Interactive Care of the So-called Dissociative Identity Disorder Between Priest and Psychotherapist: Initial Considerations

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Abstract

For the life of the parishioner who has experienced severe and debilitating trauma resulting in what was formerly named, "Multiple Personality Disorder" (now called “DID”), many spiritual and psychological realities present themselves for our attention. For example, a major concern is that dissociative defenses that protect the person also create significant psychopathology that leaves an individual vulnerable to both the demands of normal living along significant spiritual challenges. This presentation will consider the dialogue between some of the theological and psychological realities, including possible areas of overlap between the two domains. The overlap and distinctions found in this kind of case need attention between both priest and therapist. In cases like these, both disciplines are challenged to relent either-or stances which call for an all-spiritual, or all-psychological view of the case. Each discipline can and should make their unique contribution to help. After presenting a brief overview of trauma and the development of so-called PTSD/DID, a brief hybrid case will be presented to illustrate these key points and then lead a discussion to attempt to address some of the main concerns relevant to this challenging and important work in an effort to form an interactive framework that engages both theological and psychological perspectives. Thus, my goal is to have participants play a role in the development of an emerging model of the coordination of care between priests and therapists.

Overview

(1) Review and define a working understanding of trauma and dissociation; (2) A case presentation to illustrate some of the challenges that present themselves to clergy and mental health professionals. (3) The importance of having a perspective with a helpful working model for the emotional and spiritual care of these individuals, we will begin a discussion of some important factors between these disciplines in approaching these highly traumatized individuals.

A Brief Introduction to Trauma & Dissociation

Persons successfully recover from everyday trauma and return to normal functioning, usually because of a combination of factors, including milder severity (for example, little “t” trauma), adequate emotional support, biological predisposition, the provision of security and protection, and the individual’s faith and support. However, with severe and overwhelming experiences, especially when sustained, as well as with an absence of some of the important ingredients above, can make recovery more difficult. The mind has a remarkable ways of surviving when it has met an experience that is *greater than* what has been called the “Window out of consciousness that which is or was too much to bear—this is called dissociation. We all

dissociate, but it is a matter of degree. Further, even the healthiest of persons can develop serious conditions like PTSD or even DID. The separation of emotional states can be necessary, but when it becomes chronic, a person becomes unable to access different parts of their mind and become unable to be able to do what Philip Bromberg calls "standing in the spaces" between different parts of experiences and emotions,[1] more serious psychopathology may develop. On the other hand, very few persons, if in fact anyone, has full access to all parts of their mind at the same time. This is actually a relief. This would be overwhelming! Functioning with only parts of our mind at a time and being able to shift flexibly to other functions when necessary are all part of a healthy mind. The mind is marvelously made! Without getting too technical, a metaphor is that we can manage our minds like the way we wear different hats, or the roles we play—mother, priest, professional, friend, neighbor, etc., although they may run together as well. At the emotional level, the more fluidly and deliberately we can move through these, the more adapted we can be to the demands of life. This ability to move fluidly between different ways of coping, feeling, relating, and so on, we might say, is healthy dissociation. And, we might say, re-associating when necessary.

What concerns us here is *pathological dissociation*—on our way to discussing what is now called DID. Healthy dissociation helps us cope with the healthy "hiccups" of painful or stressful events enabling us to return to normal functioning. When someone cannot return to normal functioning, something within them *remains unlived*. It is a part of experiencing that one has not lived, and the person is often unaware of this because the mind has actively (consciously or unconsciously) "kicked the can down the road" because of what is called a fear of breakdown.[2] Now, when moving forward in life (after the unlived portion remains) new experiences that fall into the category of perceived threat, out of control, overwhelming, etc., are detected and perceived as presenting in or lurking behind new events. It is at this point that the unlived portion of the mind seems to shut down new experiences. When trauma is more severe, is ongoing, and the environment makes it difficult or intolerable to be present and receive support for recovery, the more likely that dissociation will persist and become chronic. This can progress to PTSD. When PTSD progresses to DID, the separate states of mind are cut off from each other in a rather arbitrary manner, and in this fashion, the person becomes unable to manage their overwhelm and some other state of mind takes over—frequently without any awareness on the person's part. When this "taking over" becomes ongoing and exhibits itself with discrete states of mind (meaning the person may have lost awareness while another ego state or part of them takes over), this becomes what we now call Dissociative Identity Disorder.[3]
Because the trauma has not been lived, or processed, many new life experiences are not integrated into a coherent narrative within the person's life. Outwardly, they may appear to be somewhat bland or even somewhat normal, while at the same time, they are not able to put together and adapt to their experiences effectively. In place of a coherent narrative is a complex inner system that dictates arbitrary responses to different circumstances.[4] For instance, an individual can suddenly become appeasing when feeling threatened by someone or may abruptly

[1] Philip M. Bromberg. Standing in the Spaces: The Multiplicity of Self and the Psychoanalytic Relationship. *Contemporary Psychoanalysis*. 32 (1996): p. 509-535.

