

Parent–Child Interaction in the Context of a Chronic Disease

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The parent–child relationship plays a crucial role in every chronic disease and especially in the course of childhood diabetes type 1. The present study explores the characteristics of parent–child interaction in Greek families in which one child suffers from diabetes, and the way that this relationship has affected the family's capacity to deal with the psychosocial aspects of the disease. Our extended research employed qualitative methods (observation and in-depth interview), using criteria based on the structural model of the 'psychosomatic family'. We provide a typology of the parent–child relationship in these families: enmeshment, mother–patient coalition, parental splitting, over-protectiveness, lack of limits, the patient's involvement in marital crisis, parentification of a non-symptomatic child, and ambiguity of roles and rules. These characteristics seem to typify the parent–child relationship in various chronic diseases.

Diabetes type 1 is a chronic autoimmune disease (Akerblom, Knipp & Hyoty, 1997) that appears mostly in children and adolescents. Patients regulate the disease by insulin injections (2–3 daily), measurements of glucose level in blood, specific nutrition, and exercise. The treatment regimen aims to prevent the severe complications that appear when there is chronic insufficient metabolic control (Kamaratos & Milonopoulou, 2000).

As in every chronic disease, the diagnosis of diabetes in a child-member of a family causes acute anxiety in the parents. The family enters a 'crisis', the resolution of which requires them to adopt coping mechanisms. Every member of the family has to deal with changes that result from the child's diagnosis. First, parents experience strong emotions: fear of losing the child in a hypoglycemic crisis (Anderson & Laffel, 1996; Anderson, Loughlin, Goldberg & Laffel, 2001) or from other complications (Bartsokas, Kassiou, Lanara, & Phylactou, 1992), anxiety regarding the child's future, grief for the loss of the healthy child they had previously had, self-accusation and

feelings of guilt about the disease. Second, the restrictions of the management regimen affect the daily life of the family. Finally, roles need to be readjusted, because of the increase in levels of care required; family members have to re-think the sharing of responsibilities and role distribution. The diagnosis of diabetes in the family is not just a nosological event but also a psychosocial one. A very important factor in the success of the treatment regimen is the family's (especially the parents') successful coping at the psychosocial level with the new state of affairs resulting from the disease. The family has to achieve a satisfactory method of

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functioning and go on with its own developmental course. It is a reasonable assumption that the successful overcoming of this crisis is an essential requirement for a successful management of the disease.

According to Minuchin (1974), family functioning can be assessed in regard to the existence of rules that control the relationships between members; healthy intergenerational hierarchy; successful solution of conflicts; and an acceptable distribution of roles. Minuchin and his colleagues (Minuchin, Rosman & Baker, 1978) formulated a clinical model



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for the study of ‘Psychosomatic Families’, as a result of their clinical work with young female patients suffering from continuous ketoacidosis attacks that caused frequent hospital admissions. Through family therapy with these patients and their families, the researchers managed not only to modify the pathological parent–child relationships but also to diminish the attacks. Follow-up studies showed no further admissions. The characteristics of those ‘psychosomatic’ families in which the glucose regulation is insufficient are:

- Absence of clear boundaries between the family’s subsystems. Family members’ autonomy is reduced as a result of an excessive involvement with others (enmeshment). Rules that determine members’ rights and commitments are neither clear nor stable, and are easily violated. Individuals’ private vital space is minimal, the possibility of individual initiative and responsibility is reduced, and as a result, ‘the individual is lost in the system’ (Minuchin et al., 1978: 30). The necessary hierarchy in parent–child relationship is not sustained, and parental authority collapses.
- Family members react in an overprotective way and exhibit excessive emotional response to every source of stress.
- The patient feels responsible for protecting the family’s unity by ‘using’ his symptoms. Taking care of him/her reinforces closeness among the members. This way of handling the illness reinforces the symptom.
- The family exhibits rigidity. During its predictable developmental stages, members’ needs for autonomy and support alter. It is difficult for psychosomatic families to alter in this way because they maintain the prescriptions appropriate to an earlier stage — a child is a child and should be supported in some way — resulting in an inadequate level of autonomy for the growing offspring.
- Family members have no concept of conflict resolution. This is due to a low degree of differentiation. Members experience conflict as a danger that must be avoided. This attitude is often supported by religious beliefs or rigid moral rules, such as ‘In our family we always agree’, ‘There should be no differences.’
- The family system operates in such a way that it keeps the symptom active. Symptom maintenance is a result of the child’s involvement in the marital crisis. Parents are over occupied with the patient

and switch from marital conflict to arguing about parenting.

