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Effects of Loneliness on Human Development

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Abstract

The issue of loneliness in adolescents with conduct disorder falls into the category of internalizing behaviors or disorders. These disorders frequently manifest themselves as externalizing disorders that are often diagnosed or categorized as conduct disorder. This paper examines the relationship of loneliness as it relates to reactive and proactive conduct disorder and how these conditions are manifested as internalizing and externalizing disorders. Also, mentioned is how there is an evidenced based methodology mode deactivation therapy (MDT) that delineates the function of all of these variables and addresses them in treatment.

Keywords

Reactive and Proactive aggression, conduct disorder, internalizing and externalizing disorders, Mode deactivation therapy, MDT

Socializing is a vital part of human development. As social animals, Bandura and Vygotsky introduced the power of social structure and social control (Bandura, 1999, & Cherry, 2010). Institutional isolation, being removed from the community, and social ostracization were all early forms of punishment to individuals not behaving within social limits. The scarlet letter and the dunce cap were all forms of humiliation that left the perpetrator alone and vulnerable. As we develop, socializing is our earliest form of education. When forced into alienation, children fail to strive. All that we are and all that we believe is found in our social perception. Identity, self-efficacy and self-regulatory systems are all developed by interacting with others (Bandura, 1999). Without satisfactory peer relations many children fail to develop healthy interpersonal relationships and will develop unhealthy social skills (Vygotsky, 2012). The social environment the child is in, is a concrete predicament, and at each age level development of the child is characterized by social situations (Vygotsky, 2012). Removing socializing or adding inadequate peer relations, a child will readjust and try to interact and most times this interaction is marred by antisocial behavior and or violence (Farmer, 2000.; Morrow, Hubbard, McAuliffe, Rubin et al. 2006; & Tremblay, 2000). "Peer relations or rejection directly links to reactive aggression and depression" (Morrow et al, 2006 p242). It is a concept of self- esteem that is affected by peer rejection.

When children experience loneliness along with abuse, neglect, and abandonment, the strength of isolation can effect children the same as soldiers experiencing Post-traumatic Stress Disorder (PTSD) (Apsche & DiMeo, 2010). Harry Harlow studied the bonding affects in the 1980s on child development. In his experiment baby monkeys were removed from their mothers and placed with a surrogate mother made of wire or cloth. Although nourishment was plentiful; the interaction was eliminated. These enfant monkeys grew up in solitude and emotional neglect (Harlow, 1980). The constant exposure to loneliness caused the monkeys to exhibit excessive and misdirected aggression. Most children diagnosed with Conduct Disorder (COD) or Oppositional Disorder (OD) may also look like their issues are with aggression but the literature review shows that these children are sad and lonely (Morrow et al, 2006). Violence becomes the child's way to interact and be seen. Any attention is better than being ignored or invisible; it validates their existence. When diagnosing COD or OD, this statement should be considered "There is no original sin in the human heart, the how and why of the entrance of every vice can be traced" (Rousseau, 1762/1979).

Social development indicates that deficits in social skills and peer relations correspond with adjustment disorder (Farmer, 2000). Over the last two decades, peer relations have become the focal point in adolescent misbehavior. Peers will modify the way one identifies, behaves and values themselves. Adolescents will attempt to protect or improve their status by gossiping, name calling, manipulation, bullying and direct physical attacks (Farmer, 2000; Wilson & Steiner, 2002). Acceptance and acknowledgement collide at this developmental stage. Aggressive conduct can be attributed to expressing hostility toward parents and society for their feelings of isolation. Anxiety about social acceptance can be relieved by drugs, alcohol and bullying. However, the point here is that social isolation precedes behavior (Wilson & Steiner, 2002). Most children are not diagnosed with COD or OD alone but have a comorbidity rate of 83% with depression (Morrow, et al. 2006). This seems to indicate that COD is not about dominance or violence but emotional health and acceptance. Loneliness is not an easily recognizable symptom and is commonly mislabeled as aggression, anxiety and depression (Solomon, 2000). Loneliness has also been considered a temporary state of being and is rarely considered important enough to relieve especially within the childhood. Loneliness has not been an interest of researchers until the last 10-15 years. The assumptions within the scientific community were that children could not understand the concept of loneliness (Solomon, 2000). In simple terms, children were too young to understand their own isolation. Understanding maybe true, but even the very young feel and adapt their behavior to relieve internal discomfort. They associate, even at 3 and 4 years of age, with words like "alone" "by myself" and "no one to play with" to describe loneliness (Solomon, 2000).

