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The Role of Pastoral Counseling in Severe Depressive Disorder with Psychotic Symptoms accompanied by Prolonged Grief Disorder: A Case Study

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ABSTRACT

This paper is a case study that examines the role of pastoral counseling in dealing with a 56-year-old woman who experienced Major Depressive Disorder, Severe with Psychotic Features and Prolonged Grief Disorder (PGD) due to the loss of her husband and children, as well as experiencing social and spiritual alienation. Using qualitative methods, data were collected through interviews, observations, and psychological assessments, indicating the presence of chronic and complex severe depressive symptoms. Pastoral counseling is positioned as an integrative approach that bridges medical, emotional, and faith needs, emphasizing the restoration of relationships with God, self, and others. This study confirms that the church has a strategic role in providing a safe and loving space of recovery, where suffering is not simplified, but rather understood in its entirety as part of the healing process in the light of God's grace.

INTRODUCTION

Depression is one of the most common mental health disorders globally, with a steadily increasing prevalence in recent decades. In Indonesia, data from the 2023 Indonesian Health Survey (SKI) shows that the *national prevalence of depression reaches 3.7%,* which is equivalent to around 9.16 million cases (Shalahuddin et al., 2024). According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), depression or *major depressive disorder* is defined as a mood disorder characterized by feelings of deep sadness or loss of interest in previously enjoyable activities, accompanied by various cognitive, somatic, and emotional symptoms that last at least two weeks (Tolentino & Schmidt, 2018). Symptoms of depression include feeling sad or empty most of the day, loss of interest or pleasure, changes in weight or appetite, sleep disturbances (insomnia or hypersomnia), fatigue, feelings of worthlessness or excessive guilt, difficulty concentrating, and recurrent thoughts of death or suicide (Dirgayunita, 2016).

Pathophysiologically, depression is associated with dysregulation of neurotransmitters in the brain, specifically serotonin, norepinephrine, and dopamine, which play a role in regulating mood, sleep, and appetite (Fouad et al., 2024). In addition, the neuroplasticity theory shows a decrease in brain-derived neurotrophic factor (BDNF) which affects the decrease in hippocampal volume in individuals with depression. Chronic inflammatory responses and hypothalamic-pituitary-adrenal axis disorders (HPA axis) are also thought to play a role in the development of depressive symptoms through increased levels of cortisol which is neurotoxic in the long term (Mikulska et al., 2021).

Depression is often associated with impairments in cognitive function, including attention, memory, and interpretation. This disorder leads to rigid automatic assessments of a situation, thereby inhibiting emotional regulation and worsening depressive symptoms (Kursakov et al., 2019). Interpersonal theories about depression emphasize the role of dysfunctional personal characteristics, such as *insecure attachment styles*. In addition, depression can cause significant difficulties in social interactions, which has an impact on relationships with family, friends, and co-workers. These social barriers have the potential to create a cycle of isolation that further aggravates the symptoms of depression (Jarrett, 1990).

Depression often does not stand alone, but is accompanied by various comorbidities, both physical and psychiatric. Some of the disorders that often accompany depression include anxiety disorders, personality disorders, persistent grief disorders, substance abuse, to chronic diseases such as diabetes mellitus, cardiovascular disease, and cancer (Gold et al., 2020; Platona et al., 2024). Persistent grief disorder, or *prolonged grief disorder* (PGD), is a condition characterized by deep and prolonged grief that lasts beyond normal periods of grief. The disorder has been recognized as a separate diagnostic entity in the DSM-5-TR and ICD-11, with the main symptoms being persistent longing for the deceased, emotional insensitivity, and difficulty moving on with life (Treml & Kersting, 2018).

The coexistence between *prolonged grief disorder* (PGD) and depression has important clinical significance because it is associated with higher symptom severity, more severe functional impairment, and worse treatment outcomes than if you only had one of these conditions. Therefore, the assessment and management process need to include both specific symptoms related to grief and depressive symptoms to achieve optimal recovery.

Holistic management includes the provision of pharmacotherapy, psychotherapy, and social interventions tailored to individual needs. One approach that is starting to gain attention is *pastoral counseling* that integrates the values of faith, spirituality, and biblical principles in the counseling process (McMinn & McMinn, 2012).