The ‘psychosomatic family’ model has been applied to other diseases such as: asthma, anorexia nervosa (Minuchin et al., 1978), Crohn’s disease, ulcerative colitis (Wood, Watkins, Boyle, Nogueira, Zimand & Carroll, 1989), and nutrition problems (Dare, Le Grange, Eisler & Rutherford, 1994). The model has been criticised for two reasons (Coyne & Anderson, 1989). The first concerns the usage of the term ‘psychosomatic’ for diabetes mellitus, since as a chronic disease, it is *automatically* affected by various psychosocial factors. Secondly, Minuchin and his associates did not provide access to their clinical data.

As Charron-Prochowik, Maihle Siminerio, & Songer (1997) state in their review article, the bulk of the research conducted on the relationship between family and diabetes mellitus focuses on how well the diabetes is controlled (good glycosylated hemoglobin levels), while an insignificant amount (Dashiff, 1993) focuses on psychosocial issues and behavioural outcomes. The present study describes parental behaviour and the parent–child relationship in Greek families where metabolic control is insufficient. The parents face difficulties in handling the treatment regimen and overcoming the anxiety they feel, although four years (mean) have passed since the diagnosis was made. When planning our study, we took into consideration the finding that the greatest intensity of distress following diagnosis usually lasts for no more than a year (Kovacs, Finkelstein, Feinberg, Crouse-Novak, Pauluskas & Pollock, 1985; Liakopoulou, 1994).

The primary aim of our own paper is to ask whether the functions and dynamics of the parent–child relationship in the Greek families we studied correspond with the criteria for Minuchin’s ‘psychosomatic families’, and how the parent–child relationship is reorganised to cope with the disease.

Method

Participants

The participants in this study were 30 families whose preschool and school-age children suffered from type 1 diabetes mellitus. The families were referred by their physician. Selection criteria for the families were: a) parental anxiety about controlling the disease, b) inability to cope with the demands of the treatment regimen, c) disease duration of more than one year, d) child’s age (range 5–11 years), e) approximately equal representation of gender (thirteen male

and seventeen female patients) and f) common socioeconomic status (middle class). All families consisted of both parents; fifteen of them had two children, five had three children while ten families had one child. Twenty parents were university graduates, ten were graduates of a college (that is, a private institution providing a program lasting three years or less), six were technical school graduates, and eighteen were graduates of secondary school, while six had dropped out their studies before the end of secondary education. All male parents and six mothers had a full-time job; six mothers stopped working after diagnosis and eighteen had never worked or had stopped working since they got married. All participants live in suburban Athens and have at least one member of the extended family living close to them.

Instruments and Procedure

The first contact with parents and children took place at the Diabetic Center, which the families visited in order to check on metabolic control. The physician in charge referred the families for psychological help if there was a reason, or if they themselves requested it. Our interviews took place at each family's home and continued until a full assessment of the family's functioning was achieved. The average number of meetings with each family was ten, including individual weekly sessions with each parent, the couple, the family, the child with diabetes, and the healthy siblings. Qualitative research methods were selected to capture the complexity of the parent-child relationship (Banister, Burman, Parker, Taylor & Tindall, 1994) and to bring to light any concepts and relationships that might not have been anticipated. Two investigative tools were used:

- A. *Observation* in the families' natural environment (their homes), to allow the capturing and recording of patterns that govern relationships among members (alliances, conflicts and emotional reactions); at the same time, observation provides the possibility for the participation of very young children (Copeland & White, 1991) who cannot fill out questionnaires.
- B. An *in-depth, semi-structured interview*, appropriate for research in the field of family medicine (La Rossa, 1989). During our interviews we paid attention to participants' thoughts and feelings, in order to explore the way that they give meaning to what happens around them; to connections between meaning and interaction, accessed through direct questions during interviews, or

through correlations between attitudes and relationships that we detected during analysis of the findings; and finally, to interpretations we derived from the application of a specific theoretical perspective. Participants were encouraged to express their thoughts and feelings freely. Interviews were tape recorded with participants' consent. After the end of each meeting, the interviewer kept notes of the members' behaviour and any significant incidents that took place but could not be tape-recorded.

