Child Abuse in Japan: Current problems and future perspectives

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Abstract
Over the past 15 years, significant progress has been achieved in the intervention of child abuse. However, while the number of child abuse cases discovered has increased, there has been no decrease in the number of cases of children dying as a result of abuse. The role healthcare has to play in saving such children is increasingly important, but at present we cannot really say that a healthcare system for treating abuse has been established. This paper examines the current situation of medical system regarding child abuse treatment in Japan, presenting an overview of the issues now requiring attention, particularly the need for: 1) education of child abuse for all physicians and other healthcare personnel; 2) establishment of internal hospital systems for child abuse; 3) establishment of community healthcare systems for intervention of child abuse; 4) collaboration between various medical fields for child abuse; 5) establishment of abuse treatment as a specialized medical field; and 6) establishment of child death review system.

Key words Child abuse in Japan, Japanese child abuse prevention system, Child abuse law, Medical problems of child abuse

Number and Characteristics of Reported Child Abuse Cases
Figure 1 shows changes in the number of child abuse cases reported to child counseling centers in Japan. In the United States, the number of reported child abuse cases is decreasing, but the number in Japan continues to increase at a rapid pace. A particular characteristic of child abuse in Japan is the extremely low proportion of sexual abuse cases reported. Figures for not only the United States and other countries at the forefront of child abuse treatment but also for Asian countries show physical and sexual child abuse to be equally high, followed by psychological abuse, or neglect. In Japan, however, the proportion of sexual abuse cases is very low at approximately 3%. The proportion of cases reported by medical institutions is also very low (approximately 4%), another characteristic of child abuse in Japan. However, these characteristics do not necessarily indicate the nature of child abuse in Japan so much as the problem of low social awareness of the need to protect children when sexual abuse is discovered. Nonetheless, clinically there has been an increase in recognition of sexual abuse; the number of sexual abuse cases reported in Japan is therefore expected to rise sharply in the future.

The History of Countermeasures against Child Abuse in Japan
Specialists conscious of child abuse began researching and educating about the issue in the late 1970s, but in Japan it was not until the 1990s that the term gyakutai (“abuse”) gained popular recognition and treatment of child abuse began to move forward. From 1991, the recognition...
and treatment of child abuse was led by NGOs established throughout the country, starting with bases in Tokyo and Osaka. These NGOs made possible multidisciplinary measures, introducing an intervention model that had until then been difficult to implement with the government's vertical administrative structure. Furthermore, in addition to collaborating with the mass media to spread awareness of child abuse among the general public, the NGOs have pursued methods for recognizing abuse situations and providing support through telephone counseling and other means.4

During the early 1990s, the Japanese government had taken a skeptical attitude towards the existence of child abuse, but in fiscal 1996 began to implement models and programs seeking collaboration with NGOs and proactively promote measures to prevent child abuse. Memoranda regarding the interpretation and application of the Child Welfare Law in recognizing and treating child abuse were issued in succession and child counseling centers were directed to proactively intervene rather than take the passive wait-and-see approach previously advocated. Moreover, from 1999 surveys detailing the number of abuse cases resulting in death despite the involvement of child counseling centers aroused social concern for this problem.

These large popular movements prompted lawmakers to enact and enforce child abuse legislation, in the form of the Child Abuse Prevention Law, in 2000. Although the initial legislation was no more than a compilation of previous Child Welfare Law and Ministry of Health and Welfare (now the Ministry of Health, Labour and Welfare) memoranda, laws specific to child abuse were established. By clearly stipulating that child abuse exerts a profound effect on the remainder of abused children’s lives, providing clear definitions, and imposing a responsibility on doctors and specialists to endeavor to identify child abuse cases early, this legislation represented tremendous progress. The new legislation also made reporting child abuse cases easier for medical professionals by stipulating that the reporting of such cases did not violate confidentiality under the Medical Practitioners Law.

