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# Posttraumatic stress disorder (PTSD) among adolescents in domestic work

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## Abstract

Adolescents in domestic work in Nigeria are at heightened risk of mental health problems resulting from sexual abuse, exploitation, condition of work and neglect. One of such mental health problems is Posttraumatic Stress Disorder (PTSD). This paper explored posttraumatic stress disorder among adolescents in domestic work in the Nigerian context. According to APA (2013) PTSD has five cluster symptoms such as exposure to traumatic events (directly or vicariously), intrusive symptoms, Persistent avoidance of stimuli associated with the traumatic event(s), Negative alteration in cognitions and mood associated with the traumatic event(s) and Marked alterations in arousal and reactivity associated with the traumatic event(s). Ignoring the challenges faced by adolescents in domestic work can lead to disruptions in education, risk for child abuse, mental health issues, poor knowledge of sexual and reproductive health (SRH) services as well as proper transition to adulthood. Psychological interventions such as Trauma-focused cognitive behavioural therapy, Eye movement Desensitization and Reprocessing therapy and Play therapy were identified and should be utilized for adolescents with PTSD. This study recommended the need to create awareness among the general public on risks adolescents in domestic work face, need for better parenting education for parents who sent their children for domestic work and need for the implementation of legal instruments that protect children and promote their well-being.

**Keywords:** Posttraumatic Stress Disorder (PTSD); Domestic work; Adolescents; Nigeria; Behaviour.

## 1. Introduction

Globally, Domestic work have increasingly gone on for decades and more. Domestic work is sometimes called modern slavery. This practice has evolved over time in different cultures. In most Africa countries, child domestic work is often viewed within the cultural, social lenses and accepted as even part of socialization. Child domestic work is a general reference to children's work in the domestic work sector in the home of a third party or employer. This definition covers both permissible and non-permissible situations. According to International Labour Organization (ILO) in Domestic Workers Convention (2011) defines Domestic worker in Article 1a) the term domestic work as work performed in or for a household or households b). The term domestic worker as any person engaged in domestic work within an employment relationship and c) a person who performs domestic work only occasionally or sporadically and not on an occupational basis is not a domestic worker.

From a statistical standpoint, the restriction of domestic work to private households also provides a convenient way of identifying domestic workers under the international Standard Industrial Classification (ISIC). The widely used ISIC revision 3.1 contains the sectoral division activities of private households as employers of domestic staff (Division 95), which corresponds to the definition convention No. 189. It captures activities of households as employers of domestic personnel such as maids, cooks, waiters, valets, butlers, laundresses, gardeners, gatekeepers, stable lads, chauffeurs, caretakers, governesses, babysitters, tutors, secretaries etc.

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The children and adolescents are within population strata that are vulnerable. According to the 2022 Survey by the Nigeria National Bureau of Statistics (NBS), International Labour Organization (ILO) and Federal Ministry of Labour and Employment (FMLE) (2024) there are over 62.9 million children 5 -17 years olds that live in Nigeria. This represents 30.3% of the total population of Nigeria. Furthermore, the survey indicated that among children 5-14 years old i.e., 42.3% are full time in school and not in any form of work or economic activity, 35.3% are both in school and engaged in economic activity while 11.2% are engaged in work only. In Nigeria, the Child Rights Act (2003) prohibits children between 5-11 years of age from working (engagement in any economic activity) but allows those between 12 -14 years of old to engage in light work. Additionally, those between 15-17 years of age are allowed to engage in work related activities that are not hazardous. Similarly, ILO (2021) designated the minimum age entry for employment as 15 years while light work is 12-14 years old. However, the average age of children and adolescents in domestic work in Nigeria is 14.6 years with average age of entry into domestic age being 10.1 years