Pastoral counseling offers a holistic approach that not only focuses on the psychological aspect, but also pays attention to the spiritual and relational dimensions of the individual (Tan, 2011). This approach is rooted in the belief that true restoration involves restoring relationships with God, oneself, and others (Benner, 2003). In the context of depression, pastoral counseling helps individuals find meaning in suffering, strengthen hope through faith, and build social and spiritual support within the church community (McMinn & Campbell, 2009). Additionally, pastoral counselors can help individuals to explore inner conflicts, guilt, or spiritual burdens that may be contributing to depressive symptoms, as well as encourage forgiveness, reconciliation, and self-acceptance as part of the healing process (Tan, 2011).

Case History

Mrs. S is a 56-year-old Javanese woman who now lives alone after losing her husband and child due to illness. He is the fourth of five children. Since converting from Muslim to Protestant Christianity, he has experienced rejection from his biological family. The eldest brother took a dominant role in the family and gave instructions to isolate himself. As a result, Mrs. S did not get inheritance rights and lived in relational isolation from her biological family.

Currently, Mrs. S lives alone, has osteoarthritis that limits her mobility and requires assistive devices. Economically, she still works at a church-based educational foundation as an administrator, and has a number of savings from her husband's legacy. Despite this, his social and emotional aspects were severely shaken after the loss.

The main problems she experienced included deep sadness, loss of meaning in life, and inability to live life as usual since the death of her child, Client complained of painful longing for the deceased, difficulty accepting the reality of loss, feeling that life no longer had meaning, as well as avoiding church-like environments that were reminiscent of the past.

In addition, Mrs. S also experienced a loss of interest in daily activities, sleep and appetite disorders, prolonged fatigue, and withdrawal from social interactions. He often experiences thoughts of death, feels excessive guilt, and even reports hallucinations and strong feelings of guilt. This often arises when the client feels alone and experiences pain. The client's view of his condition was quite good, he realized that he was experiencing a disturbance, but felt confused and helpless to overcome it.

Spiritually, Mrs. S is still trying to maintain her personal faith practice. He tried to read the Bible and pray every day. However, he refused to attend church services, because he felt very emotionally hurt. The place of worship reminded him of a dead child, and he did not want to face questions from the congregation that he thought would only arouse grief and pity.

The psychosocial history shows that Mrs. S's childhood was quite stable. Both of the client's parents have different beliefs where the client's father is Muslim and the client's mother is Christian. She followed her mother's faith and decided to marry a Christian. Despite their differing beliefs, clients have a warm relationship with their parents. After the father died, the position of influence passed to the eldest brother who later became a source of ostracism. The patient's brother excluded him as a family member and forbade other family members' interactions with clients.

The current environment seems to be struggling to provide room for recovery. Despite being involved in the church community and working in a ministry environment, he is more likely to withdraw and avoid interaction, also because he does not want to trouble others. The client also does not want to involve the family from the husband's side because he feels that he is a burden. A passive attitude and a tendency not to seek help are the main obstacles in his recovery process. He had undergone psychiatric and pastoral assistance, but both did not take place consistently due to limited access and lack of stable social support.

Based on the description that has been submitted, this case research aims to examine more deeply the dynamics of Mrs. S's condition, as well as how pastoral counseling can be part of the holistic management of this case.

METHODS

This research applies a qualitative method with a case study approach. The subject of the study was a 60-year-old woman. The research was carried out from January to February 2025 at one of the churches in Bandung. Individuals with long-term psychiatric conditions, solitary tendencies, lack of social support, and persistent depression are phenomena that are often found in the church community. Based on this, the researcher determined this subject.

Data collection was carried out through an assessment process that included interviews, observations, and the use of psychological measures, namely the Hamilton Depression Rating Scale (HDRS). The interview aims to explore the background and history of problems experienced by Mrs. S, by involving the subject of colleagues and servants of the church God. Observation was used to observe Mrs. S's behavior and emotional expression in social interactions, while psychological examinations were conducted to obtain an overview of various aspects of Mrs. S's personality.

