

Special Topic 1: The A-bomb and Medical History

Nuclear Minds: Japanese Psychiatry's encounter with the Atom

Ran ZWIGENBERG

ABSTRACT: From 1945 on, only a handful of Japanese researchers tackled the psychological consequences of the atomic bombings of Hiroshima and Nagasaki. The failure of the medical establishment to tackle psychological issues was to a large extent, at least initially, the result of American pressure and censorship, and the general secrecy that surrounded nuclear issues during the Cold War era. Coupled with Japanese psychiatrists' suspicion of trauma, this resulted in a complete lack of psychiatric care for survivors (*hibakusha*). Even after the occupation ended, Japanese psychiatrists mounted no campaign to fight for their patients' rights and conducted no large-scale research until the 1990s. Japanese psychiatry's reluctance to examine the trauma of the A-bomb, this paper argues, was the result of both long-standing aversion to war-related injuries and postwar entanglement with American research. Focusing on the work of Hiroshima- and Nagasaki-based doctors this paper will examine early psychiatric research on *hibakusha* and the factors that led to the long-term denial of care for survivors.

KEYWORDS: Hibakusha, psychiatric care, objectivity, A-bomb neurosis, censorship

Ran ZWIGENBERG is Assistant Professor at the Department of Asian Studies, Pennsylvania State University. E-mail: ruz12psu.edu

1. Introduction: the A-bomb and human psych

In February 1946, the New York Times reported from Hiroshima that “[medical] officers of the twenty fourth division now turning over the garrison to arriving British empire troops [discussed] whether the inhabitants of this city have also undergone freakish psychological effects differentiating them other Japanese.”¹ This was not a subject of mere curiosity by the departing troops. In 1945–1946 United States Strategic Bombing Survey (USSBS) have conducted extensive surveys to determine the bomb’s psychological impact and the way it affected moral. This research was only the beginning of efforts by psychiatrists, as well as the wider social sciences to tackle the complex ways in which our minds were affected by the advent of the nuclear age. Such efforts, which I examined elsewhere, ranged from debates over the problem of human aggression to research into the trauma, panic, anxiety and other psychological impacts of the bomb. In the US, such research was in line with both American military psychiatry interest in dealing with battlefield psychological trauma, and the early understanding of the A-bomb as largely a psychological weapon of “mass terror.”² American psychiatrists, who worked on the subject with nuclear and civil defense research bodies, sought to use Hiroshima and Nagasaki research to demonstrate the ability of civil defense medical personal to deal adequately with psychological trauma and keep morale high. USSBS findings were central to a new domestic civil defense effort in the US to teach Americans how to deal with a possible nuclear attack. This was done in the context of the larger efforts by psychiatrists and psychologists to harness the categories of psychological science in the service of society, or as the first head of World Health Organization, George Chisholm, put it, “healing a sick world.”³

In Japan no such body of research was allowed to develop, with very little discussion of nuclear anxiety, civil defense, or even the medical consequences of the bomb permitted under the occupation. American censorship authorities in Japan actively suppressed research on and discussion of the possible impact of nuclear warfare.⁴ The American Atomic Bomb Casualty Commission (ABCC), which was established in Hiroshima and Nagasaki as a permanent research facility to ascertain the A-bomb’s medical effects, the US military and Atomic Energy Commission (AEC) were quite resistant to admitting any long-term damage, physical or otherwise. This lack of research, tragically, also included Japanese psychiatrists, who were not sympathetic to the idea of long-term trauma. Consequentially, within this

¹ New York Times, 26 February, 1946.

² Ran Zwigenberg, “Healing a Sick World: Psychiatric Medicine and the Atomic Age,” *Medical History*, Vol. 62, No. 1 (2018), pp. 27–49.

³ *Ibid.*, p. 28.

⁴ Monica Braw, *The Atomic Bomb Suppressed: American Censorship in Occupied Japan*, (Armonk, NY: M.E. Sharpe, 1991) especially chapter 2.

