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Post-Traumatic Stress Disorder in a Child Witnessing Domestic Violence in a Rural Community of North Borneo: Case Report

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Abstract

Managing Post-Traumatic Stress Disorder (PTSD) in children from rural areas, particularly those exposed to domestic violence, presents considerable challenges. This study explores a case from North Borneo, highlighting an elevated risk of disruptive behaviour disorders in such contexts. The case involves a five-year-old boy, previously without medical history, exhibiting behavioural changes linked to two years of direct exposure to domestic violence. Meeting PTSD diagnostic criteria, the child displays symptoms including nightmares, aggression, and avoidance behaviours, emphasizing a potential risk for oppositional defiant disorder (ODD). The findings corroborate empirical evidence indicating a significant correlation between domestic violence exposure, PTSD symptomatology, and subsequent disruptive behaviour disorders in children. This case report underscores the imperative for heightened awareness and targeted interventions in rural communities, stressing the need for proactive strategies in addressing PTSD among children, particularly those facing domestic violence.

Keywords: *Post-Traumatic Stress Disorder, Domestic Violence, Oppositional Defiant Disorder, Mental Health, Child and Adolescent*

INTRODUCTION

According to the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5), post-traumatic stress disorder is a significant mental health issue that can arise following exposure to or witnessing a traumatic incident (American Psychiatric Association, 2013). While often associated with adults, particularly military personnel, PTSD also affects a significant number of children globally. A recent study revealed a 21.5 % prevalence rate of PTSD among children aged six and under, highlighting the need to address this issue across diverse populations (Woolgar et al., 2022). Despite this alarming prevalence, researchers have reported a lack of studies conducted in low-income countries.

Significant data on childhood PTSD in North Borneo, Malaysia, particularly in rural communities, remains lacking due to limited awareness, stigma, and access to mental health services. This case report sheds light on a scenario involving a five-year-old boy child residing in a rural community in North Borneo who has been enduring ongoing domestic violence. By shedding light on the challenges and potential risk of developing disruptive behaviour disorder, this study underscores the urgent need for increased awareness, culturally sensitive interventions, and improved access to mental health services for children experiencing PTSD in similar underserved, rural settings.

Case Report

A five-year-old boy residing in a rural area in North Borneo presented with escalating behavioural issues over the last two years. His early development was in line with milestones, with no significant developmental or childhood illnesses. Behavioural changes began at age three, including refusing to follow his mother's and maternal grandmother's instructions, avoiding tasks, and deliberately disobeying rules. These behaviours

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coincided with his exposure to frequent domestic violence, around once or twice a month, that started when he was three years old.

As the boy continued to witness domestic violence, his symptoms worsened, particularly after a severe incident at age three and a half years old, where his mother was seriously injured. He saw his mother with a swollen face, a broken nose, and covered in blood. His mother described this incident as the worst happened between the child's parents. Following this event, the boy exhibited marked anxiety, hypervigilance, and startle responses.

The boy demonstrated constant alertness, showing specific triggers related to his father and other male figures. He would become quiet and avoid eye contact when male figures were present. There were incidents where the patient became highly distressed and even wet his pants when unexpectedly encountering men. He experienced anxiety symptoms like shaking and sweating when exposed to triggers related to his father or male figures.

He had significant sleep disturbances, with difficulty initiating and sustaining sleep, sleeping only 3-4 hours a day, and often woke up screaming, which the mother described as frequent nightmares. His mother also noted a reduced appetite, eating three small meals per day, and frequent aggression. He displayed aggressive reactions to triggers; exposure to his father or other male figures not only made him quiet but also led to behaviours like hitting and pulling his sibling's hair. There were also incidents of him trying to hurt his cousin brother and was intervened by his mother. He would tell his mother that he wants to be characters like 'Superman' or 'Spiderman' to protect her and beat his father. There were instances of drawings depicting his father being eaten by crocodiles or being injured from fights.