From each family, data were collected that related to the three dimensions of behaviour, emotions and cognitions. These data were categorised, in accordance with the psychosomatic family model, into: subsystem boundaries, hierarchy, parental behaviour towards the patient, parents' ways of dealing with stress, conflicts around autonomy, the patient's role and the spousal relationship. An additional category, evolved during our own study, concerned parental behaviour towards the healthy siblings.

The material was analysed in cooperation with a family therapist. When the assessment of the family was complete, therapeutic assistance was offered. Twenty families were willing to receive counselling based on the study's findings. The parents of those families found the latter useful, stating that it helped them to deal with their anxiety. Six other families said that they had been helped by the assessment process itself, while the fathers of the remaining four families did not want to participate in future meetings.

Findings and Discussion

Our analysis brought to light common clinical characteristics of the families and parent-child relationships, which correspond for the most part with the main concepts evolved by Minuchin and his colleagues (1978). In the description that follows, typical statements made by parents are provided as examples of data that support Minuchin's model:

Relationships are characterised by a low degree of differentiation (enmeshed).

- 'I don't go anywhere alone, I spend all my day with him [the patient]. If something goes wrong, I want to be with him. I don't think that he can deal with the hypoglycemia'
- 'Even when my husband and I were going to school, we used to take her with us. We didn't feel safe leaving her at home with Grandmother ... Grandmother can't deal with the complications of

the treatment. She doesn't know what to do if glucose levels are very low or very high ... I know that I could teach her, but I'll still feel that she [the patient] might not be safe'

- 'Wherever we go, we all go together ... I can't go anywhere alone ... How can I go out when I know that she is staying here?'

Parents even tended to avoid individual interviews with the researchers, thus indicating how hard it was for them to understand the meaning of private space and time. The same issue appeared in all (30) families. However, all the examples quoted above seem to describe parental overprotectiveness that has evolved *as a direct result of the illness*, not overprotectiveness that already existed in the family prior to the illness. It appeared that enmeshment had existed prior to the diagnosis of diabetes, but this is an assumption based mainly on self reports. A prospective research design would have been necessary to confirm it. Enmeshment may be considered to be a parent's defense against the fears provoked by the disease. According to Almeida (1995), although parents know that diabetes is not fatal, they may still fear losing their children. The fact that they consider themselves solely responsible for their children's treatment provokes anxiety, which in turn prevents the parents from understanding their doctors' advice (death is highly unlikely to happen). For example, parents said: 'Although I have been told that a hypoglycaemic crisis is not fatal and the child will recover soon, I feel that I am losing her', 'I am afraid that he will die'.

The low degree of differentiation is exemplified by an absence of boundaries between the parent-child subsystems.

The normal hierarchy (parents are the leaders) is violated, resulting in a loss of authority, leading patients to feel anxious, insecure and angry:

- 'The boss in this family is diabetes ... We have to follow the diabetes treatment program. Even what we eat is determined by the diabetic diet. We don't want to eat or do different things, because she might feel different'
- 'I can't set limits and rules because I feel that she's already very much restricted by the diet and the program, so I don't want to cause her more problems'
- 'We can't tell him what to do because he's getting more upset and we're afraid of bad glucose results. I can't stand knowing that he may feel worse because of me ... Of course, I know that the way I treat him is wrong, but what can I do? I am responsible for his health ... if something goes

wrong in the future ... losing his leg or his kidney ... everyone's going to blame me. A mother is responsible for the bad and the good outcomes'.