NUCLEAR MINDS

growing body of research, there existed a peculiar yet telling gap, the actual victims of the bomb, the survivors of Hiroshima and Nagasaki, were hardly studied by Japanese, American or any other group of researchers. Following the initial USSBS research, only a handful of researchers worked on the long-term psychological impact of the bomb on survivors. It was not until the mid-sixties, with the work of Robert J. Lifton, that the first large scale research on survivors was conducted. Even then, it took another three decades, following the Kobe earthquake, that PTSD was introduced into Japan.⁵

As a result, *hibakusha* (A-bomb survivors) faced a dismal lack of care and understanding of the multiple psychological effects caused by their experience in August 1945. This paper aims at explaining this particular lacuna by focusing on the work of Japanese psychologists and psychiatrists in Hiroshima and Nagasaki within the context of the longer trajectory of PTSD and Trauma in Japan. The lack of research on A-bomb survivors' trauma, I argue, was the result of a confluence of developments, the most of important of which were an American campaign of censorship and neglect of the A-bomb's long-term effects, Japanese researchers suspicion of trauma and its victims, and the very complex links between radiation damage, then yet unknown, and psychiatric effects. These factors combined to make research difficult and led to five decades of denial of care for *hibakusha*'s mental suffering, even as their cause was celebrated by the Japanese public and they became subjects of intense radiation research in both countries.

2. Japanese attitudes to Trauma: a brief survey of pre and post 1945 attitudes

Japanese psychiatry's record in dealing with trauma in general – and the A-bomb in particular – was minimal and psychiatrists were not sympathetic to the idea of long-term trauma.⁶ The first to encounter and write about trauma in Japan were doctors who dealt with military casualties. The Japanese military reliance on its superior “spirit” made it hard to accept psychiatric suffering.⁷ Military psychiatry was generally neglected and doctors rarely acknowledged psychological injuries.⁸ In 1937, for instance, military psychiatrist Kamata Shirabe⁹ told doctors, “Unlike the Western militaries during the First World War, there has

⁵ Ran Zwigenberg, *Hiroshima: The Origins of Global Memory Culture*, (Cambridge University Press, 2014), pp. 171–72.

⁶ *Ibid.*, p. 147.

⁷ Janice Matsumura “State Propaganda and Mental Disorders: The Issue of Psychiatric Casualties among Japanese Soldiers during the Asia-Pacific War,” *Bulletin of the History of Medicine*, Vol. 78, No. 4 (Winter 2004), p. 808.

⁸ Nakamura Eri, ‘Nihon teikoku rikugun to “sensōshinkeibyō: senshōbyōsha o meguru shakai kūkan ni okeru ‘kokoro no kaze,’” *Sensō sekinin kenkyū*, Vol. 81, (2013), pp. 52–61.

⁹ Here and elsewhere, I follow Japanese convention in putting family name first, followed by given name.

been no neurotic illness called war neurosis in the Japanese military since the present war [the Asia-Pacific War] broke out. I'm proud as a member of the military of the Emperor that the fact shows people of the Japanese Empire have especially high morale."¹⁰

Japanese casualties were significant, but without a proper accounting and treatment system (there was only one dedicated psychiatric hospital) there is really no way of determining how widespread was the phenomenon. Doctors stressed their roles in preventing psychiatric casualties from influencing the fighting spirit of other troops. As with German doctors, who, during WW I, initially dismissed combat trauma as hysteria, Japanese military doctors tended to downplay symptoms and tried to return shell-shocked soldiers to their units as far as possible.¹¹ This was no coincidence, as Japanese psychiatry was heavily influenced by Germany.¹² The German psychiatric establishment was, as Paul Lerner and others showed, quite allergic to trauma. After WW I psychiatrists dismissed trauma as a category for receiving pension and categorized soldiers as having a "pension neurosis."¹³ Japanese doctors used the exact same language as German doctors to dismiss traumatized soldiers' claims for compensation. Soldiers who claimed to be mentally hurt during their service suffered from a "compensation neurosis" (*hoshō shinkeishō*).¹⁴