By age four and a half years old, the child's symptoms intensified, including flashbacks, intrusive memories, and avoidance behaviours. He avoided public places and confined spaces when there were male figures around, including male doctors, male family members, and strangers with a similar physical description as his father, such as skin colour, height, and physique. He also got triggered upon hearing his father's name and developed anxiety symptoms like shaking, palpitations, shortness of breath, and sweating, which lasted around 20-30 minutes.

In preschool, he refrained from using his surname. His preschool teachers observed a decline in his ability to concentrate, complete school learning tasks, and interact positively with peers. His conduct deteriorated to episodes of aggressive interactions with peers, including attempts to cause physical harm and not following school rules. Concurrently, withdrawal and subdued behaviour were noted both at school and at home; he often isolated himself during playtime.

The mother and grandmother reported increased clinginess and separation anxiety. Clinical observations confirmed these symptoms, noting the child's heightened state of arousal and difficulty in soothing himself. Repetitive exposure to violence within his home environment, a place typically considered safe and secure, likely contributed significantly to the development and severity of his symptoms.

Clinical interviews followed a structured format to systematically assess the presence of PTSD and oppositional defiant disorder (ODD) symptoms in the child. The interviews were conducted over multiple sessions to ensure thoroughness and accuracy, allowing sufficient time for the child to become comfortable with the clinician and for detailed observations of his behaviour and responses.

The clinician conducted the clinical interviews in a child-friendly environment, typically with the mother and sometimes the grandmother present as trusted caregivers. This setting facilitated the child's comfort and ease during the assessment. Age-appropriate language was used throughout the interviews to ensure the child's understanding and engagement. Additionally, we incorporated drawing as a tool during the interviews, allowing the child to express his emotions, thoughts, and experiences nonverbally.

The thorough assessment and historical evidence, including observations from both school and home settings, aligned with DSM-5 criteria and justified the PTSD diagnosis. The child exhibited distressing recurrent dreams, sleep disturbances due to hyperarousal, pronounced avoidance of male figures, heightened

startle response, and hypervigilance in the presence of males, all directly linked to continuously witnessing traumatic events and domestic violence against his mother. This analysis highlights the significant impact of trauma on the child's behaviour and emotional state, emphasizing the need for targeted interventions to address these symptoms.

However, many children and families in the rural setting face challenges with limited access to regular specialised mental health care due to the lack of specialised trained mental health providers within the rural setting, and socioeconomic factors to access mental health care in urban areas.

Occupational therapy (OT) sessions, as part of the treatment intervention, took place in a primary healthcare facility in the rural area where he lives with his mother and grandmother. OT activities included behaviour management, social skills training, play therapy, and relaxation techniques. These sessions aimed to address the child's anxiety and avoidance behaviours, providing a structured and supportive environment to help him feel more comfortable in public spaces.

He was reported to be able to go out in public but not around men in confined spaces, experiencing fewer nightmares, and engaging and talking more after starting OT sessions. Although the OT sessions yielded some positive outcomes, such as initial behavioural stability and increased comfort in custody trial in court, the child experienced regression following distressing encounters with his father. He would return to aggressive reactions to these triggers, an increase in nightmares during sleep, and self-hitting behaviours.

Despite these challenges, the mother took a proactive approach in seeking legal measures to limit the father's access to visits. contributed to managing situations that would trigger the child's symptoms. His aggression extended to physically assaulting his sibling and a close friend at school, behaviours his mother linked to imitating his father's violence. His mother struggled to manage his aggression and continued to sought solutions to his behaviour.

While he was at age six years old, the child showed progress in reducing avoidance behaviours, exemplified by his ability to attend the mosque with his uncle. Although he continued to avoid his father, he became more comfortable with other male figures including his mother's new partner. This improvement led to better-controlled aggressive outbursts and fewer triggers from interactions with men. His nightmares decreased, and he demonstrated an improved mood and focus in school, participating in activities such as storytelling competitions.