A lack of boundaries and breakdown of hierarchy appeared in 29 of the 30 families (the one exception was a family where the parents said that they had control over the child's behaviour, although the family's program was determined by the treatment regimen). As Anderson & Laffel (1996) noted, parents assume responsibility at the beginning of the treatment regimen. The mothers in the present study continue to take responsibility for the treatment several years after diagnosis. The fear of potential complications does not allow them to feel safe, or trust their children.

A hidden coalition is developed between child and mother, and the mother is mostly absorbed in her parental role.

- 'My only concern is what I will do with my child ... morning and evening I think of her ... I don't have time for anything else ... I don't feel good if I do something else.'
- 'We don't have any other life any more ... My concern is what to do to help her, what to do to have better glucose levels.'

Mothers feel responsible for their children's health status:

- 'It's very hard to know that I am my child's doctor'
- 'My child's life depends on me'
- 'Even the doctors have told me that we are the ones who have to do the hard work'.

Mothers behave overprotectively due to fears of losing their children. They visit their children at school, providing them with food, and asking them to measure their glucose levels so they can advise them what to eat. They stay while their children do athletics or evening lessons, they go to parties with them, and they follow them on school excursions. The children are never unattended when they are at home and mothers are the ones who attend them. The mother-patient coalition appeared in 27 out of 30 families, consistent with the results of other studies (Drozda, Allen, Standiford, Turner, & McCain, 1997; Faulkner, 1996). Three families were characterised by close relationships among all their members. In the present study, even though four years had passed since the diagnosis was made, most mothers spent the whole night (sixteen families) or part of it (nine families) with the patients, in order to ensure that everything was under control. If according to the daily measurements their children usually have high

levels, they are afraid of hyperglycemia, which may result in future complications (kidney failure, cardiovascular problems, amputation, retinal damage) (Sullivan-Bolay, Deatrack, Gruppuso, Tamborlane & Grey, 2003). If the child has experienced a hypoglycemic crisis in the past, they are afraid of a similar crisis, which may result in a coma.

Parents' emotional stability appears to depend on their child's daily glucose levels.

Parents feel excessively responsible for their children's health. Dealing with diabetes seems to be the most important task in their lives. The glucose levels seem to be a criterion for the assessment of their parental ability in 29 out of the 30 families. During interviews, or when glucose levels were taken during our meetings with them, they said:

- 'I go crazy when things go wrong. Whatever I do is never enough.'
- 'Tell us the blood result so that we can calm down.'
- 'When things go wrong and I see that the levels are so high, I want to start beating my head against the wall.'
- 'I wish I could know what I've done wrong. I'm sure that there's something I'm not doing right, otherwise the measurement outcomes would be better.'

In just one family in our study, the parents believed that diabetes management was the *patient's* responsibility. Mother got angry with the patient every time the glucose levels were not the expected ones and father did not get involved at all. In all other cases, the parent becomes the 'real' patient (Anderson & Laffel, 1996). According to Antisdell (2000), parents experience guilt related to their failure to achieve 'optimal' metabolic control. Similarly, the parents in our study become frustrated and experience guilt every time the glucose outcomes are not the expected ones.

The child-patient has a low degree of autonomy, and his/her psychosocial development is impeded.

- 'Now he's under control, but what will happen in adolescence? He'll go out with friends ... I won't be with him all the time as I am now.'
- 'I get panicked by the idea that he'll go to school ... I don't know what'll happen there ... Nobody can take care of him the way I do ... he's too little to know what to do.'
- 'I wait for her outside the classroom because something might happen ... There's been a hypoglycemic crisis in the past and ever since I've been afraid ... I've not discussed this with her

teacher ... I don't want other people to know that she has diabetes ... Sometimes she understands that the blood levels may be so low that she has to drink her juice, but I can't rely on this. After all, she's still a child.'

Twenty-eight families provided evidence of reduced autonomy in their child. In two cases, mothers encouraged their children to assume responsibility for the treatment regimen, although they also exhibited intense control over the patients' behaviour. For example, one mother said: 'She's started to do the measurement by herself, but of course I'm always alert. I'm the one who reminds her all the time what she has to do. I don't leave her in peace'. As a result, the children do not assume any responsibility for the regulation process. They experience themselves as incapable of dealing effectively with the diabetes and they respond negatively to having to follow a treatment regimen. They refuse to practise blood measurements, or follow the nutritional guidelines, and they expect mothers to remind them about the time for injection, measurement, and dinner. Since they do not know what to do in case of hypoglycemia

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and hyperglycemia, and they cannot assess their health status, they remain unregulated for long periods, leading to problems with metabolic control.