Civilian doctors after the war had no such inhibitions but, again – following the German tradition, they generally preferred physical and somatic evidence to mental evidence and were generally hostile to trauma. Only one long term study was conducted on military veterans and none was done on civilian victims of the fire-bombing raids.¹⁵ Thus, it is not surprising that psychiatric research on survivors' mental injuries was sporadic and not part of a consistent research effort. Significantly, the situation in which doctors were operating (or rather not operating) was not conducive to research. This was the result of a number of factors. First, severe censorship in the early years after the war curtailed any research related to the bomb. Second, cultural stereotypes and social taboos prevented many survivors from seeking help or even openly taking about their suffering. Third, as noted above, Japanese

¹⁰ Eri Nakamura, "Invisible" War Trauma in Japan: Medicine, Society and Military Psychiatric Casualties,' *Historia Scientiarum*, Vol. 25., No. 2, (2016), p. 144.

¹¹ Matsumura "State Propaganda," p. 807. For Germany see: Paul Lerner, *Hysterical Men: War, Psychiatry, and the Politics of Trauma in Germany, 1890–1930*. (Ithaca, NY: Cornell University Press, 2003).

¹² See George Blowers, "Freud's Deshi: the Coming of Psychoanalysis to Japan" *Journal of the History of the Behavioral Sciences*, 33 (2) (2001), pp. 115–126.

¹³ Christian Pross, *Paying for the Past; the Struggle for Reparations for Victims of Nazi Terror*, (Baltimore and London: Johns Hopkins University Press, 1998), p. 93.

¹⁴ Matsumura, "State Propaganda," p. 828.

¹⁵ See Katō Masaaki, *Noiroza shinkeishō to wa nani ka*, Tokyo, 1955. See also Suzuki Akihito's summary of the book (in Japanese) at <http://akihitosuzuki.blog.fc2.com/blog-entry-59.html> accessed 25 July 2016.

NUCLEAR MINDS

psychiatry, which was heavily influenced by German psychiatric culture, was traditionally hostile to trauma. Fourth, the peculiar nature of radiation and its unknown character made it hard to distinguish between physical and mental affects. Fifth, and as a result of the above, no reparation schemes were set for mental injuries, hence there was no institutional incentive to evaluate survivors.

3. Somatic Approaches and Their Limitations

Immediately after the bombing the Japanese military sent a medical and scientific delegation to the two cities, which included two psychiatrists sent by Tokyo Imperial University's Uchimura Yūshi, one of the founders of Japanese psychiatry. The two young researchers, Okada Key and Shimizano Yasuo, were sent to perform autopsies and collect samples of brains, for the purpose of ascertaining radiation damage, rather than questioning survivors. The somatic approach was typical of researchers at the time. Furthermore, Uchimura, who also went to Hiroshima himself, was quite dismissive of trauma. Though he experienced the fire-bombing personally, he admitted only "some anxiety for my family," and was actually "thrilled by the danger of bombings."¹⁶ Uchimura, "expected that numbness and despair would last only a short time."¹⁷ He, "have heard that refugees from bombed out London had suffer from emotional paralysis and depersonalization," but, like his military colleagues, expected Japanese to react differently.¹⁸

According to his memoir, Uchimura's research notes were confiscated by the Americans and not much seem to come out of this initial foray into Hiroshima.¹⁹ It is safe to assume that even if doctors were interested in conducting research, American censorship and the harsh conditions of the early occupation would have made such projects difficult to execute. It took a full four years for Japanese research to begin in earnest. Starting with the first surveys that were done in 1949 in Kyushu University by Okumura Nikichi and Hitsuda Heizaburō, a small number of researchers separately examined *hibakusha's* persistent health problems. But their research was not followed on by many others.²⁰ Connections between researchers, let alone a concentrated campaign for *hibakusha*, never materialized. Psychiatrists found it very hard to directly link the experience of mass death and psychological trauma. This was mostly because the patients' syndromes were related to general bad health, physical trauma, and radiation rather than to psychological injuries. A plausible causative link between symp-

¹⁶ Yushi Uchimura, *Waga ayumishi seishin igaku no michi* (Tokyo: Misuzu Shobo, 1968), p. 251.