His mother noted improvements in social interactions with classmates and a decrease in violent coping mechanisms. He participated regularly in classes, poetry and story-telling competitions, and had better sleep patterns, with occasional nightmares persisted. The child's drawings became more positive, depicting robots, sunsets, and nature instead of distressing images.

Nevertheless, there were still episodes of signs of regression, exhibited by tantrums and aggressive behaviour when deprived of his wants or instruct. Although there was some progress in managing aggression, his mother felt overwhelmed and worried on the progression of the behaviour when assimilating into a primary school soon

DISCUSSION

This case study highlights the impact of recurrent exposure to domestic violence on the mental health of a five-year-old boy residing in a rural community, emphasizing the diagnostic and therapeutic challenges associated with PTSD in preschool-aged children. As reported by Woolgar et al. (2022), young children are particularly susceptible to developing PTSD following interpersonal and repeated trauma exposure compared to non-interpersonal or single-event trauma, respectively, with a prevalence of a three-fold increase. These highlights the need to use age-appropriate diagnostic instruments to ensure early detection and intervention for young children subjected to trauma.

Research has shown that disparities exist in access to mental health services for children with PTSD between rural and urban areas. Studies have highlighted that rural children face challenges in receiving timely and comprehensive care for mental health conditions**Error! Reference source not found.**. Specifically, rural

children with mental health disorders, including PTSD, have been found to experience diagnostic differences, increased suicide rates, and access problems compared to those in urban area (Edwards et al., 2023). Urban settings generally offer more specialized mental health services, resources for early diagnosis, and interventions, leading to better symptom management and long-term outcomes for children with PTSD (Crouch et al., 2023).

Children in rural areas, including Borneo, face numerous barriers to accessing appropriate mental health care. Geographic isolation and specialized mental health services shortage are primary challenges (Blackstock et al., 2018; Tha et al., 2020). Low income and transportation issues compound these barriers, as traveling long distances to urban centres for treatment can be time-consuming and costly for families with limited financial resources (Blackstock et al., 2018). Cultural factors also contribute to the barriers faced by these families. There can be a stigma associated with seeking mental health services in rural communities, where close-knit social structures may lead to concerns about confidentiality and judgment from neighbours and acquaintances. Lack of school support can also further compound these issues (Blackstock et al., 2018; Tha et al., 2020).

By integrating these findings, this case report highlights the specific challenges faced by the child and enhances the broader understanding of PTSD in underserved populations. It adds to the growing knowledge of PTSD's impact on children in rural areas. This disproportion underscores the need for tailored interventions and increased resources for mental health care in rural communities. Comparing this case with those from urban settings reveals that children in rural areas face distinct and compounded challenges.

One significant diagnostic challenge is the difficulty in differentiating PTSD symptoms from other behavioural disorders in young children. Children with PTSD may exhibit externalizing behaviours (e.g., aggression, defiance) as a coping mechanism or expression of their distress. Symptoms such as defiance and aggression may be misinterpreted without considering the underlying trauma, leading to inaccurate diagnoses and possible delays in diagnosis and treatment.

The child's symptoms, which meet the diagnostic criteria for PTSD, also suggest an additional risk of developing oppositional defiant disorder (ODD). Children exposed to such traumatic events are at an increased risk of developing a range of mental health issues, including ODD and conduct disorder (CD), complicating their psychological and social development (Adeyele & Makinde, 2023).

ODD features a persistent pattern of anger, irritability in mood, argumentative or defiant behaviour, and vindictiveness (Greydanus & Dickson, 2022). The child exhibited anger and aggressive behaviours such as screaming and hurting peers and public outbursts, indicative of defiant behaviour. Notably, his behaviour improved under structured settings, such as school and occupational therapy sessions, suggesting that authority and compliance issues might arise in less structured or more emotionally charged environments. Improvement in the child's behaviour with increased maternal involvement indicated that inconsistent or negative interactions with authority figures might contribute to his symptoms.

