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Characteristics of hospital-based Munchausen Syndrome by Proxy in Japan☆

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ABSTRACT

Objective: This article explores characteristics of Munchausen Syndrome by Proxy (MSBP) in Japan, a country which provides an egalitarian, low cost, and easy-access health care system.
Methods: We sent a questionnaire survey to 11 leading doctors in the child abuse field in Japan, each located in different hospital-based sites. Child abuse doctors answered questions regarding the characteristics of MSBP cases for whom they had helped care.
Results: Twenty-one MSBP cases (20 families) were reported. Characteristics of the victims included: no differences based on sex, 4.6 years of age on average when MSBP was confirmed, and an average of 1.9 years duration of MSBP abuse. Biological mothers were at least one of the perpetrators in 95% of cases. Among the 12 cases (57%) who remained with their families, 2 victims died. Only 5% of perpetrators had a medical background or relatives who engaged in healthcare work.
Conclusion: There are similar features of MSBP cases between Japan and other English-speaking countries, such as the UK or the US. However, perpetrators of MSBP in Japan did not have a medical background. Easier access to hospital resources in Japan may give greater opportunities for perpetrators to obtain medical knowledge from doctors or nurses.
Practice implications: The findings suggest that perpetrators of MSBP should not be assumed to possess a medical background in a country which provides universal medical care such as Japan. A contributory factor of MSBP may be the high frequency of medical consultations and equal level of accessibility of medical resources for Japanese citizens. Social welfare services that need to decide on custody for MSBP victims should recognize the relatively high risk of life-threatening danger in their family of origin. Further collaboration between hospital staff including pediatricians, nurses, medical social workers and staff at the social welfare services is needed to protect children from MSBP.

Introduction

Munchausen Syndrome by Proxy (MSBP) has been recognized worldwide since first reported by Meadow in 1977. Most cases have been reported from developed and English-speaking countries, such as Australia, Canada, New Zealand, the UK,

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and the US, but a recent review reported MSBP cases from non-English-speaking countries, including Japan (Feldman & Brown, 2002). In this review, however, there was only one MSBP case reported from Japan (Honjo, 1996) and this case was not MSBP based on Rosenberg's (1987) definition (Sheridan, 2003).

Since MSBP might be, in part, related to health care accessibility, the patterns of MSBP may vary depending on the national health care system. It is our aim to compare the characteristics of MSBP in Japan with those from developed English-speaking countries. These countries, such as the UK and the US, employ a primary physician system, whereas Japan is also a developed country, but does not utilize this type of system. All Japanese citizen are covered equally in terms of medical care, and they can approach any doctor at any clinic or hospital, including a specialized doctor at a university hospital, with no discrepancy in cost, because of the egalitarian health care system (Ikegami & Campbell, 1999). In addition, parents who have an income below a specific amount do not need to pay any costs to the hospital with regards to medical care for their children.

In Japan, the process of receiving medical care for a child is as follows: when a child becomes sick, parents can approach practicing pediatricians, a children's hospital, or pediatricians in a general hospital. Occasionally, patients may go to general practitioners. When practicing pediatricians or physicians decide that the child needs further examination or treatment, he or she is referred to other larger hospitals. For example, if a pediatrician believes that a CT scan is needed because a child is frequently vomiting after a fall, that pediatrician must contact the nearest larger hospital and ask the physicians there to examine the child and order a CT scan and hospitalization. In the case of MSBP, many victims would be referred to larger hospitals because the etiology of symptoms tend to be difficult to find (i.e., they are simulated or produced).

The Japanese medical system may essentially be providing the opportunity for more frequent visits to physician offices or hospitals for mothers to bring their children in for treatment. According to the Organization for Economic Co-operation and Development (OECD) report (2005), doctors' consultations per capita in Japan in 2000 was 14.4, while the same data in the UK are 5.4, in the US, 8.9, and in Canada, 6.3, partly due to the availability of doctors and the cost of consultation for individuals. Because we can estimate that children in Japan are more frequently in contact with physicians than children in other developed, English-speaking countries, we hypothesized that the unique Japanese health care system might affect the characteristics of victims and perpetrators of MSBP in Japan. Therefore, the purpose of this study was to explore the characteristics, victims, perpetrators, and patterns of MSBP in Japan.

Methods

Subjects

We held the Child Abuse Working Group Meeting in the Nippon Association of Professionals and Scholars on the Abuse of Children, the Japanese version of the American Professional Society on the Abuse of the Children, in December 2004. In the meeting, 11 leading doctors in the field of child abuse in Japan, working in different hospital-based sites, reported MSBP cases (including suspected and confirmed cases) for whom they had helped care. Following the meeting, we sent a questionnaire survey to these 11 doctors who had reported MSBP cases. As detection of MSBP is not yet commonplace in Japan, we assumed that these specialized doctors are most able to detect probable MSBP cases. All 11 child abuse doctors reported back MSBP cases, from 1 to 4 cases each. They also answered questions regarding the characteristics of the MSBP cases, both suspected and confirmed, for whom they have helped care during a 10-year time period (1995–2004).

To include reports of cases from doctors, we defined MSBP based on Rosenberg's definition (1987) as "an odd form of abuse in which the mother fabricates illness in her child and repeatedly presents the child for medical care, disclaiming any knowledge about the cause of the child's illness."

We categorized MSBP into two groups based on Monteleone's definition (1998):

(1) Simulated:
   (a) Faked symptom by the caretaker (e.g., mother's contamination of the child's urine specimen with her own blood and subsequent claim that the child had been urinating blood),
   (b) False or exaggerated history by the caretaker (e.g., mother's continuous claim of seizures by the child, although no one had witnessed these symptoms), and
(2) Produced:
   (a) Caretaker actually inflicted (e.g., the injection by the mother of a foreign material such as feces or a drug into the child's intravenous line or formula, causing physiological disorders).

Surveyed characteristics

Investigated variables for victims of MSBP were: sex, age at first visit to a hospital, age at which MSBP was confirmed, duration of abuse, and existence of a developmental disorder.

Investigated variables of perpetrators were: relationship with victim, age of perpetrator, existence and diagnosis of mental disorder, existence of a medical background, such as nursing, having relatives or close friends who are engaged in health-care, resources of medical knowledge, and family structure. Psychiatric evaluation of perpetrators was performed based on the Diagnostic Statistical Manual (DSM) by psychiatric pediatricians who treated the victims of MSBP. However, because