[2] Donald W. Winnicott. "Fear of Breakdown." *International Review of Psychoanalysis.*

[3] Lynette S. Danylchuk and Kevin J. Conners. *Treating Complex Trauma and Dissociation: A Practical Guide to Navigating Therapeutic Challenges*. (New York and London: Routledge, 2017), 22.

[4] Bennet Braun. "The BASK Model of Dissociation." *Dissociation.* I:1 (1988), 4-23.

become angry and attacking at another instance when perceiving threats or violation. Often the person feels ashamed of not being able to control these responses and behaviors, or in some instances, are unaware of "who" took over.[5] According to the "Sequential Model of Dissociation," learning how these parts work can explain how this survival system works,[6] and in my experience, can assist with the healing process. Further understanding of the function of the divisions and the parts, such as protector, angry, reasoning, supportive, and so on, may help understand further the purpose of dissociation on the way to possible integration.

More serious dissociate represents being able to "escape when there was no escape."[7] The truth of the trauma became too much. It appears as if, as a result of being unable to suffer, dissociation's goal is not to exist or "to be. The truth has no mental space. Without a context or a relationship that creates space for what has been both unbearable and unspeakable, the emotional truth cannot be allowed. A separate space is then created for that pain that has not existed before. Chronic dissociation can work to prevent the unconscious fear of breaking down. Several implications are involved. These include: (1) the prevention of the "unthinkable,"[8] (2) protection against "disintegration anxiety,"[9] and (3) protection from "against the annihilation of personal spirit."[10]

I want to briefly mention that some have questioned how DID is different from schizophrenia. Some researchers have suggested that the difference is that the schizophrenic is unable to dissociate.[11],[12] They fall apart. DID, from this perspective, is more of a compromise, a kind of division without completely falling apart. This matter has not been resolved and remains subject to further investigation.

The cost of this "survival" can be great. Depression, rigid coping defenses, and a host of other struggles to adapt to life result, and for the purpose of our discussion, the person can become very vulnerable to spiritual problems and what has been called evil influences. They may improve with prayer, but often their emotional dysregulation continues. In the hybrid case that follows, many features of both psychological and spiritual concerns will be presented to illustrate our task for dialogue.

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[5] Steven-John M. Harris. *To Be or Not to Be: Explorations in Madness & Faith.* (Alhambra, CA: Sebastian Press, 2020), 186.

[6] Danylchuk and Conners, "Treating Complex Trauma and Dissociation: A Practical Guide to Navigating Therapeutic Challenges," 24-25.

[7] Frank Putnam. "Discussion: Are Alter Personalities Fact or Fictions?" *Psychoanalytic Inquiry.* 12 (1992): 24-32.

[8] Winnicott, "Fear of Breakdown," *International Review of Psychoanalysis.* (1974): 103-107.

[9] Heinz Kohut. *The Restoration of the Self.* (New York: International Universities Press, 1977), 104.

[10] Donald Kalsched. The Inner World of Trauma: Archetypal Defenses of the Personal Spirit. (New York and London: Routledge, 1996), 2.

[11] Andrew Moskovitz, John Read, Susie Farrelly, Thomas Rudegeair, and Ondra Williams. "Are Psychotic Symptoms Traumatic in Origin and Dissociative in Kind? In Paul F. Dell and Joan A. O'Neil eds. *Dissociation and Dissociative Disorders* (London: Routledge, 2009), 331-353.

[12] Roni Shiloh, Bruria Schwartz, Abraham Weizman, and Marguerite Radwan. "Catatonia as an Unusual Presentation of Posttraumatic Stress Disorder." *Psychopathology* 28 (6) (1995): 285-290.