The child's history of trauma, including family custody battles likely underpins his PTSD symptoms and extends into broader developmental impacts. Reports of the child being less triggered nowadays and having fewer nightmares suggest trauma-related symptoms. The case presented highlights the need for a more comprehensive diagnostic framework to capture the intricate symptom profile of complex trauma beyond the traditional PTSD diagnosis.

Developmental Trauma Disorder (DTD) provides a nuanced understanding of the boy's emotional, behavioural, and relational difficulties, which extend beyond the typical PTSD symptomatology (Ford et al., 2022). **Error! Reference source not found.** The child's defiant behaviours, attachment problems, and impaired empathy during incidents with peers and sibling are consistent with the dysregulation in emotion processing, self-organization, and relational functioning characteristic of DTD (Ford et al., 2022).

The improvement observed with stability and supportive interventions aligns with the known features of this disorder, which emphasizes the importance of a developmental perspective and relationship-based treatment approach.

Complex PTSD, which encompasses a broader range of symptoms beyond the core PTSD criteria, has been proposed as a useful diagnostic framework for capturing the diverse presentations resulting from exposure to chronic, interpersonal trauma, particularly in formative developmental periods (Maercker, 2021). By acknowledging the impact of trauma on subsequent developmental stages and life experiences, this conceptualization helps elucidate the sweeping personality changes and comorbidities that can arise in the aftermath of complex trauma.

Incorporating a developmental trauma lens is crucial for appropriately assessing and treating the array of symptoms presented by this child, including emotional and behavioural dysregulation, self-concept disturbances, and relational difficulties. Rethinking traditional treatment approaches to account for the complexity of presentations associated with complex trauma is essential for providing effective, tailored interventions, particularly in underserved rural communities.

Positive outcomes experienced by the child from occupational therapy sessions highlight similar findings in a study by (Lynch et al., 2021) that demonstrates positive outcomes of occupational therapy within a multidisciplinary team for young children who experienced trauma. However, the child's regression following distressing encounters with his father highlights the ongoing challenges in managing trauma-related symptoms in unstable environments.

Research shows trauma-focused therapies are effective for children in low- and middle-income countries, but there is limited literature on rural populations (Jordans et al., 2009). Proactive, culturally sensitive interventions are crucial for addressing PTSD among a diverse population of rural children exposed to domestic violence. Primary care interventions can improve outcomes in preventing and treating child traumatic stress (Flynn et al., 2015).

This case report highlights the need for healthcare providers to innovate and adapt their methods to better diagnose and treat PTSD in rural children. Integrated care models, training for rural healthcare providers, and culturally tailored interventions are essential to help address rural mental health disparities by focusing on the availability, accessibility, and acceptability of services through collaboration with existing structure (Jensen & Mendenhall, 2018).

With limited resources within the rural community for specialized mental health, schools in these areas face unique challenges in providing adequate mental health support. Only 2% of publications address trauma-informed approaches in rural schools (Frankland, 2021). Collaboration with school educators as part of school-based intervention can reduce stigma and promote mental health support towards a positive recovery (Kenyon & Schirmer, 2020). More research is needed on mental health support and resilience development of rural children.

CONCLUSION

This case emphasizes the importance of comprehensive, integrated diagnostic and treatment approaches, especially in underserved diverse rural communities. Proactive strategies and culturally sensitive interventions are crucial to addressing PTSD and associated disorders among children exposed to domestic violence. By increasing awareness and accessibility of mental health services, we can better support children like this child and mitigate the long-term impact of trauma exposure.

Given the complexity of traumatic experiences and familial dynamics in the development of PTSD, an integrated, multi-faceted approach to treatment is essential. It is imperative to bolster mental health services through collaborative efforts among healthcare providers, school educators, and social workers to ensure equitable care for affected children within rural communities. This case highlights the pressing need for health programs that can transcend cultural barriers and support these children in rural communities.

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Consent for Publication

Written informed consent was obtained from the patient's legal guardian for publication of this case report.

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