Despite the prescription by the Act, children and adolescents are seen to engage in work and other domestic related activities even beyond their capacity (ILO, 2023). Even though, children working in domestic work share some kind of family relationship with their employer, 88.9 percent reported working conditions that contravene Nigerian laws. 62.8% percent of children aged 16-17 work 7 days a week without rest. This underscores gaps between the laws protecting children and their implementation. In Nigeria, Children and adolescents who work long hours have limited time for education, recreational activities, health care and rest. The consequences of all these could be in children and adolescents as poor psychological health, physical issues and dysfunctionality in moral and health aspects (ILO, 2021). Furthermore, it is important to note that 37.1% of these children and adolescents work more than 30 hours per week and 1 in 5 (21.4%) work above 42 hours per week. 1 in 5 children in domestic work are not enrolled in school (19%) while 18% reported their education being disrupted by work (ILO, 2021).

Overall, 24,673,483 children between 5-17 years are documented to be in child labour. The breakdown indicated that 14,990,674 (60.8%) between 5-11 years; 5,132,574 (20.8%) between 12-14 years and 4,550,237 (18.4%) between 15-17 years are in child labour (NBS, ILO & FMLE, 2024). Many of the children and adolescents in domestic work are often forced to work, not paid or even underpaid. Children and adolescents are usually given out to work as domestic workers by nuclear and extended family members but in other cases through other informal means who know someone that knows another that knows the parents of the child. Children are taken to households to provide various services such as house chores, taking care of other children, selling of wares (hawking) and other kinds of labour. Data from NBS, ILO & FMLE, (2024) In terms of gender distribution for child labour, it showed that 39.6% of children in labour were males while 38.8% were females. Children are made to perform roles which ordinarily should be done by adults as it is often beyond the capacity of the child.

The stage of adolescence is a unique one between childhood and adulthood. It is also the stage of development changes in cognitive, physical and psychosocial growth (WHO, 2025). This range is also is within the WHO's age range for young people of 10 to 24 years old. However, According to APA (2019), adolescents are individuals between the ages of 13 to 17 years old. This typically covers pubertal age for some people till the penultimate age for adulthood. Although, there are diverse classification for age range for defining adolescence, these are commonly utilized classification for adolescents.

Although it is safe to say that adolescents in domestic work are not usually traumatized, Children are exposed to various kinds of violence and abuse which has negative impact on their mental health. Sadly, most of these go on unreported and probably no attention given these children and adolescents due to their status as those in domestic work.

In Nigeria for instance, children and adolescents involved in domestic are at high risk of various mental health problems including Posttraumatic Stress Disorder, PTSD (Olorunlambe et. al., 2024)

Posttraumatic Stress Disorder (PTSD) is one of the disorders categorized under Trauma and Stressor-Related Disorder in Diagnostic and Statistical Manual of Mental Disorder V (DSM V). Disorders under this category are mainly associated with exposure to traumatic or stressful events. PTSD is not age related and can occur in any age of an individual. In other words, it can occur in children and adolescents. Symptoms of PTSD usually begin within the first 3 months after the trauma had occurred. However, in some individuals, they could be a delayed expression of PTSD symptoms that can even take months or years for the criteria for PTSD to be met but what could be frequently seen is reaction to trauma which meets the criteria for Acute Stress Disorder (ASD) which is an immediate result of trauma. The symptoms of ASD typically manifest 3 days to 1 month following exposure to one or more traumatic events. However, for PTSD, the duration of the symptoms is more than 1 month. The development of PTSD in older children and adolescents may make them believe that they are different from their peers and cannot fit in socially. This can make them lose vision for the future, irritable or aggressive towards their peers which can interfere with their school behaviour and peer relationship.

This can also lead to risky behaviour that can result to self-injury or to others and other high-risk behaviours (Afolabi, et al., 2014; Aroyewun, et al., 2014). PTSD is more common among females compared with males (APA, 2013). For adolescents engaged in domestic work, there are more females than males (Kilpatrick et. al., 2013; Carmassi, et. al. 2013). This may also account for more numbers of adolescent females who may report higher symptoms of PTSD when examined.