By contrast, two patients practised injection and measurement, and exhibited adherence to the treatment; but in both cases their mothers provided them with guidelines and controlled their behavior. Although parental over-protectiveness towards children with diabetes is related to better glycemic outcomes, there is the risk that such children will never be able to assume responsibility for their health status and will always be dependent on other people. The findings of the present study seem to support La Greca (1998), since the children become more dependent on their mothers as the time goes by, and mothers more anxious about their children's ability to cope with the disease when they are alone. Research on training programs appropriate to the children's cognitive and emotional needs shows that even very

young children (4–11 years) can assume responsibility for the treatment regimen (Greenlach, 2000).

The patient appears to act as a go-between in his parents' marital relationship.

This happens in two ways.

a) The coalition between the mother and the child with diabetes excludes the father, who accepts this position, since he experiences himself as incapable of coping with the responsibility for the treatment regimen. We noted comments like these in 27 families:

- 'Father's always absent.'
- 'He doesn't do anything to help.'
- 'We can't rely on him, he's useless.'
- [Child to father:] '... leave me alone, I want Mummy to do this.'
- [Father:] 'I don't know what to do to help. I know my wife's very tired, but she never tells me what to do to help her.'

Bloch (2001) noted similar behaviour around 'chronic irregular pain'. In Bloch's study and in ours, past marital problems find a new expression through the mother-child coalition. Marital dissatisfaction leads mothers to get closer to the patients:

- 'We used to have problems in the past ... Of course now things are worse, because I have to do everything on my own ... I don't pay attention any more to [marital] problems, I don't have time even to think about them.'
- 'We were about to divorce when diabetes came up ... We stayed together in order to cope with the disease ...'
- 'We used to have problems with my mother-in-law ... now, I don't pay attention any more because I have so many things to do to help my child.'
- 'He's not the man I dreamed about ... he complains that I don't pay any attention to him, but what can I do? I feel so tired ... I don't get much sleep, because I wake up during the night to measure her blood glucose levels.'

b) Marital conflict in 29 of the families was replaced by conflict about parenting and focus on the child-rearing. The parents experienced intense anxiety because they thought they were the only ones responsible for the course of the disease and they believed that their diabetic children were incapable of taking care of themselves. They could not work through this anxiety, but expressed it by accusing each other. Usually the father is the one who blames the mother for not taking proper care of the

child. In one case, the husband never disagrees with his wife. Common accusations are:

- 'You have not taken care of her, that's why the blood glucose has increased.'
- 'You don't leave her alone.'
- 'It's your fault that she reacts negatively.'
- 'I'm sure that you've done something wrong, otherwise we wouldn't have these results.'
- 'I don't know why this happens, but every time things go wrong I start bawling out my wife.'
- 'This is what always happens. If I tell him the blood results, he starts shouting at me. This is the reason I prefer not to tell him anything.'

Apart from the six characteristics described above, our qualitative analysis brought to light several more clinical characteristics of the parent-child relationship that were not identified in Minuchin's model of the 'psychosomatic family'. These are:

Fathers do not involve themselves in the parenting.

According to Kiess, Galler, Schmidt, Nietzsche, Neu & Rile (2001), when children's diabetes is out of control, the father is the least involved person. Even when he does not work and the mother works, he avoids engaging with the symptomatic child. In our study, all fathers had a full-time job. When they had free time at home, they avoided any responsibility for the child:

- 'I can't be involved, my wife knows better than me what has to be done.'
- 'It's my wife's task.'
- 'She's the one who spends most time with him, so she knows better what has to be done.'
- 'I spend most of the time out of home, so he's closer to his mother. Both of them know better than me what they have to do.'
- 'She doesn't want me to help her, she asks only her mother to do so.'