Introduction to Case Presentation

The following case is not a real single case of a known person in that it does not represent the facts of any one case but represents an amalgamation of case material from the details of many cases gathered over time. Any similarity is coincidental and not accurate. Although no one case is represented here, my patients are asked to sign a consent form which gives me permission to utilize their case material for the advancement of psychology. They are also allowed to refuse to give such permission. Further, I inform them that the use of casework, including their own may be useful for case consultation, teaching case illustrations, etc., and aid future therapists in their learning and/or make concepts clearer. Also, they are informed that illustrations as such do not require releasing the personal identity or other identifying information about them. And they are further informed that another potential advantage is that the struggles and difficulties of their life might do some good to help future generations of learners and fellow human beings whose lives may be filled with some of the issues that are similar to those that have troubled them. With this in mind, I clarify that I have never shared a specific case and that I create hybrid cases that combine many cases to help illustrate these clinical realities while facilitating the process and further take great efforts to prevent any feelings of exposure. Let us now proceed with a hybrid case.

Case Presentation

"Bill" (pseudonym) is a 32-year-old male who was referred by his priest. Bill had been attending church with his family for the past few months. During this time, when he attended Divine Liturgy, he sat near the back of the church. Although quiet and reserved, when approached for a blessing, or when the Holy Cross was presented in various forms, he would let out a loud and terrorizing screech that was not only overwhelming to parishioners, but even his well-seasoned priest would shake and jump back. Also disturbing was that while passing others lighting candles in the narthex, Bill would often calmly approach them, and, seemingly out of nowhere, jump into the faces of praying parishioners and shove them, often screaming or "screeching" at them. In one instance, he punched someone in the nose as they were lighting their candle.

Bill was brought to his first therapy appointment by his parents. Given his age, despite some reservations by his parents, I wanted to see him first. He studied my office and his eyes seemed both acutely vigilant but far away somehow. When I asked him about his life, he said that he was a hopeless case because he was demon-possessed. At times that I could not predict, his face suddenly changed, and he let out one of those loud shrieks that sent me flinching backward in my chair. I found myself needing to summon up large amounts of courage as I muttered, the "Prayer of the Heart"[13] to myself, many times over during sessions. In early sessions, he was unbathed, smelled badly and his hair and clothing were disheveled. Sometimes when he shrieked, he produced a foamy saliva that resembled that of a rabid dog. One positive factor seemed to be that he seemed to calm down and feel soothed by my interest in his story and my not being too overwhelmed (relatively speaking. I am sure he knew I flinched, while at the same time, I remained engaged with him!) by sitting with him.

[13] Prayer of the Heart is another name for the "Jesus Prayer."

Later, I learned from his parents that before coming to the Orthodox church, they had brought him to Pentecostal evangelists and "healers," who prayed for him "to have his demons cast out." Many of these so-called "healers" even offered to do so for sums of hundreds to thousands of dollars! I noticed when I asked Bill to recall these prayer meetings and gatherings, that *he seemed to have formed a kind of profile of what a demon-possessed person was and that it seemed that he might have attached himself to this narrative* in order to explain to himself (and others?) his despair, depression, and disjointed state of mind—all apparently lending to his view of himself as demon-possessed. It seemed noteworthy in this regard that he was somewhat self-diagnosed in this way.

After receiving permission to call his priests (he had a few as he traveled from parish to parish), I asked one Father if he felt that Bill was demon-possessed. It somewhat surprised me when the Father told me that this was possible, but added, "I think there is something more here." I felt challenged to move out of my either-or thinking and consider what I have always wondered in theory—whether trauma and presentations of what appears to be spiritual harassment may involve a complicated intersection of both in the minds of some individuals. I decided to attempt to meet further with Bill and see if I could get him to tell me more about his history. Meanwhile, his parents were taking him to several notable monasteries to be prayed for in an effort to ward off or cast out evil spirits. He seemed to improve after these meetings and prayers. I was given permission to call these monastics but did not receive a callback. I did not take this to mean anything per se but I wished to learn more about their perspective of Bill. Meanwhile, after he improved from prayers, he continued to have his outbursts and needed to be hospitalized for psychiatric reasons after he became suicidal including voices telling him to kill himself and his family.