RESULTS AND DISCUSSION

Dasar Diagnosis

Based on the results of observations, clinical interviews, and psychological assessments that have been carried out, a diagnosis based on the DSM is established, namely Major Depressive Disorder, Severe, With Psychotic Features (*DSM-5 Classification*, 2016). Subjects met nine of the nine criteria for major depressive episodes over two weeks, including depressive mood most of the day, loss of interest or pleasure in almost all activities, sleep disturbances (insomnia), significant weight loss, fatigue and loss of energy, excessive feelings of worthlessness, decreased ability to concentrate, psychomotor agitation, as well as recurrent thoughts of death and suicidal ideation.

These symptoms are accompanied by significant impairment of social and occupational functioning, as well as the appearance of psychotic symptoms in the form of guilt delusions and nihilistic delusions that are congruent with mood. These symptoms are not caused by a common medical condition or substance use, and are not more accurately explained by other psychotic disorders. The client is accompanied by Prolonged Grief Disorder (PGD) as stated in the DSM-5-TR (American Psychiatric Association, 2022). The subject experienced deep and settled grief focused on the loss of his closest people, which had occurred more than 12 months ago.

Prominent symptoms include painful and persistent longing, difficulty accepting the reality of loss, feelings of losing a part of oneself, and an unwillingness to continue living without the deceased. Subjects also show intense emotions such as anger, feelings of emptiness, and avoiding activities or places that remind them of the deceased.

Biological Dynamics

The biological dynamics experienced by Mrs. S include physical and neuropsychiatric symptoms typical of severe depression cases with psychotic features. He has osteoarthritis that limits mobility and requires assistive devices, and exhibits symptoms such as sleep disturbances, decreased appetite, prolonged fatigue, and withdrawal from daily activities. In addition, psychotic symptoms congruent with mood appear, such as auditory hallucinations and delusions of guilt, especially when alone or in a state of pain. Although his vision was quite good, he realized that he was having a disorder his confusion and helplessness made him passive about the recovery effort.

Psychosocial Dynamics

The psychosocial dynamics in Mrs. S's life are characterized by chronic loneliness, lack of meaningful social support, and inability to re-establish safe relationships after loss. She lives alone, avoids interaction, and does not want to trouble others, including her husband's family. Despite working in a church-based ministry environment, he more often withdraws and does not open himself up to help. He had undergone psychiatric and pastoral assistance, but both were cut off due to limited access and low stability of social support. The pattern of rejection from adolescence to adulthood, especially by authoritative figures in the family, forms a pattern of deepening alienation after the loss of children and their husbands.

Spiritual Dynamics

The spiritual dynamics can be seen from Mrs. S's struggle in maintaining her personal life of faith. She still prays and reads the Bible regularly, but refuses to attend church services because it triggers emotional memories related to her son's death. He felt pitied and was unable to face social interaction in the church. The background of his conversion from Islam to Protestant Christianity was also a source of spiritual wounds, especially because he was ostracized by his biological family who rejected his faith. This leads to a sense of alienation from the family community and doubts about one's acceptance before God, which reinforces the inner narrative that her suffering is divine punishment.

Clients face complex conditions, with the primary diagnosis of Major Depressive Disorder (MDD) and Prolonged Grief Disorder (PGD), accompanied by comorbidities of physical disorders as well as various social pressures, such as deep loneliness and lack of stable social support. This situation reflects the reality that in the church community there are often cases that cannot be simplified as spiritual matters alone. Therefore, the church needs to have a complete understanding and a holistic response, which involves cooperation between spiritual ministry, psychosocial assistance, and professional support, in order to bring the love of Christ to life in a real and comprehensive way in the recovery of the wounded people.

From a neurobiological point of view, the symptoms of depression experienced by Mrs. S can be explained through dysfunction in the brain tissue that regulates cognition, emotions, and motivation. Concentration disorders reflect hypoactivity in the dorsolateral prefrontal cortex (DLPFC) a region of the brain responsible for attention, decision-making, and emotional control. Dysfunction in this area is directly related to increased ruminative activity, in which the patient is trapped in a repetitive negative mindset without resolution (Disner et al., 2011; Pizzagalli & Roberts, 2022). In addition, hypothhalamic-pituitary-adrenal (HPA) axis dysregulation triggers hypercortisolemia and decreased melatonin levels, which contribute to insomnia and sleep fragmentation commonly found in depressed patients (Palagini et al., 2021). In parallel, the dopaminergic reward circuit, especially in the ventral striatum, experiences a decrease in responsiveness to pleasurable stimuli, resulting in anhedonia, which is the inability to feel or imagine positive experiences (Pizzagalli, 2014). This decrease in activation not only reduces motivation, but also reinforces negative thinking schemes that state that the future no longer offers hope or happiness. Thus, cognitive, affective, and biological disorders in the brain form pathological circuits that sustain severe depressive episodes chronically and recurrently.

