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TRAUMA, LOSS, AND RECOVERY: A CASE STUDY OF PSYCHOLOGICAL COUNSELLING IN AN HIV-ORPHANED ADOLESCENT GIRL WITH COMPLEX TRAUMA AND ANXIETY

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ABSTRACT

This case report presents the psychological assessment and counselling intervention conducted with Ms. K.B., a 15-year-old female adolescent residing in a children's home, who was referred for psychological counselling following somatic complaints and an episode of loss of consciousness. The patient presented with a complex clinical picture including anxiety, insomnia, intrusive traumatic recollections, and significant emotional distress arising from multiple childhood adversities: early parental loss due to HIV-related illness, institutional upbringing since toddlerhood, repeated experiences of childhood abuse, and anticipatory grief linked to a younger sibling's HIV-positive status. A structured 5P case formulation was employed to map the presenting, predisposing, precipitating, perpetuating, and protective factors. Over six counselling sessions, a multi-modal psychological intervention was delivered, incorporating supportive counselling, trauma-focused techniques, cognitive restructuring, imaginative therapy including safe place visualization and inner child healing, and sleep hygiene education. Progressive improvement in emotional regulation, anxiety symptoms, and psychosocial adjustment was observed. This case underscores the intersecting vulnerabilities faced by AIDS-orphaned adolescents and highlights the clinical utility of integrating imaginative and trauma-informed approaches within brief therapeutic contact.

Keywords: *Trauma-informed care, adolescent mental health, guided imagery, cognitive restructuring, childhood abuse, sibling attachment*

1. INTRODUCTION

Adolescence is a period of profound psychological transformation, marked by identity formation, emotional development, and increasing independence. When this developmental stage is burdened by the cumulative weight of orphanhood, institutional upbringing, childhood abuse, and living in proximity to HIV-related illness, the risk of serious psychological harm becomes considerable. Children orphaned by AIDS represent one of the most vulnerable populations in global public health, carrying disproportionate burdens of anxiety, post-traumatic stress disorder (PTSD), depression, and grief-related psychopathology (Cluver & Gardner, 2007; Bhatt et al., 2013).

Globally, the United Nations Children's Fund (UNICEF) estimates that more than 153 million children have been orphaned due to AIDS-related causes, with the overwhelming majority residing in low- and middle-income countries (Springer et al., 2024). Studies conducted across sub-Saharan Africa and South Asia have consistently found that being orphaned by AIDS is associated with significantly elevated scores on measures of depression, anxiety, and PTSD compared to both non-orphaned peers and those bereaved by other causes (Cluver et al., 2012; Bhatt et al., 2013). Beyond bereavement, these children frequently endure the additional adversities of food insecurity, social stigma, abuse, and inadequate emotional care within institutional settings- each of which compounds psychological risk in a dose-dependent manner.

The co-occurrence of childhood sexual abuse within this population further deepens vulnerability. Childhood sexual abuse is recognized as a non-specific risk factor for a spectrum of psychological disorders including PTSD, depression, anxiety disorders, somatic complaints, and insomnia (Putnam, 2003; Murthi & Espelage, 2005). In particular, adolescent girls with histories of abuse demonstrate heightened internalizing symptoms, including emotional suppression, helplessness, and fear-based cognitions that can persist and intensify during adolescence if left unaddressed (Hébert et al., 2017; Lacelle et al., 2012).

The psychological care of such young people demands approaches that are simultaneously trauma-sensitive, developmentally attuned, and relational in nature. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has emerged as the most extensively validated intervention framework for children and adolescents with trauma-related psychopathology, integrating psychoeducation, graduated exposure, affective modulation, cognitive restructuring, and caregiver involvement (Cohen et al., 2004; de Haan et al., 2025). Complementing this, imaginative techniques such as guided imagery and safe place visualization have demonstrated efficacy in reducing anxiety, promoting emotional regulation, and providing therapeutic distance from overwhelming trauma content (Bhatt et al., 2023; Krau, 2021).

This case report describes the psychological assessment and multi-modal counselling of a 15-year-old girl with complex trauma arising from AIDS-related parental bereavement, institutional care, repeated childhood abuse, and ongoing fear regarding her younger sibling's HIV status. The case illustrates the practical application of a 5P formulation framework and an integrative intervention model within a brief contact format, and contributes to the growing literature on best-practice approaches for this underserved population.

