Parental Overprotection and Psychological Problems among Chronically Ill Children

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Introduction

When a serious, long-term illness afflicts a child, the initial reaction of parents usually includes acute fear and anxiety related to the possible fatal outcome of the illness, disbelief, and denial in the diagnosis. The parents often become uncooperative, grieve for the "loss" of their desired normal child, and blame themselves for the child's illness (Mattson, 1977). A crucial factor in determining the parents' acceptance is their ability to master resentful and self-accusatory feelings of having transmitted or in some way "caused" their child's illness. The parents who remain highly anxious and guilt -laden about their ill child tend to cope with their emotional distress by overprotecting and pampering him, and by limiting his activities with other children (Mattson, 1977). The parents view the child as fragile, vulnerable, and different, thus engage in overprotective parenting (Melnyk, Moldenhouer, Feistein, & Small, 2001).

An overprotective parenting is defined as the child rearing practice that results from a combination of high control (characterized by restricting, structuring, and/or directing the patterns of child's behavior) and high nurturance (characterized by showering of affection, love, and care towards the child) demonstrated especially by the mother (Muhamed, Mohd Taib, Hashim, & Yusuf, 1990). Parental overprotection involves excessive physical or social contact (e.g. continuous companionship and extended co-sleeping), prolonged infantilization (e.g. persistent breast or bottle feeding beyond the usual age of weaning or routine assistance with feeding, dressing, and toileting, despite the child's ability to perform such task autonomously), active prevention of independent behavior and social maturity (e.g. delaying school

entry by one year or allowing the child to play only within the mother's sight), and either an overindulgent absence or a dominating excess of parental control (e.g. inability to set limits or a rigid overregulations of the child's behavior) (Thomasgard, Metz, Edelbrock, & Shonkoff, 1995)

Parental emotional and behavioral overinvolvement has been shown to influence the course of childhood psychological disorders (Asarnow, Goldstein, Thompson, & Guthrie, 1993; Kavanagh, 1992; Stubbe, Gwendolyn, Zahner, Goldstein, Leckman; Vostanis, Nicholls, & Harrington, 1994). Family characteristics, which have been associated with a child's poor adjustment to his illness, include fearful and overprotective parenting (Mattson, 1977; Minuchin, Baker, Rosman, Liebman, Milman, & Todd, 1975). It was found that excessive parental restriction, anxiety, overprotection, high level of conflict and disordered modes of communication, and limited resources and social supports lead to psychological maladaptation in children (Burr, 1985; Johnson, 1985). Daniel (1989) found that mothers of emotionally disturbed children had more dependency-fostering attitudes and overprotective attitude compared to mothers of normal children. Minuchin, et.al. (1975) suggested that the development of psychological disturbances among children with asthma, anorexia nervosa, and diabetes was associated with certain patterns of family organization and functioning, which include overinvolvement, overprotectiveness, rigidity, and lack of conflict resolution.

Overprotective parenting style places children at risk for the "vulnerable child syndrome" (Estroff, Yando, Burke, & Snyder, 1994; Green & Solnit, 1964; Perrin, West, & Culley, 1989) which could result in a disturbed parent-child interaction, dependent, demanded, and out of control children needing increased medical services (Bendell, Field, Yando, Lang, Martinez, & Pickens, 1994). Studies further showed that children with prolonged poor adjustment to their chronic illness tend to show certain behavioral patterns (Mattson & Gross, 1966; Prugh, 1963) such as fear, inactivity, lack of social interests, and a marked dependency on their families, especially their mothers. These children present the psychiatric picture of early passive dependent states and their

mothers are usually described as constantly worried and overprotective toward them.

Although no specific childhood illness can be directly associated with parental overprotection, parents of children with cancer as compared to epilepsy and asthma, are more likely to be overprotective. This is because cancer is normally perceived as a serious, chronic illness that usually has a shorter life expectancy. Treatment procedures also place greater challenges upon the children. Thus, parents might tend to be overprotected, as they are fully responsible and sympathize to the child's condition. Possibly, they do not want to make any mistake about the child, or resist any of the child's wishes. As a result, they pamper the child and this kind of parent-child interaction leads to poor adjustment of the child.