¹⁷ *Ibid.*, p. 252.

¹⁸ *Ibid.*, p. 251.

¹⁹ *Ibid.*

²⁰ Okumura Nikichi and Hitsuda Heizabur. "genbakudan hisai kanja seishinkei byōgakuteki chōsa seisek," *Kyushu shinkeiseishin igaku* Vol. 1 No. 50 (1949), pp. 50–52.

toms and trauma was very hard to prove scientifically.

It was hard for researchers to isolate the psychological effects of the bomb from the effects of radiation – a still unknown phenomenon.²¹ Many articles by psychiatrists and psychologist lament the lack of research on the matter. In 1956, Yuzuki Takeshi observed, “ten years after the bomb although there were no surgical or other medical problems *hibakusha* still complain of fatigue, memory and other subjective issues.” But his research as well remained on the level of diagnosis. Conducting research on both *hibakusha* and non-*hibakusha* group he found that indeed *hibakusha*, especially laborers, suffered disproportionately more than non-*hibakusha* but no significant difference was found in urine samples or other physical measures. Yuzuki however offered no explanation to this.²² Starting in 1953, Konuma Masuo, in the largest survey of its time, examined 132 cases of *hibakusha*. He found autonomic ataxia (lack of muscle coordination), dizziness, headaches, sleep disorders, amnesia etc. Konuma noted that that these symptoms are usually the result of brain injury. However, he could detect no such injury. Konuma concluded that these were in “high probably because of changes in the brain and nervous system which were caused by radiation damage.”²³ There is no explanation why these are attributed to radiation rather than other factors. Yet, given how little was known about radiation, and how closely guarded much of its information was, it is not surprising that cognitive issues as well were also regarded as a result of radiation damage. Konuma, significantly, was one of the only researchers that worked on long term issues, such as A-bomb fatigue (known as *bura bura byo*) and made connections between military and *hibakusha* research. But Konuma worked mostly alone and his impact was limited.

4. Kubo Yoshitoshi: Toward a Psychology of *Hibakusha* Suffering and the Ideal of World Peace

The narrow scope of Konuma’s and others’ research continued well beyond the occupation. Japanese “self-censorship,” and dependence on government funding added to the silence on the matter well into the 1960s. As Osaka Eiko demonstrated the occupation also heralded a shift in Japanese psychology towards American methodologies.²⁴ This shift continued after the occupation as Japanese researchers tried to integrate themselves into the

²¹ Ibid. p. 153.

²² Yuzuki Takeshi, “genbaku hibakusha no jikakuteki hirōshōjō chōsa narabi ni nyū do hannō ni yoru hirō chōsa sesaki ni tuite,” *Hiroshima igaku*, Vol. 9, No. 2 (1956), pp. 78–80.

²³ Nishimoto Minae and Matsumoto Kazuo, “Saigai no shinshin hoken gakuteki kenkyū: hanshin daishinsai 6 nen ato ni okeru [Research on Preserving the Health of Mind and Body after Disasters: A Report 6 Years after the Great Hanshin Earthquake],” *Jim bun ronkyū*, 52, 3 (2002), 66.

²⁴ Osaka Eiko, ‘Senryō Nihon shinrigaku,’ *Surugadai Daigaku kyūyō kenkyūsho*, Vol. 1 (2011), p. 181.