According to APA (2013), Post-traumatic Stress Disorder (PTSD) diagnostic criteria in DSM V are as follows;

- Exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways:
  - Directly experiencing the traumatic events
  - Witnessing in person the event(s) as it occurred to others
  - Learning that traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
  - Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) Example: first respondents collecting human remains; police officers repeatedly exposed to details of child abuse.
- Presence of one or more of the following intrusion symptoms associated with traumatic event(s) beginning after the traumatic event(s) occurred:
  - Recurrent, involuntary and intrusive distressing memories of the traumatic event(s). For children older than 6 years old, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed
  - Recurrent distressing dreams in which the content and/or effect of the dream are related to the traumatic event(s). Here, children may have frightening dreams without recognizable event(s).
  - Dissociative reactions Example: Flashbacks in which the individual feels or acts as if the traumatic event(s) were recurring. Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings. It is important to note that in children trauma –specific re-enactment may occur in play.
  - Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
  - marked physiological reactions to internal or external cues that symbolizes or resemble an aspect of the traumatic event(s).
- Persistent avoidance of stimuli associated with the traumatic event(s) beginning after the traumatic event(s) occurred as evidenced by one or both of the following:
  - Avoidance of or efforts to avoid distressing memories, thoughts or feelings about or closely associated with the traumatic event(s).
  - Avoidance of or efforts to avoid external reminders (people, places, conversions, activities, objects or situations) that arouse distressing memories, thoughts of feeling about or closely associated with traumatic event(s).
- Negative alteration in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred as evidenced by two or more of the following:
  - Inability to remember an important aspect of the traumatic event(s) typically due to dissociative amnesia and not to other factors such as head injury, alcohol or drugs.
  - Persistent and exaggerated negative beliefs or expectations about onset, others or the world (Example: I am bad; No one can be trusted; The world is completely dangerous etc.)
  - Persistent distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
  - Persistent negative emotional state (Example: fear. horror, anger, guilt or shame)
  - Markedly diminished interest or participation in significant activities.
  - Feelings of detachment or estrangement from others.
  - Persistent inability to experience positive emotions Example: inability to experience happiness, satisfaction or loving feelings
- Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred as evidenced by two or more of the following:
  - Irritable behaviour and anger outbursts with little or no provocation typically expressed as verbal or physical aggression toward people or objects
  - Reckless or self-destructive behaviour
  - Hypervigilance
  - Exaggerated startle response
  - Problems with concentration
  - Sleep disturbance Example: difficulty falling or staying asleep or restless sleep.
- Duration of the disturbance for criteria A, B, C and E is more than 1 month.

- The disturbance causes significant clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not attributable to the physiological effects of a substance Example: medication, alcohol or another medical condition.

From the above diagnostic criteria from DSM V, PTSD was presented as events based that are discrete and identifiable with examples of psychological significances. DSM V organized PTSD with modification of symptoms and distinct from anxiety disorders unlike what it was in DSM IV. There are other specifiers that are used to show more clarity in diagnosis. They include; specify whether with Dissociative symptoms and specify if with delayed expression. The DSM V also has additional criteria to look out for children 6 years and younger (i.e., the subtype).

Several changes in the DSM V definition stand out immediately, such as the inclusion of sexual violence within the core premise of trauma. Experiencing sexual violence may precipitate PTSD, as can witnessing it, learning about it and experiencing repeated exposure to stories of such acts. Furthermore, loss of a loved one to natural causes is no longer considered a causal factor. For example, now a client whose partner unexpectedly died of a heart attack no longer fits PTSD criteria. Lastly, a new subset of possible exposure has been established, namely vicarious trauma.

*Objectives*

Specifically, the objectives of this study was to state the need:

- To raise awareness among the general public on the status of adolescents in domestic work and the traumatic experiences they are exposed to.
- To advocate for the implementation of laws aimed at protecting children and adolescents especially those in domestic work.