The present study examines the influence of parental overprotection in children's psychological problems. More often than not, parents of sick children tend to be overprotective. Overprotective relationship is understandably common in sick children and often exacerbates psychological problems (Lask & Fosson, 1989). The study hypothesizes that children with cancer will be more overprotected by their parents compared to epilepsy and asthma children, and overprotected children will show more psychological problems as compared to less-overprotected children.

Method

Participants

Sixty-three (N=63) parents of chronically ill children participated in the study included 51 mothers (81.0%) and 12 fathers (19.0%). There were 28 parents (44.4%) in the age range of 31-40 years, 21 parents (33.3%) in the age range of 41 - 50 years, 10 parents (15.9%) were 51 years and above, and 4 parents (6.3%) were in the age range of 20-30 years. Majority of them i.e., 37 parents (58%) were housewives, 34 parents (31.7%) worked in government sectors, and 5 parents (7.9%) worked in private sectors. A total of 68 parents of chronically ill children were approached by

the researcher while waiting in the outdoor pediatric clinic or while accompanying their children in the ward. One parent (1.5%) refused to participate and 4 cases (5.9%) were excluded from the sample because of the child's age. The study was a cross- sectional design that used accidental sampling procedure. The sample of children consisted of 39 male (61.9%) and 24 female (38.1%) children in the age range of 50–202 months (i.e. approximately 4-17 years). There were 24 children (38.1%) in the age range of 4–7 years, 18 children (28.6%) in the age range of 7-11 years, and 21 children (33.3%) in the age range of 11 -17 years. Majority of the children, i.e., 33 children (54.4%) had 5-8 siblings, 27 children (42.9%) had 0-4 siblings, 3 children (4.8%) had more than 9 siblings. Most of them i.e., 29 children (46.0%) were the middle child. There were 15 children (23.8%) who were the eldest and 17 children (27.0%) who were the youngest in the family. Two of them (3.2%) were the only child in the family. As regards the schooling of these children, 25 of them (39.7%) attended school for 1-3 years, 15 children (23.8%) attended school for 4-6 years, 16 children (25.3%) attended school for 7-9 years and 5 children (8.0%) attended school for 10-12 years. There were 2 children (3.2%) had not yet attended school. There were 34 children (54%) came to the clinic to follow-up their cases and 29 children (46%) were hospitalized for treatment. The demographic characteristics of the respondents and the children are presented in Table 1.

Measures

Two measures were used to collect data. These included Child Behavior Checklist (CBCL) (Achenbach, 1991) and Parent Protection Scale (PPS) (Thomasgard, Metz, Edelbrock, & Shonkoff, 1995).

Psychological problems

Psychological problems among children were assessed through CBCL (Achenbach, 1991). It is a 118-item checklist, which obtains

information about children's competencies and problems from parents and surrogate parent. Responses are scored using a 3-point scale from 0 through 2 (0 = " not true of the child"; 1 = "sometimes true of the child"; and 2 = " very true or often true of the child") during the past six months. The profile in CBCL displays eight syndromes that were derived from statistical analyses of problems scored by 4,455 children who had been referred to mental health services.

Table 1: Demographic characteristics of the parents and their chronically ill children

Variable	Frequency (n)	Percentage (%)
Respondents Characteristics		
1. Parent completing the form		
Mother	51	81.0
Father	12	19.0
2. Age (in years)		
20-30	4	6.3
31-40	28	44.4
41-50	21	33.3
50 and above	10	15.9
3. Occupation		
Housewife	37	58.7
Government servant	20	31.7
Private sector	5	7.9
Others	1	1.6
Child Characteristics		
1. Sex		
Male	39	61.9
Female	24	38.1
2. Age (in years)		
4-7	24	38.1

7-11	18	28.6
11-17	21	33.3
3. Number of siblings		
0-4	27	42.9
5-8	33	52.4
9 and above	3	4.8
4. Order of siblings		
First child	15	23.8
Middle child	29	46.0
Youngest child	17	27.0
Only child	2	3.2
5. Years of schooling		
Not schooling	2	3.2
1-3	25	39.7
4-6	15	23.8
7-9	16	25.3
10-12	5	8.0
7. Type of visit		
Follow up	34	54.0
Sick (warded)	29	46.0

There are two major groups of disorders subsumed under the headings of internalizing and externalizing problems. The externalizing problems involve children's conflicts with others and social mores, which comprise of aggressive behaviors and delinquent behaviors syndromes. The internalizing problems involve disorders of emotion and subjective inner distress in the children, which comprise of anxiety and depression, withdrawn, and somatic complaints syndromes. In addition, CBCL assesses mixed problems, namely thought, attention, and social problems (Achenbach, 1991).