According to mothers and children with diabetes, fathers' full-time job is not the reason for their lack of involvement:

- 'When he is at home, he stays in his room and watches television, he never helps me with anything.'
- 'Daddy always spends his time reading.'
- 'My husband doesn't know what to do, he acts like our child is healthy ... when they go out together, he forgets to ask him to eat, to do blood levels and so on.'

- ‘My husband prefers to spend his time with my other child. Maybe this happens because the other child’s healthy.’

Five fathers were involved in active management of their child’s condition. Interestingly, in these cases the mothers did not work. These five fathers were engaged in their children’s lives and treatment regimen following the mothers’ guidelines. In most of the cases (28), fathers could not be involved in measuring blood and giving insulin injections. These were considered to be very hard tasks, which were performed by mothers. The fathers themselves could not explain their avoidance of these tasks, but seemed to experience them as very painful and preferred not to be the ones to cause the pain to their children:

- ‘I can’t do injections, I don’t know why but I can’t.’
- I can’t even give myself injections — how could I ever do it to my child!’
- ‘Having to inject my child is the worst thing that could ever happen to me.’
- ‘At the beginning of the treatment, I wanted to show him that injecting is not a big deal, so I took the syringe and I started pricking all over my arm. But I could never do this to my child.’
- [Mother]: ‘I think my husband is afraid of the sight of blood.’

In both cases where fathers had become involved with injections, this only happened because mothers became so frustrated, after five and seven years respectively, at having sole responsibility for the child’s treatment that they gave up:

- ‘I can’t stand injecting her any more. Either she does it herself, or my husband does it.’
- ‘I gave up one day after I gave him an injection in his leg and he went into a coma. Ever since, I’ve been terrified that this will happen again. I told my husband that I’d never give him an injection again.’

The non-symptomatic child, regardless of age, assumes a parental role towards the diabetic sibling.

All families in our study where there was more than one child reacted this way. Parents, and especially mothers, seemed to deal with their anxiety about being the only ones who are responsible by involving a non-symptomatic child. Parents usually communicate by command:

- ‘Get him some water ... keep an eye on him, come and tell me immediately if he doesn’t feel well.’
- ‘You should take care of her.’
- ‘... the baby must be quiet so I can look after her.’

- ‘I hope that they’ll always be together so that his brother can take care of him.’
- When I’m away, you’re the one who must take care of her.’
- ‘I want you to tell me everything she does, what she eats, if she takes the blood levels.’

The child adopts this role, even against his/her developmental needs. When a child suffers from a chronic disease, then the healthy sibling of the family, regardless of age, takes care of the sick child (Stoneman & Brody, 1993). This may lead to a confusion of roles, causing anxiety to both children (Begun, 1989).

The non-symptomatic child experiences parental neglect as rejection.

Eighteen healthy siblings (but only one child in any given family) reported feeling neglected, even when families had at least two healthy siblings:

- You always take care of her.’
- ‘Nobody cares about me.’

Correspondingly, mothers say: ‘I have a problem in my house. My other child’s become jealous. She complains that I don’t pay any attention to her.’

Children say:

- ‘My brother beats up on me but my mother always slaps me down ... I know that they treat him in a different way than me because he has diabetes.’
- ‘I know that you pay him attention because of his diabetes ... when I grow up, I want to leave home.’

Conflicts and rivalry between siblings are common problems that parents of children with diabetes have to cope with (Stoneman & Brody, 1993). Parental over-occupation with the treatment regimen and the healthy sibling’s feelings of being neglected exacerbate sibling rivalry. However, the healthy siblings in this study do not feel safe enough to express their feelings. The parental role assigned by their mothers prevents them from doing so:

- ‘You’re the one who must backpedal. I want your help. You know that we can’t cause him more distress.’
- ‘Please, darling, don’t make me feel more distressed. Taking care of your sister is enough.’