## 2. Cognitive Theories of Posttraumatic Stress Disorder

### 2.1. Dual Representation Theory

This theory suggests that trauma experienced during childhood creates two types of memories: one that is verbally accessible and another that is automatically accessible in certain situations. These types of memory are used to explain the complex phenomenology of posttraumatic stress disorder including the experience of relieving the traumatic events and of emotionally processing the trauma. This theory looks at three possible outcomes of the emotional processing of trauma such as successful completion, chronic processing and premature inhibition of processing. Brewin et al.

According to the Dual Representation Theory of PTSD (Brewin et al., 1996; Brewin & Holmes, 2003), trauma is processed emotionally within two memory systems. The first system involves conscious processing, whereby a traumatic event is integrated into long-term autobiographical memory. These memories were originally called “verbally accessible memories” because they can be both voluntarily and involuntarily retrieved, verbalized, and updated. However, Brewin et al.'s (2010) revised model, which integrates the original model with neurobiological models of memory and imagery, refers to these memories as “contextual-based representations” (C-Reps). C-Reps contain information about the context and events that occurred prior to, during, and following trauma, as well as the individual's appraisal of the meaning of a trauma (Brewin et al., 2010; Brewin & Holmes, 2003) C-Reps may include primary emotions that occurred during the event (Example :fear), as well as secondary emotions about the perceived meaning of a trauma that are retrospectively generated (Example: guilt or shame; Brewin & Holmes, 2003). Heightened arousal during trauma limits an individual's capacity to process large amounts of information (Brewin & Holmes, 2003), which, combined with attentional biases toward highly threatening aspects of the trauma, can result in fragmented and poorly contextualized C-Reps (Brewin et al., 1996; Brewin & Holmes, 2003). The second system involves unconscious processing of the physiological, motor, and sensory information associated with the trauma (Brewin et al., 1996). These memories are inflexible and cannot be retrieved intentionally. Instead, these memories are involuntarily accessed when the individual is exposed to internal (thoughts or bodily sensations) or external stimuli that match elements of the trauma (Brewin & Holmes, 2003). As they are comprised of mental representations of sensory information, they are difficult to verbalize (Brewin & Holmes, 2003 and, therefore, were labelled “situationally accessible memories” and later, in the revised model, “sensation-based representations” (S-Reps)

According to Brewin et al. (1996; 2010), PTSD is the result of a lack of integration between C-Reps and S-Reps. When an individual is exposed to situational reminders of a trauma, highly detailed sensory, motor, physiological, and emotional features (S-Reps) are automatically activated in the absence of temporal and contextual information (C-Reps).

Consequently, rather than recollecting a trauma memory, the individual re-experiences the memory as if it were occurring in real time along with the distressing affective, motor, physiological, and sensory experiences associated with the original memory (i.e., flashbacks or nightmares). Ehlers and Clark (2000), in their contribution to this model suggests that negative appraisals, disjointed trauma memories and unhelpful coping strategies maintain PTSD. The negative appraisals and emotions prompt dysfunctional cognitive and behavioural responses that have the short-term aimed at reducing distress that have long-term consequences of preventing cognitive change and then maintain the disorder.

Integrated models of PTSD amalgamate tenets from learning, schema-based, and information processing theories. In doing so, they address some of the limitations of earlier models and provide a more comprehensive account of PTSD. Ehlers and Clark (2000) cognitive model of PTSD suggest that impaired cognitive processing during trauma, which may be attributed to dissociative reactions at the time of trauma (peri-traumatic dissociation), combined with pre-existing beliefs about trauma, its sequelae, and oneself, influences the development of PTSD symptoms. The authors suggest that the central characteristic of PTSD is a sense of current threat, which is maintained by two key cognitive processes. First, idiosyncratic negative appraisals about the meaning of a trauma and its sequelae perpetuate a sense of current threat. Individuals may overgeneralize the probability of the event reoccurring (Example: nowhere/nobody is safe) and negatively appraise their behaviour in relation to the trauma (Example: I deserved this), and these appraisals keep the threat "alive". Second, impaired memory encoding during trauma leads to the trauma memory being fragmented and poorly integrated into long-term memory, which makes it difficult for the individual to accurately position the memory in time and place, link the memory to preceding and proceeding information, and to other autobiographic memories. However, strong associative learning occurs, and exposure to trauma-associated stimuli causes strong emotional reactions.