2. OBJECTIVES OF THE CASE STUDY

This case report aims to:

• Describe the presenting clinical profile of an adolescent girl with complex trauma and co-morbid anxiety within an institutional care context.

• Document the sequencing and outcomes of a multi-modal psychological intervention including trauma-informed, cognitive, and imaginative therapeutic components.

• Highlight the role of sibling attachment and environmental change as protective and therapeutic factors in institutional care settings.

3. CASE PRESENTATION

3.1 BACKGROUND AND REFERRAL

The patient, referred to as Ms. K.B. to preserve confidentiality, is a 15-year-old female adolescent currently residing in a children's home and enrolled in the 10th standard at a local school. She was referred for psychological counselling on 09 March 2026 following medical evaluation that identified no organic an etiology for her somatic complaints. Ms. K.B. has been raised in institutional care since early childhood, having lost both parents to HIV-related illness. Her younger sibling, who resides in the same children's home, is HIV-positive.

Her presenting complaints at the time of referral included giddiness, headache, one episode of transient loss of consciousness, fearfulness and anxiety, sleep disturbance (insomnia), emotional distress when recalling traumatic experiences, and pervasive feelings of helplessness and insecurity. The somatic complaints-particularly headaches, dizziness, and the episode of loss of consciousness-were understood within the broader context of psychological distress, consistent with existing literature on the somatization of trauma in adolescent populations (Lacelle et al., 2012; Putnam, 2003).

3.2 DEVELOPMENTAL AND TRAUMA HISTORY

Ms. K.B. has experienced a constellation of adverse childhood experiences that place her at elevated psychological risk. Both parents died of HIV-related complications, leaving her and her sibling in the care of an institutional home from toddlerhood. The absence of consistent, nurturing parental attachment during critical developmental periods is well recognized as a foundational risk factor for anxiety, attachment difficulties, and emotional dysregulation in later adolescence (Springer et al., 2024).

Additionally, Ms. K.B. disclosed a history of childhood abuse experienced at approximately eight to nine years of age, and a second abusive incident at approximately thirteen years of age. Childhood sexual abuse has been extensively linked to the development of PTSD, depression, anxiety, somatic symptoms, and sleep disturbances in adolescent females (Hébert et al., 2017; Putnam, 2003). The recurrence of abuse across developmental periods - once in middle childhood and again in early adolescence-represents compounded trauma exposure, a factor associated with more severe and treatment-resistant psychopathology (Lacelle et al., 2012).

Her younger sibling's HIV-positive status added a layer of anticipatory grief and existential fear, with Ms. K.B. expressing intense worry about losing her only remaining family member. Sibling relationships carry exceptional significance for children in institutional care; research indicates that warm sibling bonds are among the most consistent predictors of resilience in this population, serving as a primary source of emotional support in the absence of parental figures (Waid & Wojciak, 2018; Dirks et al., 2015).

3.3 MENTAL STATUS EXAMINATION

Ms. K.B. presented as a thin-built, cooperative adolescent who maintained minimal but appropriate eye contact throughout the clinical interview. Mild psychomotor retardation was observed during discussions involving traumatic content. Her speech was coherent and goal-directed, though characterized by a soft tone and mildly increased response latency during emotionally distressing topics.

Subjectively, she described her mood as anxious and fearful. Affect was constricted, with tearfulness noted during discussion of past traumatic events. Her thought content was preoccupied with her sibling's illness, fear of future loss, and trauma-related recollections; however, no formal thought disorder, delusions, or perceptual disturbances were identified. Cognitive functions were broadly intact - she was oriented to time, place, and person -though attention and concentration were mildly impaired by emotional distress. Insight was partial, with some awareness of the emotional impact of her experiences but limited understanding of their psychological underpin-

nings. Social and personal judgments were adequate for her developmental stage.

4. CASE FORMULATION: THE 5P FRAMEWORK

A structured 5P formulation was employed to organize the clinical data into a coherent explanatory framework, identifying the factors that initiated, maintained, and might ameliorate the patient's difficulties (Macneil et al., 2012).