Non-symptomatic children seem to comprehend their mothers’ difficult position:

- ‘I know that mummy’s very tired and I want to make her happy.’
- ‘I think that I’m not going to get anywhere if I discuss my feelings with them. Besides, I know that they’re right. My brother has got a problem ... ’

Non-symptomatic children react to the rejection they feel by trying to attract attention the same way the children with diabetes do, through somatisation. In our study, no less than seventeen healthy siblings complain about physical symptoms:

- 'He asks me to stay with him during the night, to hold his hand, to massage his stomach because he says that he has a stomach-ache. We've been to the doctor, but he told us that there's nothing to worry about.'
- 'Out of the blue, she starts complaining about belly-ache ... you know, belly-ache is one of the symptoms of diabetes. At the beginning, I was terrified ... I thought "Not again" ... but every time we take her to the hospital, they tell us that it is psychosomatic.'
- 'Do you know what he does? He says he's got a headache or he's so careless that he falls down and then he complains about his legs, arms ...'
- 'There's something wrong with her, she falls down, like she has an epileptic fit, but there's nothing serious.'

In just one family, neither the parents nor the child himself mentioned any physical symptoms, while in two cases, healthy siblings were old enough to take care of the patient without trying to divert their mother's attention onto themselves.

Parental behaviour is characterised by intense polarisation.

This occurs when one parent permits the child with diabetes to have everything and treats him in an indulgent way and the other becomes more withholding (and vice-versa). When the mother is overprotective, the father accuses her of 'spoiling' the child. However, in 29 of the 30 families, when the mothers were occupied with interviews and could not pay their usual attention to the diabetic child, the fathers became more anxious. In one family, as reported previously, the husband never questions his wife's way of dealing with the patient. Fathers expressed their anxiety by saying:

- 'We must go to her room to check if she's feeling well.'
- 'You shouldn't leave her unattended for such a long time.'
- 'Did you check the blood levels?'
- 'You better call him to check how he's feeling.'

The polarisation is reinforced by the parents' fear of a hypoglycemic crisis (Bartsokas et al., 1992), and seems to be a central characteristic of families in which children have a chronic disease (Goldbeck, 2001).

Our data support Minuchin's model of the 'psychosomatic family'. Our study also suggests new features that might be incorporated into the model: parental polarisation, the mother's role as the most important one, the absent father, the infantilisation of the child with diabetes, while the non-symptomatic sibling is parentified. These characteristics lead to the development of a dysfunctional dynamic. The absence of clear roles and rules in families facing problems with metabolic control is supported by findings of other studies as well (Wysocki, 1993). The dysfunctional dynamic acts as a chronic stressor and is associated with the frequent occurrence of a ketoacidosis crisis (Liss et al., 1998).

Implications for Practice

In Greece, state-funded psychological help is given to parents who have a child suffering from diabetes mellitus only in the period directly after the diagnosis has been made. If families face problems in the longer term, psychological support is provided to them either by volunteer psychologists, or by professionals in private practice. Though the families accept a great deal of help from their physicians, who do their best to guide them, they are left to find mechanisms to cope with the stress of the disease. Diabetes mellitus, as a chronic disease, demands treatment on various levels: medical, psychological and social. In this paper, we have shown that the fears provoked by diabetes do not decline into insignificance as time goes by. On the contrary, these anxieties govern some families' lives. Parents' inability to work through their thoughts and feeling cause them to behave in such a way as to interfere with the individuation of individual members

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and of the entire family. Providing continuous psychological support, treating the family as a whole, helping parents to get on with their own lives, running educational programs for families and training children to assume responsibility for their own treatment regimen, are some of the measures that may prove that diabetes mellitus is not such a threat as those Greek parents who participated in our study experience it to be.

Conclusions

The parent–child relationship plays a crucial role in the way that the child with diabetes deals with the course of the disease. Over-protectiveness, rigidity, lack of self-differentiation, inability to set limits, a mother–patient coalition, polarisation in the parental relationship, parentification of non symptomatic children, and absence of paternal engagement lock the child with diabetes into an ‘infantilised’ role, preventing him/her from assuming the responsibility for dealing effectively with the disease.

Since this study is a qualitative one, our findings cannot be generalised. However, they do appear to correspond with those of several other studies, as cited above. A comparison with Greek families who have adjusted well to the conditions imposed by the disease

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and who deal effectively with the treatment regimen could bring to light important mechanisms in parent–child interactions that could be utilised as guidelines for practitioners who treat children suffering from diabetes mellitus.

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