### 2.2. Challenges faced by Adolescents in Domestic Work in Nigeria

- Risk for Abuse and Neglect: Nigeria is a multi-ethnic country that maintain mainly collective culture where the child is not nurtured within the nuclear family but also the extended family. Children and adolescents are sometimes viewed as one who belong to all and will require nurturing from other members of the community. In addition to the view, Parents/Caregivers/Guardians send children and adolescents to households even beyond the extended family unit to others not related to them by blood where they are made to perform different roles in the host family. Although, there is a usual promise to train and nurture the children and adolescents through provision of education, healthcare and generally good life, most often the reverse is the case. Even when these promises are kept, it may be done in a less humane way compared with other children in the host family (Onyemaechi, 2025). While at the host family, sometimes their parents who gave them out seldom ask about them and in other cases, the children and adolescents do not have opportunity to communicate with their own parents constantly. These gaps create opportunities for these children and adolescents to be abused (physically, sexually, psychologically etc) usually within their host family. All children should be protected from all forms of sexual exploitation and other sexual abuses (UNCRC, 1989). Children when exposed to domestic violence and lead them to experience symptoms of PTSD (Sekhar et. al. 2024). It seems to be a norm for adolescents in domestic help to subjected to hard labour, abuse of all kinds, neglected and deprived of a lot of developmental needs (sleep, association, nutrition, health needs etc).
- Risk for Mental health disorders: Adolescents in domestic work are at risk of mental health disorders such as depression, anxiety, substance use disorders, suicidal ideation etc. PTSD in adolescents when left untreated can persist and impair their psychological functioning (Bolten et al., 2000, Okonkwo, et al., 2023)
- Poor knowledge to Sexual health and Reproductive Health Services (SRH): Adolescents in domestic work in Nigeria do not have adequate knowledge to constant and quality sexual and reproductive health services in their host families. It makes them vulnerable to poor menstrual health, infections and risk for cycles of abuse (Umeaku, et al., 2024). Adolescents without proper information to SRH may become vulnerable to sexual exploitation, stigmatization by peers and control over their health which could lead to low self-esteem, anxiety.
- Sleep Deprivation, Recreation and Rest: Children and adolescents in domestic work are made to work long hours even more than their strength could carry. They are usually the first to wake up in their host family and most often the last to sleep. Recreation is an important activity which promotes motor and cognitive development, however, children and adolescents are denied this and even punished for engaging in it (Achebe & Onyemaechi, 2023). These children and adolescents are also allowed to have adequate rest as they are kept active throughout the day and most of the times. There are always some chores or trade for them to do. Sleep deprivation and lack of rest can have wide range impacts on children and adolescents generally including those in domestic work. Recreation and rest are fundamental rights of children (UNCRC, 1989).
- Poor Access to Education: while a lot of people may argue this point, it is also important to mention here that even when children and adolescents in domestic work are given access to education, it given to them as a

privilege and conditional and not as a right. Access to quality education is a fundamental right for children categorized under the Developmental Right (one of the four baskets of right) of the United Nations Conventions on the rights of the child (1989).