During his hospital stay, he was prescribed heavy doses of anti-psychotic medications, major tranquilizers which he took for a few weeks but ceased taking them because of the dead zombie-like behavior they produced. In sessions, he became clearer and more lucid, and the number of violent shrieks became less frequent. Sadly, when a child-like voice emerged in a session, I was to learn that a paternal uncle had sodomized him repeatedly since he was six years old. He stated that he tried to tell his grandparents, whom he was staying with, about these incidents, but reportedly, they never believed him. Instead, they shamed him and told him that if he told anyone his parents would be killed. Although he felt my empathy for him these parts of him seemed to respond well, an adult part of him seemed to not believe it. He would say that it is like another person told me it happened to them, "it was not my experience." Meanwhile, he related that he was having unrelenting nightmares of being chased by invaders from outer space, watching people get killed, and other horrors.

A second priest called me after Bill gave me permission. This priest was concerned about the possibility of demonic influences but was also curious about his history. When I explained to him the violent sexual trauma of his early life, the priest became very disturbed and saddened and became profoundly empathic for Bill. We shared our concern about how his efforts to improve seemed to get undermined. His parents had seemed to focus on his "craziness" and demonic elements and there seemed to be collusion between them and Bill to not have anyone know about the trauma. I wondered if they were more invested in him being demon-possessed, mentally ill, or both). I thought that no matter how we want to know the truth, whether some

truths were too painful or shameful to bear. Further, the question was raised in my mind if in his likely role as a "symptom bearer,"[14] it may have been emotionally easier to accept or bear the reality of demon possession rather than expose sexual abuse and trauma to be found in the family. Either way, the multiple levels at which one might wonder how this poor soul was traumatized, possessed by the idea of being possessed, or possessed. Not only that, but the spiritual cost of his condition seemed immense. Finally, the overlap between deception, intimidation, and shame between what might be wicked and traumatized forces in his mind seemed quite daunting. Over the next few months, Bill had lengthier psychiatric hospitalizations that interfered with his progress in his treatment. Some hospitalizations appeared to arise out of big family conflicts. After his last hospitalization, he did not reschedule further sessions.

Discussion

Parishioner Response

Disturbing behaviors, especially those that are aggressive, bizarre, and apparently out of control can illicit significant fears in the minds of a church parish. Churches are starting to work on equipping their parishes with ways to respond to problematic behavior. The rather extreme behavior illustrated in Bill and many others can often be alleviated by having it spotted much earlier. There can be many signs to parishioners and ways to approach and help individuals find help long before they mount to serious levels. Parishioners do not have to be mental health experts but can learn to observe concerning behavior and find ways to engage and converse in supportive ways to assist in a fellow parishioner's finding help. In other words, the parishioner does not have to be the help.

For example, together with the Orthodox Christian Association of Medicine, Psychology, and Religion (OCAMPR), the Assembly of Canonical Orthodox Bishops has developed a new program that launched in 2022 called "Peace of Mind" to address these matters. Peace of Mind is a composite training program on mental health crisis response that includes a clinically based course (*Mental Health First Aid™, owned by the National Council for Mental Wellbeing*) which is augmented by a theologically based presentation developed by the Assembly of Bishops. The training program is administered by trained individuals, "Peace of Mind Facilitators," who train others in parishes to train their parishes how to identify concerning behavior and intervene through thoughtful engagement with the potential to offer support and possible referrals to receive further help. Briefly, it is important to acknowledge that parishioners can be a supportive community for people going through difficult times and do not have to stand by at a loss as to what they can do.

In the case of Bill, in the eyes of a lay-trained Mental Health First Aid parishioner, early signs of preoccupied behavior, and any other oddities, with appropriate timing, can be engaged through greeting and asking how they are doing and finding ways to discuss and share experiences, and when the opportunity presents itself in conversation, to indicate what they are

[14] A symptom bearer is a concept similar to a scapegoat, a family member who is targeted as the problem when it focuses the family away from other matters of family dysfunction.

observing and try to find inroads into what might be happening. First aid workers do not diagnose or confront, but provide an interested, curious, and supportive approach to parishioners who appear to be having troubles. Provided that Bill would start to share any difficulties, the mental health first aid worker can normalize human struggles and how anyone can need further help and begin to offer support and resources to help guide them towards the mental health and spiritual needs Bill likely has. Much more can be found out by this program at its website.[15] Further, more features of this program are provided at a talk given at the 2022 OCAMPR conference by Philip Mamalakis, PhD and Sangeetha Thomas, MS.[16] All of this amounts to not only addressing the clergy and mental health practitioners, but also helping a parish be informed and able to address its mental health needs in a supportive manner.

