government Veterans Bureau, and this activity has special psychiatric hospitals, such as the MUSASHIRYOYOJO and KONODAI hospitals, which were in the TOKYO area. The latter is still an army institution. These institutions are staffed by the KOSEISHO doctors, but provided necessary treatment as noted above.

ENCLOSURE (D)

JAPANESE ARMY PSYCHIATRY
Interview with Y. UCHIMURA M.D. and T. MURAMATSU, M.D.

UCHIMURA, Yushi, M.D.

Dossier: A graduate of the TOKYO Imperial University Medical School, two years study in MUNICH at the German Research Institute of Psychiatry. For the past ten years, Professor of Psychiatry at the TOKYO Imperial University Medical School and Chief of Staff at the MATSUZAWA Psychopath Hospital, TOKYO.

Military Connections:

1. Prewar he gave lectures at the Navy Medical School (15 hrs/year) for the post-graduate group with clinical demonstrations at the MATSUZAWA Hospital. Classification and types demonstrated were the main groups of civilian psychopaths (schizophrenia, manic-depressive, etc.) - no emphasis on peculiarly military psycho-problems.

2. In response to Navy requests he was flown to RABAUL after the GUADALCANAL campaign to consult on problems of sleeplessness and fatigue (war neurosis) among aviation personnel. The latter findings and recommendations are in printed form at the Aviation Medical Research Institute, YOKOSUKA.

3. Towards the end of the war he was again consulted by the Navy relative to psychiatric selection rationale of aviation personnel - but he has not as yet organized a report even in his own mind.

MURAMATSU, Tsuneo, M.D.

Dossier: A graduate of the TOKYO Imperial University Medical School. Postgraduate coursed - Two years in BOSTON (1933-35) at the Psychopath Hospital, followed by two years in MUNICH at the Research Institute of Psychiatry. Good speaking command of English and German, familiar with technical medical terminology. Apparently an able psychiatrist form the viewpoint of education and training. Assistant to Dr. UCHIMURA at the MATSUZAWA Psychopathic Hospital in TOKYO, lecturing to classes at the University and with a limited private practice.

1. SUMMARY OF THE RABAUL FINDINGS:

a. Problems - "sleeplessness" and fatigue entities.

b. Recommendations:

(1) Construction of adequate air-raid shelters.

(2) Instead of phenobarbital, amytol and adaline, to use the shorter-acting barbiturates evipan and phanodon (from GERMANY).

(3) Long rest removed from the front.

(4) Line officers to accept medical officers' advice.

c. Results: The Professor was dubious there was any application of his recommendations. Other than the term war neurosis "shin ji shin kei sho," no further diagnostic nomenclature was made. The civilian nomenclature (1) Schizophrenia, (2) Neurotics, (3) Hysteria, (4) Traumatic Neuroses, (5) Psychoneuroses, was followed.

2. SYMPTOMATIC CRITERIA OF WAR NEUROSIS GROUPS.

a. Tremors.
b. Paralysis.
c. Rigidity.
d. Conversion (i.e., plasticity of parts).
e. Neuralgias (back aches, etc. - of all parts).
f. Post-beri beri syndrome - "residual leg pain."

3. TREATMENT:

a. "Persuasion," i.e. explanation that complaints were not on an organic basis.
b. Occupational therapy.
c. For "chronics" orders to labor gangs (The doctor stated the latter treatment usually proved adequate).

4. PSYCHIATRY IN THE SERVICE:

There were no psychiatrists proper in the Navy, the closest being ONO, who was an internist interested in psycho-somatic complaints. In the Army, civilian psychiatrists who were inducted at first did ordinary M.D. work, then later in the war when the Army recognized the psychiatric problem the psychiatrists resumed their specialty. The KONODAI Hospital had ten psychiatrists and became the clearing house for all Army psychiatric patients from other hospitals. Here "persuation," followed by electric shock treatment was the most common treatment. The majority of patients from here were discharged from the service. (No data on percentage cured.)

Psychiatrists played a step-daughter role in the armed services. Consultations with civilian psychiatrists were a phenomenal and surprising thing for the military to do. There was no official discussion or journal publication of service psycho problems, all such matters being secret. From M.D. friends occasionally a psychiatrist learned of the problems. Morale matters were kept jealously guarded by line officers and M.D.'s did not lecture to line officers on such matters. At most, psychological means were employed to classify and estimate men (I.Q. for lower echelons, more elaborate psychometric and aptitude tests for aviation) but psychiatric evaluation of personnel was not done. Induction centers did not use psychiatrists.

5. PROFESSOR UCHIMRA'S LECTURES TO HIS STUDENTS DURING WAR.

Professor UCHIMURA's lectures to university students were for 1½ hours per week for 2½ years. They covered medical and clinical psychiatry with out-patient demonstrations. During the war, "war neuroses" were emphasized and with our bombing of TOKYO his advice was sought on behald of civilians. Specifically in reference to the broad subject "War Neurosis" the following was emphasized:

a. More exact diagnosis.
b. Treatment methodologies (persuasion, rest and work).
c. Psychogenic factors:

(1) "Shell shock."
(2) Fixed complaints.
(3) Escape mechanisms.

d. Recognized elements:

(1) Front line warfare (extremes of environment).
(2) Fear of defeat.
(3) "Unconditioned" troops.