### 2.3. Psychological Interventions for PTSD

- Trauma focused Cognitive Behavioural Therapy: this is an evidence-based treatment designed to help children and adolescent recover from PTSD. It combines cognitive-behavioural principles with trauma sensitive interventions and help individuals' process their traumatic experiences in a safe and supportive manner. This can be done individually or in groups. Here adolescents are educated about the traumatic events, helped to identify and process unhelpful thoughts, reframe negative beliefs and trained on relaxation techniques in order to reduce hyper arousal common in PTSD.
- Child-Parent Psychotherapy (CPP): this evidence-based intervention can be used to assist adolescents with PTSD. Here the psychotherapy focuses on restoring trust and emotional security between adolescents and their caregivers (Onyemaechi. et al., 2019, 2022). During the therapy, the therapist works with the adolescents and the caregiver to improve communication, trust, belief system, emotional needs and other needs of the adolescents in relation with the traumatic experience. Sessions are done in dyadic and narrative style with the therapist providing psychoeducation.
- Eye Movement Desensitization and Reprocessing Therapy (EMDR): this therapy model was developed by American Psychologist, Francine Shapiro (1989). It is useful in managing individuals with conditions stemming from traumatic events such as PTSD. The goal of EMDR is to assist an individual to heal from trauma and it involves moving one's eyes in a particular way while one processes traumatic memories. It focuses on changing emotions, thoughts and behaviours are associated with the traumatic events. EMDR consists of eight phases which occur over multiple sessions. Generally, it can take from 8 to 12 sessions or more to assist one with long term trauma of 1 hour to 90 minutes.
- Play therapy: play therapy is one therapy that has been used in assisting children with traumatic life events and other psychological issues. During play children and even adolescents can reveal patterns which show aspects of their life requiring psychological intervention. It is also important to note that in working with children with different age range, one should consider models that are developmentally appropriate that reflect strengths, linguistic, motor and introspective abilities.

## *Implications of the Study*

Practical Implication: many children and adolescents involved in domestic work might experience disruptions in educations, attachment disruption with parents, development of low self-esteem, withdrawal, peer relationships and vulnerability to abuse, exploitation and other mental health issues (anxiety, depression and suicidal ideation).

Developmental Implication: we grooming a generation whose adulthood could be filled with history of trauma and like the saying once abused have the potential to abuse another.

Policy Implication: there is need to strengthen the implementation of laws protecting children. Duty bearers such as Ministry of Women Affairs, Police, Child Welfare officers, Child Rights Advocates are beckoned to raise up to their responsibilities of implementing laws that protect children and adolescents.

## *Recommendations*

This study recommends the need to create awareness among the general public about engaging children and adolescents in domestic work and the tendency of child abuse (sexual, physical, psychological) and neglect.

Need for implementation of legal instruments that protect children and adolescents by all the duty bearers so as to ensure accountability and safeguarding the rights of the children and adolescents in Nigeria.

Need for parenting education for all parents who sent their children into child domestic work to understand the potential consequences associated with sending out their children for such.

More awareness on the risk factors among adolescents involved in domestic work is needed to protect more adolescents from experiencing traumatic events and eventually being diagnosed of PTSD

## 3. Conclusion

Adolescents involved in domestic work are indeed susceptible to posttraumatic stress disorder given that they are exposed to various cluster symptoms associated with it such as traumatic events directly or vicariously, intrusive symptoms, persistent avoidance of stimuli associated with the traumatic event, negative alterations in mood and cognition as well as marked alterations in arousal and reactivity associated with traumatic events. These symptoms are consequences of abuses (sexual, physical, emotional), deprivations and other challenges faced with adolescents engaged in domestic work. Despite the foregoing, psychological interventions such as Trauma-focused Cognitive Behavioural Therapy, Child-parent psychotherapy, Eye Movement Desensitization and Reprocessing therapy and Play therapy are useful in relieving symptoms associated with PTSD. Not providing adequate psychological assistance to address symptoms of PTSD experienced by adolescents involved domestic work could affect their proper transition to adulthood and psychological well-being. This study will benefit the general public, parents and the society at large as an awareness creating paper on the mental health challenges faced by adolescents in domestic work more so, PTSD. Given the need to prioritize the well-being of adolescents, this study advocates for the implementation of laws protecting children and adolescents by relevant institutions, training personnel or agents involved in protecting adolescents, strengthening the child protection systems and promoting initiatives that empower parents to plan and cater for their children, sensitization of parents who give out their children for domestic work and challenges associated with it and safeguarding their well-being.

## Compliance with ethical standards

*Disclosure of conflict of interest*

No conflict of interest to be disclosed.

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