NUCLEAR MINDS

American dominated Cold War world of postwar research.²⁵ The occupation used a number of psychologists in conducting surveys of Japanese attitudes towards occupational reforms. Kubo Yoshitoshi, a Hiroshima native and former Imperial Navy doctor, was one of these psychologists.²⁶ Kubo's work on *hibakusha* represents one of the only sustained efforts to tackle the psychological impact of the bomb. Kubo was the only one among Japanese researchers who stuck to psychological explanations and did not connect damage to radiation or other aspects of *hibakusha* health. Significantly Kubo was concentrating, like his American colleagues who worked on civil defense issues, on the issue of panic and individual and mass nervous breakdown.²⁷ Kubo divided survivors' reactions into five stages in which they went from "instinctive action," to "panic," "quasi panic" and a "blank" (stupefied) stage. None of these stages, however, lasted beyond a week or two after the bomb.²⁸ Kubo's work completely neglected any impact beyond these two weeks and curiously stopped with the day of the bomb. Even though he was writing in 1952, seven years after the bomb, Kubo asserted, "We can hardly estimate the next stage," concluded Kubo, "but perhaps some time after, every respondent succeeded in slowly adjusting to their circumstances."²⁹ Kubo's emphasis in later research was, likewise, on short term impact of the bomb and his work tend to stress more and more the political aspect of his work, in relation to promotion of peace, rather than its medical aspects.³⁰

Politics, however, were driving greater and greater interest in the *hibakusha*'s plight. 1956, the year where awareness to the plight of *hibakusha* peaked – following the establishment of *hidankyo*, saw a number of other studies. That year a medical survey by a *hibakusha* organization found 7.3 percent of *hibakusha* suffering from nervous disorder, and an "overwhelming number of people who suffered from neurasthenia." The survey prompted at least two different research schemes.³¹ One of these groups, led by Kondō Toshiyuki and Yoshioka Ichirō did research in Hiroshima and concluded that *hibakusha* indeed have higher rates of memory problems, excitability and other symptoms than prevalent in general population. Kondō et al. as well did not progress beyond that conclusion.³² But, crucially, neither

²⁵ Ibid., 177, 186

²⁶ Ibid., 177, 186.

²⁷ Ran Zwigenberg, "Wounds of the Heart": Psychiatric Trauma and Denial in Hiroshima," *History Workshop Journal*, Vol. 84 (Fall 2017), pp. 12–13.

²⁸ Ibid; Kubo Yoshitoshi, "Hiroshima hibaku chokugo no ningen Hiroshima hibaku choku go no ningen kōdō no kenkyū," *Shinrigaku ken'yū*, Vol. 22, no. 2 (1951), pp. 103–110.

²⁹ Ibid., p. 109.

³⁰ Zwigenberg, "Wounds of the Heart," pp. 15–17.

³¹ Nishimoto Minae and Matsumoto Kazuo, "Saigai," p. 66.

³² Kondō Toshiyuki et al., "genbaku higaish no shinriteki chōsa," *Hiroshima igaku*, Vol. 9. No. 2 (1956), pp. 59–64.

the Kondō group nor any of the other studies examined here cite each other.³³ Whatever Japanese research on *hibakusha* they do refer to is from radiation and related studies. None mentioned research done at the time on survivors of the Nazi camps or other traumatic experiences.

This failure can be partly attributed to *hibakusha*'s reluctance to come forward. Also, in 1956, a survey conducted by *hidankyō* reported, somewhat cryptically, on many *hibakusha* who "suffer from problems of the heart, which lead to family problems and a-social behavior."³⁴ The report did not go beyond this observation. This was not surprising as the subject was taboo at the time. Many *hibakusha* did not even raise the issue within the survivor community, let alone publicly speak of their mental issues, preferring to complain, like Holocaust survivors, of more "normal" physical ailments instead.³⁵ Significantly, *hidankyō* did not even raise the issue of treatment for mental damages when it campaigned for a medical law with the government. Reparation from the Americans was, of course, out of the question.