The syndrome scales are scored by summing the items for each syndrome. High score indicates numerous problems and are

clinically important for the profile. The borderline clinical score range is 95th - 98th percentile of the normative sample (t scores 67-70). Score below this range is in the normal range, because they are below 95th percentile. Score above this range is in the clinical range, because they indicate more problems than were reported for 98% of the normative sample. Thus, a t score of 70 and above is an indicative of clinically significant level of psychopathology.

The CBCL has been used extensively in child psychopathology literature and has good psychometric properties. The test-retest reliability of CBCL scale scores was supported by a mean test-retest r = .89 for the problems scale over a 7-day period. The internal consistency of each scale was in the range of .54 to .96. Content validity is supported by the ability of nearly all CBCL items to discriminate significantly between demographically matched referred and non-referred children. Construct validity is supported by numerous correlates of CBCL scales, including significant associations with analogous scales on the Conners (1997) Parents Questionnaires, and the Quay-Peterson (1983) Revised Behavior Problem Checklist. Criterion- related validity is supported by the ability of the CBCL's quantitative scale scores to discriminate between referred and non-referred children after demographic effects were partialled out. Clinical cut points on the scale were also shown to discriminate significantly between demographically matched referred and non-referred children (Achenbach, 1991).

Parent protection attitude

Parent Protection Scale (PPS) (Thomasgard, Metz, Edelbrock, & Shonkoff, 1995) was used to measure parental protection. It is a self-report measure that consists of 25 statements regarding parental protective behavior toward their children. Responses are scored using a 4-point scale from 0 through 3 (0 = 'never', 1 = 'sometimes', 2 = 'most of the time' and 3 = 'always'). Items 5,6,10,14,16,19 and 25 are negative items and are reverse coded. The total score on the Parent Protection Scale is derived from the sum of all the 25 items. Data for the development of the PPS were

obtained from separate groups of parents (1) reliability sample: parents of children aged 2-5 years; (2) clinical sample: parents of children who routinely see the physicians for immunizations, child care, and sick visits, aged 2-10 years; and (3) validity sample: parents of children referred to a mental health professional, aged 2-10 years. The PPS scores were normally distributed and ranged from 13-54 (total range is 0 to 75).

Age norms, as determined by cutoff points corresponding to one standard deviation above mean (85%) were provided by the authors. The mean scores for children aged 2-10 years ranged from 35.6 - 25.6. The cutoff scores for children age 2-10 years are in the range of 41-29. The mean and cutoff scores decreased as the children's age increased. A significant linear decline in total protection scores was noted as the child's age increased (linear trend F (1, 1190) = 188, $p<.001$). Scores above one standard deviation of the normative sample were identified as being overprotective. The internal consistency of PPS scale was 0.73. The test retest reliability (3 to 5 weeks later) of PPS scale was 0.86, $p<0.001$ (Thomasgard, et.al., 1995).

Translation of measures

Translation and back translation procedure was used to translate PPS and CBCL into Bahasa Malaysia. One lecturer and one research officer from Communication Department translated the original English version of the scales into Bahasa Malaysia. Then two postgraduate students in Psychology were recruited to translate the scales from Bahasa Malaysia into English. Later the scales were again translated into Bahasa Malaysia. Finally, the Malay version was revised to reduce the discrepancies between the original version and the re-translated English version.

Procedure

The data was collected at the Pediatric Department, Kuala Lumpur General Hospital. The hospital director informed the head

of Pediatric department and other nursing staff to help the researcher in data collection. There are five pediatric wards and three pediatric clinics for children suffering from cancer, epilepsy, and asthma. The researcher contacted the parents of children suffering from cancer, epilepsy, and asthma in these eight places during their visit to the pediatric outpatient clinic or when accompanying their children in the ward. If both parents were there, the researcher requested the mother to fill in the questionnaire. The researcher explained to the parent purpose of the study, which was to know about the psychological and other problems of chronically ill children. Their consent was obtained and they were ensured about the confidentiality of information provided by them. The respondents completed the CBCL and PPS. Most of the parents preferred the researcher to interview them rather than completing the questionnaires themselves. The researcher individually administered all the questionnaires to the respondents. It took between 25- 40 minutes to complete a set of questionnaire.