Clergy and Mental Health Response

Many questions arise from such a complex and challenging case for both clergy and psychotherapists. I will list a few here:

(1) Is there justification for considering both spiritual and emotional problems at the same time in this case, or must it be determined which "cause" is predominant?
(2) What are some ways that a priest can support the therapy process while keeping an eye on both his parishioner and the safety of his overall parish?
(3) How can the psychotherapist coordinate with the priest/spiritual father to support Bill's spiritual progress?
(4) What are some of the important issues to consider when trying to balance the matter of evil and psychopathology in this case? With this issue in mind, a very evil "protector"[17] will appear during times of high vulnerability.
(5) Are there theological perspectives that help with the complicated mix of psychological and spiritual problems illustrated with this case?
(6) How might the psychotherapist transgress (go too far) into the spiritual life of the parishioner/patient and how should (s)he find ways to manage this with the priest/spiritual father?
(7) What theological perspectives may help us disentangle some of the factors of this case (e.g., St John of Damascus and St Maximus the Confessor whose discussion of passions are not necessarily spiritually resistant but are wayward or are rooted in other mental problems and in the latter whose discussion of corruption of the will as set apart from a secondary result from The Fall, the corruption of natural energies[18]).

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[15] <https://www.assemblyofbishops.org/ministries/mentalhealth/peace-of-mind>

[16] <https://youtu.be/O6vryF10fh4>

[17] A protector is a name for an altering state or part of the personality in dissociated individuals who act out in various ways, protectively of the person during times of real or perceived stress.

[18] This is discussed more at length in, Steven-John M. Harris. Science and Orthodoxy Around the World (SOW) Psychoanalysis and Orthodox Theology. "Healing of the Person from Psychological and Theological Perspectives: Are They Compatible?" Presented September 30, 2022, at the Volos Academy for Theological Studies, Volos, Greece (in press).

Although all of these questions will not be answered here, this is a starting point for matters that seem inescapable for the life of a parish. These matters will not go away so we may well begin to prepare ourselves for these eventualities. Also, many cases of mental health challenges may not be as serious as the case of Bill but need a perspective to hold for intervention. It is hoped that clergy and mental health practitioners will continue this important conversation as we move forward to address these matters. In what follows, I would like to introduce a mental health perspective that seems vital for beginning to address this matter.

The Human Subject & God

With its great tradition, sacraments, and practice the church plays its part in facilitating our awareness and availability of God's provisions of love and grace in restoring us to Him. Christ readily knocks on the door of human hearts[19] and the response across human beings is complex. "A healthy body, mind, and soul are imperatives for the salvation of the human person," cites Archbishop Elpidophorous.[20] While this statement implies many things, the complexities of the emotional, mental, and spiritual well-being of the human person are implied.

The case of Bill raises the importance of what is so pivotal for some persons' ability to respond to God, *the human subject* (meaning here the person and their ability to respond to God). At stake here is the question of whether the human subject can consciously perceive and respond if it has not come into being. For the Patristic Fathers such as St Maximus, coming into being results from the human rejoining with God. Non-being then, for St Maximus, is to be without God. I am calling attention to another kind and level of non-being, that of either not coming into an awareness, conscious, participant of human experience, or as in the case of Bill, having a traumatic human experience that shatters the mind. This state of mind (or lack of an ongoing coherent state of mind) is "prior" to moral resistance or rejection of God. In the case of Bill, one cannot easily discern whether church or liturgical rituals are being rejected outright, or whether the human connection present in the liturgy has become traumatic for Bill. The hope for him to interact, initiate, or respond to another seems to rest on his becoming able to experience himself in the presence of another. This being able to come into being through a relationship with others (priest, parishioner, friend, therapist, God, etc.) is pivotal participation in any primary or meaningful participation in the faith. Over time, the process of the healing presence facilitates what D. W. Winnicott called, "going on being,"[21] which promotes movement and growth through the healing relationship.

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[19] Revelation 3:20.

[20] Peace of Mind, Assembly of Canonical Orthodox Bishops of the United States of America. <https://www.assemblyofbishops.org/ministries/mentalhealth/peace-of-mind>

[21] The author is grateful to George Stavros, PhD, for pointing the connection between the healing process being described here and the description of Winnicott's in his seminal paper, D. W. Winnicott, The theory of the parent-infant relationship. In Donald W. Winnicott, The Maturational Processes and the Facilitating Environment. London: Karnac Books, 1990, pp. 37-55.