**New Directions in Child Abuse Intervention**

**Directions in social awareness**

Establishment of the Child Abuse Prevention Law in 2000 resulted in a leap in the already-increasing number of child abuse cases reported to child counseling centers (Fig. 1). The Child Abuse Prevention Law contained a provision under which the law was to be reviewed in three years; after extensive debate on all quarters,
the law was amended in March 2004. The Child Welfare Law was amended at the same time, demonstrating a new direction in the recognition and intervention of child abuse. Article 1 of the Amended Child Abuse Prevention Law stipulates that “Child abuse seriously infringes upon the human rights of children,” an addition concerning human rights that was left out of the initial Child Abuse Prevention Law due to strong opposition from the ruling LDP party. With regard to reporting child abuse, “those discovering children that are being abused” was amended to “those discovering children that are believed to be being abused,” prescribing a clear responsibility to report any suspicion of child abuse. Other amendments include: the addition of “witnessing domestic violence (DV)” to the definition of child abuse; clear stipulation of the responsibilities of national and local government bodies; addition of not only individual specialists but of specialist organizations to those with a responsibility to endeavor to identify child abuse cases early; prescription of cooperation by those individuals and organizations responsible for identifying child abuse in the protection of abused children and with national and local government bodies in the formulation of policies; and prescription of consideration of the possibility of abuse of children entering nursery school or kindergarten and other educational issues concerning abused children. In other words, both doctors and medical institutions now bear a responsibility to not only identify child abuse cases early, but also cooperate in the protection of children and other relevant policies.

However, the greatest change regarding the recognition and treatment of child abuse was the regional focus established by the amendment of the Child Welfare Law. Children who have been abused or otherwise need society’s protection are deemed “Children Requiring Care”; municipalities are able to establish either independently or jointly in collaboration with relevant organizations regional councils for implementing measures to assist Children Requiring Care (hereunder referred to as “councils”); and municipalities receiving reports of child abuse ensure the safety of “Children Requiring Care” while at the same time provide support for the child and the child’s family. However, cases where specialist intervention is thought to be required must be referred to a child counseling center. Council membership must of course include doctors and/or medical institutions and councils must be involved in intervention within the community as well as in the support of parents and family. Council members have a responsibility to maintain confidentiality, and so the disclosure by medical professionals to a council of personal information believed necessary for protecting a child does not violate the law. Proactive participation in the Councils is required.

**Issues and directions in medical intervention and treatment**

The following changes are required in the medical intervention and treatment of child abuse.

**Universalization and education of child abuse intervention and treatment**

Intervention and treatment of child abuse has until now been regarded as the role of certain specialists; in the future, however, it will be imperative that general intervention and treatment of child abuse be able to be carried out by anyone, anywhere, in a uniform manner. In other words, the distinction between hospital and doctor must be eliminated and education provided to enable a universal response. At present, interest in child abuse intervention and treatment is gradually growing and taking shape in pediatrics, but awareness is still not high in other fields. The majority of abuse cases involve external injuries that not infrequently require examination at surgeries or emergency care centers. Education about child abuse is required for doctors and other medical professionals in fields that predominantly treat adult patients.

**Establishment of hospital systems**

It is unusual for only one medical department or profession alone to treat child abuse. For example, when an infant suddenly stops breathing or has seizures, a pediatrician examines the child and if they suspect a head injury caused by physical abuse, careful examination of the ocular fundus and taking and reading bone survey hopefully by a pediatric radiologist—become necessary. Furthermore, a medical social worker (MSW) and public health nurse are required for cooperation between doctors within and coordination with the resource outside the hospital.

Furthermore, in the intervention of child abuse, doctors and medical professionals tend to hesitate to intervene the child abuse by them-
selves because of 1) feeling guilty for doubting the parents; 2) being fearful of perceived child abuse cases turning out not to have been child abuse; 3) wishing to avoid identifying a problem as child abuse because of the effort involved and the psychological pressure that follows; and 4) having anxiety for making enemy. Therefore, child abuse intervention and treatment systems of the hospital that involve professionals other than the patient’s primary physician are very effective. In particular, establishment of a committee lead by senior hospital staff so that decisions are made by not only the primary physician but also the hospital facilitates confronting parents and encourages coordination with resource outside the hospital. It also enables the accumulation of case studies within the hospital and can be expected to improve child abuse intervention and treatment. Such systems are currently being constructed at some university hospitals and children’s hospitals. It is recommended that as many hospitals as possible implement such systems.

