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Parent-Child Co-Dependency's: Co-Laziness, Co-Suicidality, Co-Obesity and Other Dependencies: Review and Impact in Pediatric Psychology

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ABSTRACT

Background: The term "co-dependency" originates from the realm of addiction psychology. Co-dependency mechanisms may also appear between parents and children. The Covid-19 situation and the confinement restrictions highlight some of these issues, which may be exacerbated by the current environment.

Objective: Provide an overview of clinical observations in parent-child codependencies and propose a biopsychosocial model for clinical management of these issues, in order to avoid further parental enmeshment.

Methods: Between February 2020 and April 2020, a literature review based on electronic bibliographic databases as well as other sources of information (grey literature) was conducted to investigate various forms of codependencies prevalent between parent and child. We subsequently focused on clinical examples to develop an integrative biopsychosocial model of the relevant parent-child codependencies.

Results: Parents, children and caregivers are particularly vulnerable to certain forms of co-dependencies; co-laziness, co-obesity, co-phobias and co-suicidality. However, research is largely limited to adults and comorbidity mechanisms attached to these co-dependencies remain poorly understood particularly in relation to the pediatric population .

Conclusion: Co-dependencie soften emerge from great altruism, tolerance towards inappropriate and maladaptive behaviours and emotions that are difficult to manage. Co-dependencies may help in coping with destructive situations but frequently correspond to an excessive need for control. The examples we used on co-laziness, co-obesity, co-phobias and co-suicidality are not to make parents and care workers feel marginalized, but to help illuminate these situations and de-emphasize the co-dependency phenomenon. Ideally, positive connotations should only be granted to relevant behaviours and secondary gains should be minimized in dysfunctional situations.

INTRODUCTION

Both concepts of pathological altruism [1,2,3] and co-dependency or relationship addiction have been long known [4,5].

The term "co-dependency" originates from the realm of addiction psychology. It is most often identified with Alcoholics Anonymous and the realization that Alcoholism

was not solely about the addict but also included the involvement of his/her social network (friends and family). In the 1980's this term increased in popularity especially in the United States, where multiple books were published on the subject matter. A list of diagnostic criteria, based on DSM III-R, was proposed by Cermak, to define "co-dependency" [6]. These have proven to be relevant in many fields: substance or drug abuse [7], alcoholism [8,9,10,11], eating disorders [12,13], intra- family abuse [14] and childhood trauma [15].

Furthermore, the systemic approach, while studying the human systems surrounding schizophrenic patients, identified some co-operation or contribution from subjects around the "designated patients" [16].

The literature includes many clinical descriptions of co-dependency, as authors tend to define the term according to their personal observations and data. However, there are though very few objective and experimental studies on the subject.

The notion of co-dependency is relatively unfalsifiable, as we all share co-dependency mechanisms to a certain extent [17].

This article has a dual purpose. First, is the aim to illustrate the different forms of parent-child co-dependencies, and second is the delinearization of the phenomenon for preventive purposes, so that it does not continue to be enabled by the environment.

CO-LAZINESS

Nowadays increasing numbers of parents complete the schoolwork and assignments instead of their children. Wishing their children to be successful in school or in college, more and more parents will achieve tasks and projects intended for their children rather than supervising them, so that they get "better results". The Covid-19 situation intensified the process; as the few exercises remotely sent to the children, are to be done at home due to the confinement.

In college, similar facts are observed. Indeed if in the beginning of the academic year, many students attend lectures; however this trend does not have staying power. Throughout the year, fewer and fewer students attend 'early or boring' lectures. Lazy students who stay home after partying hard, rely on the few who keep attending classes, asking for their notes and handouts before the exams. Therefore the few brave, meticulous and disciplined students enable the laziness of the others and can be considered as "co-lazy".

The time, when a child was reprimanded in school and received extra punishment at home, is in the distant past.

CO-OBESITY

Co-obesity, direct (voluntary) or indirect, is a major parameter on which there should be greater focus [18]. Unfortunately, it is common for parents and grandparents to use food (e.g. sweets, junk food, snacks and take-away) to bribe children; especially in a competitive attempt to get them on "their" side when the parents are separated.

It was also proven that the frequency, with which parents allow their children to sleep in their bed, is a risk factor for short sleep duration and poor sleep quality, factors which may contribute to obesity [19].

In the same vein, many parents struggle to maintain a sound sleep routine around their children's bedtime. Some parents say they want to "enjoy" their kids in the evening time as this is their main opportunity to be together, and therefore keep them awake late at night, while some other parents "let the children decide when they want to go to bed"; these alterations of the circadian cycle, often coupled with extra snacking, also tend to co-obesity.

CO-PHOBIAS

Phobias of all sort, are strongly generating co-dependencies and hyper-protection, in both young people and adults.

For example, Sean, an 8 year old boy, daily walks from home to school (distance 800m). One day, he comes home totally panicked as a big dog scared him on his journey. In reaction to his fears, Sean's parents decide they will drive him to school from now on, while they could have opted for a gradual desensitization (on the first day, Dad walks with Sean all the way to school, the following day, Dad also accompanies Sean but walks 10m behind him, and everyday Dad walks further away behind Sean till he is able to go to school on his own again). These secondary gains are quite frequent in all types of phobias, in both children and adults.

Similar responses can be observed in scenarios of asthma, enuresis and encopresis, when the parents' reaction (solution) is based on good intentions, but turns out to be a "problem" due to positive reinforcements. That dynamic is often responsible for changing isolated episodes into chronic syndromes [20,21,22].

CO-SUICIDALITY

Self-destruction can also lead to co-dependency; this is particularly the case with children.

It is quite logical for parents to worry if their child (no matter his/her age) voices some suicidal ideation.