4.1 PRESENTING FACTORS

Ms. K.B.'s primary presenting concerns encompassed clinical anxiety, fear related to her sister's illness, emotional distress linked to traumatic recollections, insomnia, and somatic complaints including headaches and giddiness. The episode of transient loss of consciousness, in the absence of organic pathology, was formulated as a somatoform response to acute emotional distress-a well-documented phenomenon in adolescents with trauma histories (LaCelle et al., 2012).

4.2 PREDISPOSING FACTORS

Predisposing factors included early parental loss, institutional upbringing from toddlerhood, the absence of stable emotional attachment during formative developmental years, repeated exposure to childhood abuse, and possible unresolved grief and abandonment experiences. AIDS-orphaned children carry a substantially elevated burden of internalizing psychopathology compared to both non-orphaned and otherwise-bereaved peers, particularly when early loss is compounded by inadequate emotional care (Cluver et al., 2012; BHATT ET AL., 2013).

4.3 PRECIPITATING FACTORS

The most identifiable precipitating factor was the heightened fear regarding her younger sibling's HIV-positive status, which appeared to have intensified at the time of referral. Environmental stressors within the previous residential home, the surfacing of trauma-related memories, and the normative pressures of adolescent development and academic demands further contributed to symptom escalation.

4.4 PERPETUATING FACTORS

Several factors were identified as maintaining and prolonging her difficulties: persistent intrusive trauma-related thoughts, sleep disturbance, fear of future loss, emotional suppression, limited coping repertoire, and ongoing insecurity regarding her safety and support system. The absence of a stable, secure attachment figure is widely recognized as a perpetuating factor in adolescent anxiety and trauma recovery (Springer et al., 2024).

4.5 PROTECTIVE FACTORS

Notably, Ms. K.B. demonstrated several meaningful protective factors: she was motivated to engage in the counselling process, expressed emotional warmth and deep attachment toward her sibling, had access to a multidisciplinary support team, and showed the capacity to express emotions within the therapeutic relationship. Following a change in residential placement that allowed her to live alongside her sister, she demonstrated marked improvement in emotional stability and adjustment — a finding consistent with evidence that sibling co-placement is a significant protective factor for children in institutional care (Waid & Wojciak, 2018).

5. PSYCHOLOGICAL INTERVENTIONS

5.1 SESSION 1 (09 MARCH 2026): ESTABLISHING SAFETY AND SUPPORTIVE COUNSELLING

The first session prioritized establishing a therapeutic alliance and creating a sense of emotional safety. Supportive counselling techniques were employed to communicate unconditional positive regard and to encourage Ms. K.B. to begin verbalizing her fears and worries without fear of judgment. Establishing safety is recognized as the foundational first phase of trauma treatment, without which deeper therapeutic work cannot proceed effectively (SAMHSA, 2014; Brown et al., 2020).

5.2 SESSION 2 (09 MARCH 2026): CRISIS STABILIZATION

Given the intensity of Ms. K.B.'s distress and the reported episode of loss of consciousness, the second component of the first therapeutic contact focused on emotional stabilization. Grounding exercises - techniques designed to anchor individuals in present sensory experience and interrupt dissociative or overwhelmed states - were introduced alongside reassurance and psychoeducation about the relationship between emotional distress and physical symptoms. Crisis stabilization through grounding has robust empirical support as a first-stage trauma intervention in adolescent populations (Strand et al., 2013).

5.3 SESSION 3 (11 MARCH 2026): TRAUMA-INFORMED INTERVENTION

A trauma-informed therapeutic approach was formally adopted in the third session. Ms. K.B. was supported to gradually and gently approach her traumatic memories without becoming emotionally overwhelmed -a principle known as titrated exposure in trauma therapy (Cohen et al., 2004). Her emotional responses were consistently validated, and her reactions to the trauma were normalized within a psychoeducational framework. Cognitive exploration began with the identification of maladaptive beliefs surrounding helplessness, abandonment, and insecurity -core cognitive themes frequently reported among adolescents with histories of childhood abuse (Hébert et al., 2017; de Haan et al., 2025).