Results

Internal consistency reliability of the Child Behavior Checklist - for Ages 4-18 (CBCL/4-18) and Parent Protection Scale (PPS) was obtained. The coefficient alpha indicated a high internal consistency accounting to 0.94 for CBCL and 0.78 for PPS.

One-way between subject analysis of variance was performed on the parental protection behavior scores for three illnesses. The results in Table 2 showed a significant difference between three groups of chronically ill children for their parental protection behavior, $F(2, 60) = 18.2$, $p < .001$. The mean of parental protection scores of children suffering from cancer, epilepsy, and asthma were 39.9 (SD= 9.4), 37.7 (SD= 8.4), and 24.6 (SD= 8.3). The results show that parents of children suffering from cancer were more protective than parents of children suffering from epilepsy and asthma.

Table 2: One way between subjects ANOVA on the parental protection behavior for cancer, epilepsy, and asthma children

Source	Sum of squares	df	Mean square	F	p
Between group	2836.75	2	1418.37	18.2	.001
Within group	4651.56	60	77.52		
Total	7488.31	62			

A priori comparisons was done between one type of illness (i.e. cancer) and the combination of other two types (i.e. epilepsy and asthma) for parental protection to find out the pattern of parental protection for particular illness and in comparison to other illnesses. This comparison was computed according to the procedure suggested by Vaughan (1998). A priori comparison between children with cancer and epilepsy and asthma children on parental protection showed a significant difference, $F(1, 60) = 14.6$, $p<.01$. Consistent with the above prediction, the result in Table 3 shows that children with cancer were more overprotected than children with epilepsy and asthma considered together.

Table 3: The mean squares within, degree of freedom, and F- values for the comparison of scores between children with cancer, epilepsy, and asthma on parental protection

Comparisons	MS	df Within PPS	F	p
Cancer VS Epilepsy & Asthma	77.52	(1,60)	14.6	0.01

The children were divided into two groups based on PPS score as overprotected children and less-overprotected children. The cut-off points of the normative samples were used for this categorization (Thomasgard, et.al., 1995). The categorization showed that 47 children (74.6%) were overprotected whereas 16

children (25.4%) were less overprotected by their parents. A t- test for independent groups was conducted to see the difference between overprotected and less-overprotected children for psychological problems on CBCL.

The result in Table 4 shows a highly significant difference between the psychological problems of overprotected and less-overprotected children, t (61) = -7.173, p<. 0001. The mean of psychological problems for overprotected children is 66.46 (SD= 22.10) and the mean of psychological problems for less-overprotected children is 23.37 (SD= 15.9). These results indicate that overprotected children showed more problems compared to less-overprotected children.

Table 4: The mean, standard deviation, and t- value for the scores of overprotected and less-overprotected children on CBCL

	M	SD	df	t	p
Overprotected	66.46	22.1			
Less-overprotected	23.37	15.9	61	-7.17	.001

Correlation was computed between PPS and CBCL. The results indicated significant correlations between the psychological problem of children and parental protection, r = 0.68, p<. 001. This result shows that more the children were protected, the more psychological problems they showed.

Discussion

The aim of the study was to examine the role of parental overprotection in psychological problems among children suffering from three chronic illnesses i.e., cancer, epilepsy, and asthma. As regards to the type of the chronic illness and the parental overprotection, our hypothesis was supported by the results

indicating that parents of children with cancer reported greater overprotective behavior towards the children as compared to parents of children with epilepsy and asthma.

Parental overprotection is obvious among parents of children with cancer because of the obstructive view they have on cancer as an illness. Cancer is always perceived as more severe in nature, incurable and has shorter life expectancy, as compared to epilepsy and asthma. Cancer is constantly associated with death. Some parents assume the child will not live longer so they shower the sick child with excessive love and compassion. Other parents assume their children are vulnerable thus they keep them away from any activity they perceive as dangerous and harmful to the children.

In addition, the parents of children with cancer reported having negative and pessimistic emotion toward their ill children. Parents feel guilty for the child's illness. They assume full responsibility of the child's condition and at the same time try their best to fulfill the child's wishes. Therefore, they indulge in high control and high nurturance in dealing with the sick child. Parents fear of losing the children, realize potential separation from their children and feel that they are unable to care, control, and protect them from the illness. The parents constantly worry, uncertain, and fear of their children's future. The lack of control and sense of powerlessness lead to controlling and overprotective behaviors of the parents to their children (Faulkner, 1996).