Ms. S's psychological dynamics show a typical depressogenic thinking pattern as described by Beck's theory, in which negative views of self, the world, and the future form a mutually reinforcing cycle between her emotions and her depressive state. She blames herself for her son's death and believes that she has failed as a mother, which reflects the core scheme of "I'm not good enough" and the distortion of thinking in the form of *personalization* and *overgeneralization*. The feeling that life no longer has meaning and the belief that he will live in solitude reflects a negative view of the world and the future, exacerbated by past experiences in the form of repeated family rejections.

Automatic thoughts that arise such as "my life is heavy and desperate" are no longer processed reflectively, but are accepted as absolute truths that deepen despair. This suggests that the long-ingated negative scheme is now intensely activated by the experience of loss, trapping Mother S in an ongoing cycle of inner anguish with no room for recovery or hope.

Social aspects play a key role in the occurrence and sustainability of depression and Prolonged Grief Disorder (PGD). One of the most significant factors is the feeling of thwarted belonging—the experience of being cut off from meaningful social connections. In the context of PGD, the loss of close people often collapses a person's core social structure, triggering a sense of alienation and detachment from the previously familiar social world. Limited social support, as well as lack of validation from the environment on grieving experiences, are strong predictors of the appearance of PGD and depression symptoms after loss (Prapunoto & Soetjiningsih, 2024). When an individual feels unheard or judged because of his or her prolonged grief, this reinforces isolation and prolongs the grieving process.

This condition is exacerbated by the emergence of "existential loneliness" and "social alienation", in which individuals feel that they no longer have a place in a world that has changed drastically after loss. Loades et al. (2020) in their systematic review showed that social loneliness has a two-way relationship with depression: loneliness triggers depressive symptoms, and depression reinforces the tendency to withdraw from social environments (Loades et al., 2020). In PGD, this alienation can be even deeper, because the social world not only feels silent, but also seems to lose meaning. The feeling of "living without a part of yourself" as experienced by Mrs. S is a reflection of chronic social identity disruption.

Spiritually, this condition occurs because humans live in a world that has fallen into sin, where relationships with God, themselves, others, and creation are damaged (Genesis 3; Romans 8:22–23). In the light of Christian theology, the suffering of the soul such as depression is not merely a psychological symptom, but a manifestation of existential and spiritual fragility due to the disconnection from the true source of life, namely God himself. In particular, depression often arises as a reaction to the reality of loss, guilt, alienation, and the collapse of the meaning of life as did Bible characters such as David, Job, Elijah, and Jeremiah. In the case of Mrs. S, deep depression arises from a series of important relationships (children and husband), social exclusion, and unhealed spiritual wounds. He experienced a deep struggle about God's identity, meaning, and existence thinking that God was far away, indifferent, and even condemning him. In fact, as Psalm 34:19 affirms, "God is near to those who are brokenhearted." Yet her subjective experience is unable to reach that objective truth because her emotional and spiritual reality has been obscured by trauma and loneliness.

He forgets grace, as if God's love is available only to those who are strong and worthy, not to the broken. This reflects a spiritual failure to receive unconditional grace, as stated in Romans 8:1: "There is no condemnation for those who are in Christ Jesus." Therefore, Ms. S's recovery requires not only psychological therapy, but also spiritual redemption the restoration of the image of God, the reminder of her identity as a child of God, and the restoration of the relationship with the community of the body of Christ that should be an extension of God's love.

The Role of a Pastoral Counselor

Mrs. S's case is a complex case that requires holistic handling. The counselor needs to work together with other mental health practitioners, but the pastoral counselor needs to be involved in pastoral mentoring. Several things to note.