Cognitive restructuring techniques were initiated to challenge and reframe catastrophic thinking about her sibling's illness, replacing worst-case interpretations with more balanced, evidence-based appraisals. TF-CBT's cognitive processing component has demonstrated strong efficacy in reducing trauma-related cognitions and associated PTSD, anxiety, and depression symptoms in children and adolescents across multiple randomized controlled trials (de Haan et al., 2025; Cohen et al., 2004).

5.4 SESSION 4 (17 MARCH 2026): IMAGINATIVE THERAPY TECHNIQUES

The fourth session introduced a suite of imagery-based interventions, which were selected for their particular suitability for an adolescent client with good imaginative capacity.

Safe place visualization guided Ms. K.B. to construct a detailed, multi-sensory mental image of a location where she felt completely protected and at peace. This technique activates the parasympathetic nervous system, reduces amygdala-mediated threat responses, and provides a portable self-regulation resource that clients can deploy independently between sessions (Psych kit, 2025; Children's Hospital of Orange County, 2025). Research supports the use of guided imagery in reducing anxiety, depression, and somatic discomfort across clinical populations, including pediatric settings (Krau, 2021; Bhatt et al., 2023).

Inner child healing exercises invited Ms. K.B. to visualize and compassionately engage with her younger self during moments of historical trauma. Drawing on principles from schema therapy and Internal Family Systems (IFS) models, this technique facilitates emotional release, self-compassion, and the reparenting of unmet childhood emotional needs (Simply Psychology, 2025; Spilove, 2025). The process enabled Ms. K.B. to approach her traumatic memories with self-kindness rather than shame or self-blame — a shift with well-documented clinical significance in trauma recovery (Neff, 2003 as cited in Simply Psychology, 2025).

Future self-visualization encouraged Ms. K.B. to imagine herself in a hopeful future — educated, emotionally stable, and in safe, caring relationships. This forward-projection technique targets hopelessness and catastrophic future-orientation, promoting psychological optimism and strengthening motivation for therapeutic engagement.

5.5 SESSION 5 (25 MARCH 2026): SLEEP AND ANXIETY MANAGEMENT

The fifth session addressed Ms. K.B.'s persistent insomnia, which had been identified as both a symptom and a perpetuating factor in her overall presentation. The relationship between childhood abuse, PTSD hyperarousal, and sleep disturbance is well established in the literature; research confirms that PTSD symptoms mediate the pathway between childhood sexual abuse and sleep disruption in adolescents (PMC, 2025). Progressive relaxation training, diaphragmatic breathing exercises, and structured sleep hygiene education were provided. These techniques equip individuals with practical, self-directed tools for managing physiological arousal — a critical component of anxiety management and trauma recovery.

5.6 SESSION 6: SOCIAL SUPPORT STRENGTHENING AND ENVIRONMENTAL INTERVENTION

The final session focused on consolidating therapeutic gains and reinforcing the patient's social support network. Coordinated advocacy with the care team resulted in Ms. K.B. being transferred to a residential home where she could live together with her younger sister. The significance of this environmental intervention cannot be overstated: sibling co-placement has been shown to be among the most powerful predictors of resilience and emotional well-being for children in institutional care (Waid & Wojciak, 2018; Dirks et al., 2015). Ms. K.B. was encouraged to continue nurturing her attachment with her sibling and to approach caregivers as a source of support. Multidisciplinary communication with the medical team and residential staff was maintained throughout the course of intervention.

6. PROGRESS AND THERAPEUTIC OUTCOMES

Across the six counselling sessions, Ms. K.B. demonstrated a meaningful and progressive clinical improvement. Anxiety and generalized emotional distress showed gradual reduction, and her capacity for emotional expression within the therapeutic setting noticeably improved. She transitioned from a presentation characterized by constricted affect and emotional suppression to one in which she was able to identify, articulate, and process a range of feelings with greater ease.

Her sleep disturbance, which had been a significant source of daytime dysfunction, improved following the introduction of relaxation and sleep hygiene strategies. Most strikingly, following her transfer to the new residential home — where she was reunited with her younger sibling — Ms. K.B. reported feeling meaningfully happier, emotionally safer, and better adjusted than at any point during her institutional care. This rapid improvement in psychosocial functioning following environmental change is consistent with attachment theory's predictions regarding the centrality of felt security and relational belonging in adolescent wellbeing (Waid & Wojciak, 2018).