The result of the comparison between overprotected and less-overprotected children on psychological problems confirms our hypothesis that overprotected children would show more psychological problems as compared to less-overprotected children. The correlational findings are also consistent with the hypothesis showing a positive relationship between the extent of overprotection and the psychological problems of chronically-ill children. This indicates that that the greater the overprotection of the parents, the greater the psychological problems. These findings are consistent with the studies of Burr (1985) and Johnson (1985) who noted that excessive parental restriction and overprotection lead to psychological maladaptation. Thomasgard et al., (1995) have argued that children raised in an overprotective environment

may be at an increased risk of anxiety disorders and dysthymia in adulthood.

The concept of parental overprotection, particularly in Malay society, who is the majority of the respondents in this study, can be understood with a description of some Malay beliefs and assumptions on childbirth, parent–child relationship, and parental influence on children.

The nature of relationship between parents and children is dynamic and not static. This relationship progresses in accordance to the development of children's age and personality. In Malay society, this dynamic relationship starts at birth. Childbirth is considered as "*cahaya mata*" (the brightness of the eyes) that gives "*sinaran kehidupan*" (liveliness) to one's marriage life. It extends the husband and wife relationship into familial status. Having a child is a necessary criterion in Malay and Islamic family. Therefore, the elders will always advise couples, who do not attempt to have children to do so. In general, Malay society believes that having a child is a solution to all problems, for instance, it transforms irresponsible husband or wife into responsible parents and it brings happiness and the family is blessed. Whenever a couple is destined to get a handicapped or a sick child, they are supposed to perceive the child as a gift from God and "*pembawa tuah*" (a source of good fortune) for the family in the future. Family members and relatives will advise parents who show negative attitudes towards the handicapped or sick child. If the parents' attitudes remain the same, usually some close relatives will offer themselves to take care of the child and become his/ her adopted parents (Othman, 1993).

Parental love towards the children is human nature. One who hates his/ her child is considered abnormal. Many Malay proverbs and poems remind parents about their responsibility for their children. Malay society advises parents who hate and abuse their children through a saying "*takkan harimau memakan anaknya*" (tigers will not eat their cubs). Parents who reject their children, afraid of being humiliated by the society, are considered as "*badak memakan anak*" (a rhinoceros eats its child) (Othman, 1993).

Parenting styles influence the relationship between parents and children as well as influence the children's personality development. According to some studies on Malay society, some parents assume all negative and anti – social behaviors in children will disappear naturally as they grow older. Parents need not instruct and educate the children. All they need to do is to protect their children and shower them with love and affection (Firth, 1966). Consistent with our findings that revealed a majority of the parents is overprotective towards their children, Firth (1966) noted that according to some Western measures, she found that Malay parents normally pamper their children.

Moreover, it is a customary belief that a babyish attitude is normal for a child. Babyish attitude is not the effect of parental treatment, but it is inherited from the earlier generation and need not to be altered (Othman, 1993). One popular Malay poem (Bakar, 1991) illustrated this belief as:

Lapun dibawa orang menjaja
Datang dari Pulau Batu
Budak kecil biasa manja
Mamak dahulu juga begitu

However, this attitude is expected to disappear as the children grow up, because they will undergo maturity process. This assumption of this maturity process causes the parents to be over-indulgent – one component of overprotective parenting in dealing with their children. The researchers observed that during the interview parents gave the children full freedom to choose for example in what, where, and when they want to eat. Children can get all kinds of food they wish to eat. Some parents believe that if they refuse to give what the child wants, he/ she will be "*kempunan*" (desperate). Normally, when the children reach adulthood stage, they would realize that they must accept societal role and responsibility as other people do. It is a common belief that the children will understand their roles, as they become adults.