**Construction of a medical system to intervene and to treat child abuse**

For a reasonably large hospital, the hospital system described above could be implemented, but for doctors in private practice and small hospitals, implementation of such methods involve many difficulties. Moreover, in general, all cases of abuse of infants and children up until the age of three require full-body x-rays and examination of the ocular fundus, but only a limited number of hospitals can perform these examinations adequately. Consequently, there is a need for a system in which centralized hospitals that can treat child abuse are established and patients are referred to these in cases where another medical institution suspects child abuse. Currently, even where such systems have been conceived, only a few have actually been established. In future, such a system will need to be established in either each prefecture or each medical care zone.

**Promotion of cooperation between organizations**

Collaboration between welfare, health, and education organizations is also important. In many cases this is very difficult for one doctor to achieve. At reasonably sized hospitals, MSW or public health nurses are necessary to enable cooperation with the local community. It is also recommended that local government bodies establish councils, as described above, to promote child abuse intervention and treatment in local communities. It is vital that medical professionals be included on such councils in order to protect infants, who are especially vulnerable and in danger.

**Establishing preventative methods**

Methods of intervention have advanced to some extent, but in comparison, methods for prevention of child abuse and treatment of abused children and their families have been slow. Medical care begun during pregnancy needs to promote the prevention of child abuse, in collaboration with public healthcare, from the gestational or postpartum period. Abuse prevention is particularly necessary from the gestational period onwards in cases such as fetal abuse or denial of the fetus during gestation, DV or other domestic problems, parents feeling no affection for the fetus, or high-risk parents or relatives. For example, precipitate delivery can result in denial of the fetus and presents an extremely high risk for abuse. Despite this, in some such cases mothers and babies are released from hospital without a community network being constructed for them beforehand. The problem here is that there is a strong possibility of the danger of child abuse death being overlooked. It is vital that a community network be created before the mother and child are released from hospital.

**Involvement in treatment and care**

Treatment and care of parents who abuse their children and of the abused children themselves is an issue to be faced by the medical field in the future. Medicine is expected to provide the appropriate evaluation of the psychological state of parents that abuse their children and identification of appropriate treatments. However, those treating the abusive parents often developed a parent-centered outlook and may have only low awareness of the need to protect the child. For example, there have been cases in which children have died because healthcare professionals opposed separation of the parents from the children on the grounds that “separation from the children will worsen the parent’s condition.” The reality of taking the life of their child is a situation that needs to be prevented for the parents’ sake, too. Caregivers must be conscious of the fact that care for the parents must also be care for the parents and child.
Children that have been abused tend to have difficulties feeling affection, experience trauma, and suffer interpersonal and behavioral problems. The role required of medical professionals is to evaluate these psychological problems and indicate the direction treatment should take. Treatment of dissociative problems that are common in cases of sexual abuse in particular should be improving.

**New specialty**

It is common for the diagnosis of child abuse to require medical specialization. However, knowledge of child traumatology is limited and diagnosis is often difficult. In Japan, there has been a particularly low accumulation of knowledge, and child abuse intervention frequently requires legal procedure. A forensic medicine response is therefore required. Furthermore, as described above, psychological care needs to be established. The specialized nature of abuse medicine needs to be established, research conducted, and knowledge accumulated so that these may be used in intervention and treatment that will ensure that the physical and psychological dangers of abuse to children is avoided. There is a growing need for the establishment of abuse as a specialization and for research by specialists to be promoted.

**Child death review team**

In the case of child abuse, the cause of death is frequently given as “non-intended injury.” In order to prevent child abuse that is hidden in the shadows, it is imperative that all children’s deaths, including accidents, are investigated. In Japan, the Ministry of Health, Labour and Welfare has established a committee to investigate child abuse deaths, making recommendations for investigations in each region. The issue of examining cases of child abuse death is one in which the participation of doctors is vital. The proactive participation of doctors will be vital in the establishment in the near future of regional systems for examining child abuse cases. Furthermore, in the future, it should be critical to establish Child Death Review Team at least in each prefecture.

**Feasibility assurance**

Child abuse intervention and treatment requires a tremendous amount of time and specialized knowledge, yet its feasibility it not assured now. Accordingly, the current system becomes increasingly negative as more and more child abuse are identified and addressed. Treating child abuse and protecting the physical and psychological safety of children will help to secure social stability in the future. As long as there is no feasibility assurance in any form, it is obvious that treatment of child abuse in the medical field will plateau; thus measures to counter this are also required. Resolving this problem will lead to the improvement of child abuse treatment in medicine.

**References**