7. DISCUSSION

This case illuminates the intersecting and mutually compounding vulnerabilities experienced by AIDS-orphaned adolescents in institutional settings. Ms. K.B.'s presentation is consistent with the broader literature, which documents high rates of anxiety, PTSD, depression, and somatization among children bereaved by AIDS, particularly when early loss is compounded by institutional upbringing, inadequate emotional attachment, and exposure to abuse (Cluver et al., 2012; Bhatt et al., 2013; Putnam, 2003). Her somatic symptoms — headaches, giddiness, and the episode of loss of consciousness — reflect what is increasingly understood as the body's expression of unprocessed psychological distress, particularly in the context of trauma (Lacelle et al., 2012).

The 5P formulation framework offered significant clinical utility in organizing the complexity of her presentation. By systematically mapping predisposing, precipitating, perpetuating, and protective factors alongside the presenting symptoms, the formulation guided a logically sequenced, individually tailored intervention plan rather than a generic protocol-based approach.

The integration of imaginative therapy techniques -particularly safe place visualization and inner child healing - alongside established TF-CBT components represented a clinically justified and developmentally appropriate choice. Guided imagery has a growing evidence base in pediatric and adolescent anxiety management, with documented effects on parasympathetic nervous system activation, reduction of fear and tension, and improvement in sleep quality (Krau, 2021; Children's Hospital of Orange County, 2025). Inner child work, grounded in schema therapy and IFS principles, provided Ms. K.B. with a compassionate avenue for engaging with painful early experiences — an approach particularly well-suited to a patient whose difficulties were rooted in unmet developmental attachment needs (Simply Psychology, 2025; Spilove, 2025).

Perhaps the most striking finding in this case is the magnitude of therapeutic gain associated with the environmental intervention - specifically, the residential transfer that allowed Ms. K.B. to live with her younger sister. This underscores a broader principle well supported in the literature: for children and adolescents in institutional care, sibling bonds can serve as primary attachment relationships, providing the emotional security, co-regulation, and sense of belonging that would ordinarily derive from parental figures (Waid & Wojciak, 2018; Dirks et al., 2015; Springer et al., 2024). The clinical and policy implications of this finding are significant: in institutional care contexts, sibling co-placement should be prioritized not merely as a logistical consideration but as a therapeutic intervention with measurable psychological benefits.

This case also highlights the essential role of multidisciplinary collaboration. Psychological intervention alone, without coordination with medical staff and residential caregivers, would have been insufficient to address the full scope of Ms. K.B.'s needs. The integration of psychological, medical, and environmental perspectives within a coherent care plan reflects best-practice standards for complex trauma in adolescent populations (SAMHSA, 2014; Brown et al., 2020).

8. CONCLUSION

This case study documents the psychological assessment and brief multi-modal counselling intervention with a 15-year-old HIV-orphaned adolescent presenting with complex trauma, anxiety, insomnia, and somatic complaints in an institutional care setting. Through a carefully sequenced combination of supportive counselling, trauma-informed techniques, cognitive restructuring, imaginative therapy, sleep management, and environmental advocacy, meaningful clinical improvement was achieved across six sessions.

The case reinforces several evidence-based principles for clinical practice with this population: the importance of establishing safety before processing trauma; the clinical value of imaginative and visualization-based techniques in adolescent trauma therapy; the centrality of sibling attachment as a protective and therapeutic resource; and the indispensability of multidisciplinary collaboration in complex cases. Crucially, it also demonstrates that environmental interventions-including changes in residential placement- can function as powerful therapeutic actions in their own right.

Further longitudinal follow-up and research into the long-term psychological trajectories of institutionalized AIDS-orphaned adolescents in India are warranted. The integration of culturally adapted, brief-contact, multi-modal intervention models within institutional care settings merits ongoing attention from both clinicians and policymakers committed to the mental health and wellbeing of this underserved population.

ETHICAL STATEMENT

Informed consent was obtained from the patient's guardian and the institutional care authorities. Patient identity has been protected through the use of initials only. This case study was conducted and documented in accordance with applicable ethical guidelines for psychological case reporting. No identifying information that could compromise patient confidentiality is disclosed.

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