It is clear that overprotective parenting is associated with some common beliefs and assumptions in Malay parenting practices. Therefore, it is not surprising to find that the parents are overprotective towards their chronically-ill children. Overprotection

of chronically-ill children undeniably contributes negatively towards the children's psychological development as this parental style limits the children's freedom. The children fail to acquire specific skills they should gain at a specific age. The development of feelings of inadequacy and incompetence in the children might lead to psychological problems and isolation from peers. This also hinders the growth of autonomy and the development of interpersonal relationship of the child (Thomasgard et al., 1995). In addition, parental worry and overprotection may exaggerate the child's anxiety and initiate age-inappropriate dependency on the parents. An increased dependence on the parents would make the child more vulnerable. This pattern of protective parenting frustrates the child's desire to explore and master the environment and the child may regress to an early infantile stage (Wenar & Kerig, 2000).

Children's reactions to illness are significantly influenced by parental behavior. Overprotective parents tend to pamper their children and restrict them from outdoor activities. Prolong over-concern and expectations of parents that the children are vulnerable might affect the children in two ways. It may lead the children to accept their parents' view by assuming passive-dependent characteristics. On the other hand, the children may rebel against the parents and may become daring and careless challenging the parents' notion of their fragile condition.

In Malaysia, some changes have occurred in the traditional family structure during the last two decades. The trend has slowly shifted from an extended family system to the nuclear family system. Studies have shown that the number of nuclear families have been steadily increasing from 55% in 1980, to 60% in 1991, and up to 70.3% in 1992 (Abdul Karim, 1994). This change has resulted in the loss of traditional support, care, and love, especially, from grandparents, aunties and uncles, who used to help in household chores and child rearing. In a nuclear family system, everyone has a greater responsibility and more stress in managing the household. Families with chronically ill children have extra stressors and challenges. Lack of extended support system leads the parents to become more anxious and protective towards the children. Unavailability of guidance and advice from the older

generation may lead to an inappropriate parenting style on the part of parents of ill children. The disturbed patterns of relationship between the children and the parents involve inconsistent or lack of discipline - one characteristics of overprotective parenting. It has been highlighted in certain studies that such patterns of parenting occur in families who have children with conduct disorder (Balder, Jain, & Machanda, 1972).

In sum, an important finding of our study shows that parental overprotection leads to psychological problems in children. Parents of chronically ill child often feel guilty and responsible for the onset of the illness, and become anxious over their responsibility in the course of the illness. Since negative parent reactions could affect the child negatively, we would like to recommend that the treatment of the child should involve the whole family, particularly the parents. The clinicians should inform the parents about the prognosis and answer their queries with regard to the illness. Clinicians should also aware of possible problems in the parents in dealing with the illness of their child, for example marital stress, financial constraints, and negative attitudes towards the child. The clinicians should help parents recognize their skills and strengths that may be helpful to overcome their doubts and lack of confidence. Both clinicians and parents can also look for a new and effective ways of handling such problems. The parents must also be trained in vital skills in dealing with their chronically ill child. For example, clinicians can educate the parents about the effective communication skills, parenting style, effective coping strategies, and specific diet for the child. The clinicians should encourage the parents to being persistent and optimist in treating the child. Muslim clinicians, for example should emphasize on the *Qada'* and *Qadar* and at the same time, motivate the parents to accept the future events and to pray for the betterment of the child. The Muslim clinicians may pray to Allah (S.W.T) with the parents for the health of the child. In many Hadith it is mentioned that praying for the sick people is Sunnah of the Prophet (S.A.W). According to tradition cited by Imam Tirmizi and Ibn Majah with reference to Saed Khudri, Prophet Muhammad (S.A.W.) said:

When you visit a sick person, console him by praying for his long life, although this produces no effect, yet the prayer does please the patient.

Imam Bukhari and Imam Muslim quote a tradition with reference to Hazrat Aisha according to which:

Whenever Prophet Muhammad (S.A.W.) visited any ailing member of his family to enquire about his/her health he used to pat the sick person with his right hand and say the following prayer "O Allah, O Lord of mankind, remove his ailment, restore his health, for Thou art the one who bestowed remedy. Remedy is that which Thou bestowed and which roots out diseases.

In another occasion, whenever Prophet Muhammad (S.A.W.) visited a sick person, he sat beside his head and repeated the following words several times which means:

I pray to Allah the Most High, Lord of the Great Throne to restore your health.

If the ailing child's illness prolonged, then the above words had the soothing effect upon the child (Aijaz, 1980).

Childhood is an important phase in human development. Chronically ill children in particular demand additional attention as well as appropriate parental care to ensure their well-being.

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