1. Recognize the importance of psychiatry's role for the stabilization of biological symptoms.

   The Church needs to understand that severe depression like the one experienced by Mrs. S is not only spiritual or moral, but also has a real biological basis. Disorders of the central nervous system, such as dysfunction of the prefrontal cortex (which causes impaired concentration and rumination) and dopamine dysregulation (which gives rise to anhedonia), require medical and pharmacological interventions. In this case, the church should not deny or replace the role of psychiatrists, but instead support the sustainability of treatment as part of a holistic recovery (Pizzagalli, 2014). Affected physical conditions such as sleep disturbances, hallucinations and the inability of executive functions to think need to be assisted with medication to restore their function.
2. The Church needs to be aware of the complexity of the case and not just a spiritual problem.

   In cases like Mrs. S, the suffering that arises is not only rooted in mood disorders or negative thoughts, but from the loss of a very meaningful and life-defining relationship. It's not just a matter of grief—it's a crisis of meaning, identity, and disconnectedness, as described in Prolonged Grief Disorder. The Church often softens this kind of suffering as a lack of faith when the reality is much deeper. Prolonged sadness and feelings of emptiness are not signs of weak faith, but rather inner screams that cannot find a safe place to express themselves. The church's approach, then, must not be hasty in advising, but must be willing to be a community that dares to live with the lost, without judgment and without rushing to give answers.
3. Pastoral Counseling Is Also Present As Pastoral

   In Mrs. S's case, pastoral counseling has a vital role to play in providing counseling that is not only supportive and empathetic, but rooted in the gospel and the truth of God's Word. Pastoral counseling of a pastoral nature is necessary to help Mother S reinterpret suffering and loss not as punishment or a sign of failure, but as part of the reality of a fallen world that remains within the scope of God's love and nurturing. Through exposure to the Word, the church counselor can lead Mother S to realize that her identity is not determined by bitter experiences or feelings of guilt, but by the grace of God who loves unconditionally (Romans 8:1; Isaiah 43:1). Pastoral counseling is present as a shepherd who continues to sow the truth and accompany the client in living a journey of faith with God.
4. Building Church Community as a Safe and Restorative Space.

   S's mother withdrew from the church not because she lost her faith, but because she felt that the church was no longer a safe place—she was afraid of being pitied, questioned, or considered weak. This is where the church must repent from performative culture and return to the healing body of Christ (Galatians 6:2). A healing community is one that dares to be present in the wounds of others, without rushing to give advice or judgment. The church is called to be a space where people can be honest in pain and still be accepted, because the love of Christ is never dependent on one's mental or spiritual state.

5. Providing Social Assistance and Practical Assistance for Daily Life.

   Depression often makes it difficult for sufferers to do simple things: taking care of the house, mobility, and even talking to others. The church can play a role in providing concrete support through visits, logistical assistance, or simply accompanying to health facilities. This simple form of love has a profound impact, as it affirms that a person is not alone, and that God's love is manifest through the body of Christ who is practically present (James 2:15–17).

CONCLUSION

The case of Mrs. S shows the complexity of suffering that cannot be understood from just one dimension. The combination of Major Depressive Disorder, Severe with Psychotic Features, and Prolonged Grief Disorder shows that prolonged grief can transform into a major depressive disorder that impairs overall life functioning—both biologically, psychologically, socially, and spiritually. Neurocognitive and hormonal dysfunction exacerbates emotional symptoms, while negative thinking schemes, pathological guilt, and spiritual alienation form a repetitive and profound circuit of suffering. In a theological framework, Ms. S's experience reflects the struggle of faith in a world that has fallen into sin, where the wound of loss triggers a crisis of identity and separation from God's grace.

In this context, the church has a very important and strategic role. Holistic counseling must be done by acknowledging the need for medical intervention, providing psychological support rooted in the values of faith, preaching the liberating and non-judgmental gospel, and building a safe community for the long-term recovery process. Moreover, the church must understand that the wound of loss is not a sign of a weakness of faith, but often the field where God's love wants to be most evident. Therefore, the church is called to be a place where tears are not forced to stop, but are accommodated and slowly, made into spaces where hope is re-established through living love in Christ.

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