But the road to hell is paved with good intentions…

On the top of their legitimate concerns, parents will often develop varying reactions which can make the child act upon his thoughts.

Here are 2 examples:

- One day, Ava expresses some suicidal thoughts to her Mum. Subsequently, Mum does not go to bed, she also makes sure medications are under lock and key and sharp objects removed. Mum keeps Ava under constant supervision and dedicates all her time and attention to her, while possibly neglecting Ava's siblings. Mum will also organize for Ava to be seen by a professional, driving and accompanying her to appointments…

So because of her issue, Ava becomes the centre of interest and receives an increased amount of attention that she might lose if her problem resolves…

Instead, it is recommended that behaviours with a pathological connotation, receive discrete attention.

Kyle is 16 years old and his parents are divorced after an acrimonious separation. They do not even talk to each other anymore. One night, Kyle swallows 30 paracetamol tablets and ends up in ER. Emergency staff contacts Kyle's parents who both rush to the hospital and, after years of silence, present together at the bedside of their son. Kyle has, unconsciously, managed, thanks to his suicide attempt, to reunite the family cell. This positive reinforcement might make him consider reiterating his suicidal gesture. In this case, we recommend not to see both parents together at the time of assessment as this would just emphasize the reunion process.

CONCLUSION

As described above, the meaning of co-dependency remains a contentious issue and is also hardly falsifiable: it is impossible not to develop any co-dependencies.

Co-dependencies soften emerge from great altruism, tolerance towards inappropriate and maladaptive behaviours and emotions that are difficult to manage. Co-dependencies may help in coping with destructive situations but frequently correspond to an excessive need for control. The examples we used on co-laziness, co-obesity, co-phobias and co-suicidality are not to make parents and care workers feel marginalized, but to help illuminate these situations and de-emphasize the co-dependency phenomenon. Ideally, positive connotations should only be granted to relevant behaviours and secondary gains should be minimized in dysfunctional situations.

The examples we used on co-laziness, co-obesity, co-phobias and co-suicidality are not to make parents and care workers guilty, but to help them face these situations without any risk of emphasizing the co-dependency phenomenon, in a preventive clinical perspective. Ideally, positive connotations should only be granted to relevant behaviours as secondary gains should be minimized in dysfunctional situations.

REFERENCES

1. Oakley BA. (2013). Concepts and implications of altruism bias and pathological altruism. Proc Natl Acad Sci U S A. 110: 10408-10415.
2. Sattes H. (1951). Pathological altruism. Arch Psychiatr Nervenkr Z Gesamte Neurol Psychiatr. 187: 231-249.
3. Seelig BJ, Rosof LS. (2001). Normal and pathological altruism. J Am Psychoanal Assoc. 49: 933-959.
4. Angel BR. (1992). Codependency. J Psychosoc Nurs Ment Health Serv. 30: 47-48.
5. Knapek E, Kuritarne Szabo I. (2014). The concept, the symptoms and the etiological factors of codependency. Psychiatr Hung. 29: 56-64.
6. Cermak TL. (1986). Diagnostic criteria for codependency. J Psychoactive Drugs. 18: 15-20.
7. Hawks RD, Bahr SJ, Wang G. (1994). Adolescent substance use and codependence. J Stud Alcohol. 55: 261-268.
8. Carson AT, Baker RC. (1994). Psychological correlates of codependency in women. Int J Addict. 29: 395-407.
9. el-Guebaly N, West M, Maticka-Tyndale E, Pool M. (1993). Attachment among adult children of alcoholics. Addiction. 88: 1405-1411.
10. Hinkin CH, Kahn MW. (1995). Psychological symptomatology in spouses and adult children of alcoholics: an examination of the hypothesized personality characteristics of codependency. Int J Addict. 30: 843-861.

11. Prest LA, Benson MJ, Protinsky HO. (1998). Family of origin and current relationship influences on codependency. Fam Process. 37: 513-528.
12. Meyer DF. (1997). Codependency as a mediator between stressful events and eating disorders. J Clin Psychol. 53: 107-116.
13. Riley EA. (1991). Codependency and the eating-disorder client. Nurs Clin North Am. 26: 765-775.
14. Borisov SN, Volkova OA, Besschetnova OV, Dolya RY. (2020). The domestic violence as factor of disorder of social and mental health. Probl Sotsialnoi Gig Zdravookhranenniiai Istor Med. 28: 68-73.
15. Irwin HJ. (1995). Codependence, narcissism, and childhood trauma. J Clin Psychol. 51: 658-665.
16. Gilleen J, David A, Greenwood K. (2016). Self-reflection and set-shifting mediate awareness in cognitively preserved schizophrenia patients. Cogn Neuropsychiatry. 21: 185-196.
17. Stafford LL. (2001). Is Codependency A Meaningful Concept? Issues in Mental Health Nursing. 22: 273-286.
18. Gomes AI, Barros L, Pereira AI. (2017). Predictors of parental concerns about child weight in parents of healthy-weight and overweight 2-6 year olds. Appetite. 108: 491-497.
19. Olsen NJ, Rohde JF, Handel MN, Stougaard M, Mortensen EL, et al. (2018). Joining Parents' Bed at Night and Overweight among 2- to 6-Year-Old Children - Results from the 'Healthy Start' Randomized Intervention. Obes Facts. 11: 372-380.
20. Davidhizar R. (1994). The pursuit of illness for secondary gain. Health Care Superv. 13: 10-15.
21. Rouviere H, Seguy E. (1985). The sick person--his illness and the others. Soins. (463): 31-36.
22. Sousa Filho D, Kanomata EY, Feldman RJ, Maluf Neto A. (2017). Munchausen syndrome and Munchausen syndrome by proxy: a narrative review. Einstein (Sao Paulo). 15: 516-521.