One exception to this trend was the aforementioned Kubo Yoshitoshi, who was one of the principal backers of the compensation movement. Kubo's motivation for his research can be very much tied to his political activity, both with the University Scholars Society and the larger, all Japan, "Japanese Psychologists for Peace." This organization sought, in a similar manner, and inspired by, American social scientists, to further the "link between psychoanalysis and peace."³⁶ Kubo was among the founding members of the society and is signed on a 1950 "peace appeal to American Psychologists," which was crafted at the fourteen-annual conference of the Japanese Psychological Association. The peace appeal, as well as the peace society as a whole, made a point of the Japanese psychologists unique situation as citizens of "the country [which] experienced the terrors of the atomic bombs in Hiroshima and Nagasaki."³⁷ Significantly, however, the society's and Kubo's points of intellectual reference were exclusively American. In his 1952 paper he cited research, that was tied to USSBS and similar Civil defense research, as well as an article on the psychological impacts of Orson Welles' famous "War of the Worlds" scare.³⁸ But Kubo, through his politi-

³³ Konuma Toshio et al., "seishin keika no matome," *Nagasaki igaku ka zashi* vol. 36 (1961), p. 101.

³⁴ Gensuibakuikinshi Hiroshima kyōgikai genbaku higaisha kyūen iinkai, "genbaku higaisha jitai chōsa hōkoku," (Hiroshima, 1956), p. 6.

³⁵ Author interview with a group of *hibakusha* from the HIP (Hiroshima Interpreters for Peace) group, 23 January 2012 Hiroshima Peace Memorial Museum, See also Monica Braw, "Hiroshima and Nagasaki: The Voluntary Silence," in Laura Elizabeth Hein and Mark Selden, *Living with the Bomb: American and Japanese Cultural Conflicts in the Nuclear Age* (M.E. Sharpe, 1997), p. 157.

³⁶ Heiwa no Tame no Shinrigakusha Kondankai, *Heiwa shinrigaku no ibuki*, (Kyoto: Hōsei Shuppan, 1990), p. 1.

³⁷ *Ibid.*, p. 2.

³⁸ Kubo, "Hiroshima hibaku chokugo," p. 32.

cal work, together with Nakano Seiichi and others as well as the main survivor relief organizations was important in pushing for the publication of white papers and other reports on the state of hibakusha that were instrumental in bringing about the medical relief laws for the *hibakusha*.³⁹

5. Conclusion: the question of Denial

The question remains, however, why Kubo and other psychologists and psychiatrists did not push for inclusion of mental health provisions in these laws. There is no easy answer to this conundrum. A number of possible explanations can be found in the evidence examined above. Japanese psychiatrists and psychologists did not deny *hibakusha* suffering. Unlike their American counterparts they did not try to downplay it, or as with their colleagues in the military, claim that *hibakusha* are just being lazy and malignant. Hibakusha suffering was definitely acknowledged. However, for psychiatrists, who preferred physical and organic explanations, what caused psychiatric symptoms was in doubt, thus leading to much confusion and little involvement in *hibakusha* relief. For Kubo, the explanation was psychological (in the “stimuli produced by the bomb”), nevertheless, he was not interested in offering cure but in how to prevent the next war and the politics of the peace movement.

Researchers did report of many symptoms that together constituted what came to be called “A-bomb neurosis,” but time and again they failed to connect disparate research and come together with an agreed definition of the problem or any sort of methodology to deal with it. Researchers were acutely aware of the untidy and confusing nature of their findings and struggled to connect and make sense of it. In what they did find there was an overwhelming preference for somatic explanations and aversion to psychological ones. This was perhaps due to the stigma attached to mental issues among both patients and doctors. We must remember that up until 1950 mental patients in Japan were still locked up in cages, and that most of these researchers grew up in a system where racial thinking, which saw mental defects as a sign of racial inferiority, was the norm. The result of such shortcomings was, tragically, that only in the 1990’s following the Kobe earthquake that thinking about trauma started to change in Japan.

³⁹ Hamatani Masaharu, “Genbaku taiken to ‘kokoro no kizu,’ IPSHU kenkyū hōkoku, no. 41, (2009), pp. 5–6.