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Parent-Child Co-Dependency's: co-laziness, co-suicidality, co-obesity and Other Dependencies: Case Reports and Clinical Management

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Abstract

Background: The term "codependency" originates from the realm of addiction. Codependency mechanisms may also appear between parents and children.

Objective: Provide an overview of clinical observations in parent-child codependencies and propose a biopsychosocial model for their clinical management.

Methods: Between February and April 2020, a literature review based on electronic bibliographic databases and grey literature, was conducted regarding family codependencies. We subsequently focused on clinical cases to illustrate some 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.

Discussion: Codependencies may help coping with destructive situations though frequently correspond to an excessive need for control. The clinical examples are given to help face these situations and de-emphasize the codependency phenomenon.

Conclusion: Ideally, positive connotations should only be granted to relevant behaviours while secondary gains should be minimized in dysfunctional situations. Currently, research is largely limited to adults and comorbidity about codependencies remains poorly understood in children.

Keywords: Co-dependency; Addiction; Parent-child relationship; Co-obesity; Co-suicidality; Co-laziness; Co-phobia

Introduction

Both concepts of pathological altruism [1-3] 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 became quite popular, especially in the United States., where multiple books were published on the subject. 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 [8-10,11], 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].

Objective

This article has a double 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.

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 prevelent between parent and child. We subsequently focused on clinical examples to develop an integrative biopsychosocial model of the relevant parent-child codependencies.

Results

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 get up to 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 long gone.

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, which may lead to them being overweight [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 800 m). One day, he comes home totally panicked as a big dog scared him on his way. 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 10 m 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 children and adults.

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

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

Here are two examples:

1st: 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 organise 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.

2nd: 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, probably 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.

Discussion

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 often 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 caregivers feel marginalized, but to help illuminate these situations and de-emphasize the co-dependency phenomenon.

Conclusion

Ideally, positive connotations should only be granted to relevant behaviours and secondary gains should be minimized in dysfunctional situations. Some further works on the subject is needed as currently, research is largely limited to adults and comorbidity mechanisms attached to these co-dependencies remain poorly understood particularly in relation to the pediatric population.

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