Aggressive behavior is punctuated with restlessness, irritability, and impulsivity and prone to violence (Werbach, 1995). Two types of aggression have been identified as proactive and reactive. Both require a societal interaction that supports their violent behavior. A child who displays proactive violence is provoking an interaction. The goal is the interaction; a social contact. Regardless of the reaction of the victim, the bully gets to be involved with another human being and at this point they are validated in their existence (Morrow, et al. 2006). Reactive aggression is seen when a threat or provocation appears; peer rejection directly links reactive aggression and depression (Morrow et al. 2006). There are also two types of aggressors' callous and unemotional or impulsive thus making treatment hard to pinpoint. New forms of therapy for COD and OD children include socializing and acceptance. Less attention is spent on behavior and more on the child's core beliefs especially when isolation is a factor. Mode Desensitization Therapy (MDT) is just one of these new therapies to uncover internal self-beliefs before altering behavior. Conduct disorder is strongly associated with social and educational disadvantages (Scott, Knapp, Henderson & Maughan, 2001). This would lead others to believe that only the poor are diagnosed with COD or Oppositional Disorder which is not the case. Of course, professionals know that poverty does not produce angry and aggressive children, exclusively, so other factors must be identified. It wasn't until the late 1980s that researchers considered loneliness in children under 10. It didn't seem possible for children to experience loneliness until their adolescent years (Solomon, 2000) when socialization is at its peak. By adolescents the "child is trying to rupture the social situation of development and create a social position for themselves in a new social situation" (Vygotsky, 2012). When this is difficult or met with rejection, the child has very few options. According to Solomon, a child without peer support will self-preserve in one of 5 ways, over-eating, join clubs, become actively solitary, and seek help from teachers or parents and finally aggressive behavior (2000). Although not discussed in this article, loneliness can be linked to eating disorders including emotional over eating, but is a surprise to hear that the higher body mass of an individual will predict the likelihood of victimization or aggressor/perpetrator (Storch & Ledley, 2005)? Emotional eating is only one form of self-medicating loneliness produces (Solomon, 2000). If it is not controlled early; "body dissatisfaction and eating disturbances will carry into adulthood" (Storch & Ledley, 2005 p33). Like Conduct Disorder, the internal and external behaviors are reciprocal. The heavier a child becomes the more invisible they feel. As therapies mature from behavioral modification such as CBT to internal treatments (ex: Mode Deactivation Therapy) the child is treated by addressing mindfulness, acceptance, validation, clarification and re-direc-

tion but not nutrition. Nutrition will need to wait again for the next wave of therapies. Future studies will hopefully uncover the link between food and emotions validated by the drug companies themselves.

MDT uses mindfulness as its center core (Hollman, 2010) opening new doors to recovery. Simply changing behavior or thought is not enough for children who have suffered trauma in their early years. In MDT, the child is included in the transformation and empowers them to change. The treatment emphasizes acceptance, diffusion, validation, clarification and re-direction (Hollman, 2010). The Apsche Institute recognizes that behavior is shaped and re-enforced. Each child at the institute is validated first. The pain the child encountered is not dismissed but acknowledged and incorporated into the therapy which is designed uniquely for each child. Aggression is the interplay between trauma, personality and their belief system. By identifying the Mode, a channel in which live situations are processed and formed from previous interpersonal experiences, a reaction is simply 'kindling' for a fire (Hollman, 2010). MDT helps the child control their reaction to these subconscious igniters. This ends the continuous cycle of ingrained behaviors and habitual responses and gives the child options that were never identified before; depression and loneliness are internalizing events that left untreated will activate external behaviors and disorders.

Internalizing disorders include anxiety, depression, obsessive-compulsive disorder, and trauma, and painful events such as isolation and loneliness that creates such internalized discomfort that it is manifested by other internalized behaviors, such as worry, sadness, or ruminating. However, in adolescents, these disorders are also often expressed through a variety of aberrant externalized behaviors, for example, aggressiveness, opposition, or isolation from others. In the adolescent brain, if you can't join them hate them, becomes a common form of solace.

Accordingly, anxiety permeates the child's emotions, thoughts, and actions. As a result, the cognitive behavioral methodology developed by Kendall, Furr and Podell, "coping cat," is designed to address the internalizing disorders of anxiety in order to reduce its comorbidity with externalizing behavioral disorders in children and young adolescents (2010). MDT expands the treatment of internalizing problems to reduce the strength and frequency of externalizing behaviors to include adolescents with severe conduct problems.

Externalizing disorders are conceived as disorders that are manifested in a variety of aberrant behaviors. These behaviors can include sexual and physical aggression, verbal aggression, suicidal and parasuicidal acts, substance abuse, and sometimes even criminal activity.

Effects of loneliness as PTSD including discomfort within social situations, feelings of isolation, hyper vigilance and depression; in adolescents this disorder has lethal, comorbid behaviors associated with suicide and parasuicide. Sadly, its prevalence continues to escalate. In 1996, Birmaher et al. reported that depression was present in 3 to 5 percent of the general adolescent population and in nearly 20 percent of adolescents by age 18. The National Institute of Mental Health (NIMH) identified suicide as the third leading cause of death in 2007 for young people ages 15 to 24. In 2003, Links, Gould, and Ratnayake reported on the prevalence of attempted and lethal suicide in adolescents and suggested that depression, existing comorbidly with a personality disorder, increases the likelihood of a lethal suicide. Recent news reports have demonstrated that social media, when used against the teen, produces increasingly isolated emotions with deadly consequences. Apsche and DiMeo (2010) indicated that up to 20 percent of adolescents had symptoms of depression comorbid with anxiety, trauma, and personality beliefs. The complexities of depression comorbidity with other internalizing disorders as well as externalizing disorders create a difficult therapeutic problem for clinicians in outpatient or clinical practice. Nonetheless, evidence-based treatments for depression have reported success for specific and well-defined populations of children and adolescents.

Adolescents presenting these insidious behaviors are often frustrating for the clinician to treat due to the provocative nature of their opposition and resistance to life in general, especially after years of conditioning instilled 'useless' and ' unwanted' into their internal beliefs. Many of these behaviors fit the diagnostic category of the *DSM-IV-TR* (2000) referenced here for conduct disorder and oppositional defiant disorder.

As therapies advance they are focusing less on external behaviors and more on the wholeness of the child. Acceptance, mindfulness, validation, clarification and re-direction are all the new parts to advanced treatment and the cornerstone of MDT. Although deep hidden trauma is associated with COD and OD, simple exclusion from the human race can upset the same delicate balance within a child's development. Socializing is more than learning to share toys; it instills value and self-confidence. Vygotsky, Piaget and Erickson all define development within the perimeters of social interaction. Developmental milestones are defined by interaction within their world including parents, siblings and peers (Berk, 2010). When loneliness is added to a child's development, major dysfunction will fill the void.

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