Before proceeding, it must be acknowledged that sometimes Divine Grace decides to work with a soul while the psyche is in a very morbid condition. In such a case we can see an important opposite path: spiritual visitation by Grace contributes to mental constitution and improvement. Also, Spiritual restoration of the soul should not be confused with salvation. For sure there will be saved people who have serious psychological troubles throughout their lives who are nevertheless in the grasp of salvation. And finally, there are certainly cases in which the person is not granted by God inner peace, because it is for their spiritual benefit to remain in trouble. Obviously, the matter is complicated. In my discussion, I wish to address those individuals who struggle like the Case of Bill, to engage their faith, and whose ability to participate in a healing relationship may be able to aid in their participation more productively in the practice of their faith.[22]

In his recent work *Ethics of Beauty,*[23] the author Timothy Patitsas argues that through identifying with Christ and going through his passion and resurrection, his prescribed ethic of beauty is one of turning from the trauma towards the good, it is the *Eros* for the Other, God. He focuses man's object away from himself toward the centrality of God. God is the subject of our attention. He states boldly that trauma takes us away from coherence and solidity into non-being, a state of hell, and he adds that the liturgy of Christ can absorb any amount of chaos and bring it back into being. This statement presents an important truth. He further points out that many trauma victims, especially war veterans, can overcome both emotional and moral injury, the coming out of the shame, isolation, and despair, restoration to the *hypostasis* can provide immense relief, healing, and restoration,

> Seeing ourselves as suffering with Christ, seeing that He suffers with us, reverses all of this. It stops the panic and reintegrates the soul. In consenting to suffer with Christ as He consents to suffer with us, we overcome all possible attacks and find our integrity being restored.[24]

This sweeping pronouncement promises profound healing as one identifies with the Holy Cross. The welcomed penetrating experience of the deeply loving embrace of all eternity is unmistakably foundational to existence. Important for this powerful transformation is one's existence and the existence of the Other. In this article, what is being added to this discussion about severely traumatized individuals, is the question of whether in certain cases are there certain fundamental relational elements of functioning in the human subject that condition that are necessary *on their way* to participating in the practice of their faith.

This perspective raises the question about the human subject who has been annihilated by experience. How does the person relate to the other through its damaged, perhaps even distorted Eros? How does God become the central concern when they possess little or no identity either prior to or as a result of the trauma? Some traumata, notably lengthy and cumulative, can greatly diminish or shatter the identity. Essential to the development of self and existence in the world is

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[22] Many of the elements in this paragraph arose out of an email conversation with Fr Vasileios Thermos. Email correspondence: February 11-12, 2023.

[23] Timothy Patitsas. *The Ethics of Beauty.* Maysville, MO: St Nicholas Press (2019).

[24] Patitsas, "The Ethics of Beauty," 94.

the beautiful exchange between the nascent self and the other. If there is no other or if when the was the presence of the other is absent or destructive, even annihilating, there are consequences. Simply reacting or dissociating impinges on the process of being or becoming.[25] At stake are being or annihilation. Without the other, there is no existence or very little to put it more conservatively. If the "I" does not exist, how does it find the "other"? Patitsas points out, "By eros, we mean that the love that makes us forget ourselves entirely and run towards the other without any regard for ourselves […]," a self-forgetting. This sounds like a very important solution and is advisable. My question is: Can the person make those choices if they have no coherent awareness of self and other? And in a related manner, is there an other when there is no me?

The formation of the self arrives in earnest but at the hands of the other. In its psychological origins, this development is often signified by the arrival of the breast, but also nurtured and protected, more or less, throughout life, which when adequate enough, these beginnings gather enough its necessary subsistence. When this nurture and protection are absent, volatile, or violently interrupted, the self's capacity to experience itself or have the experience of the other can be non-existent, diffuse, diminished, or unreliable. Subjectively, there are varying degrees of there being no other if there is no me. We must ask if there is no or very little establishment of self, is there a feeling of existence, or can the other exist, subjectively? We know the Other exists objectively.

In a certain way, a collaboration between priest/spiritual father and psychologist may be helped by either of them not having to be completely responsible for the different facets of the process. Psychologists can point towards certain confessional and liturgical elements to be addressed by the pastor, while perhaps a priest can trust the theologically aware or informed psychotherapist to address emotional difficulties, assured that they will not seek unnecessary and unhelpful avenues of self-fulfillment, autonomy, and self-sufficiency that sometimes take one away from helpful avenues of their faith.

It may be important to determine which psychotherapeutic factors work against the healing liturgy and which ones may support it. Also, at times, spiritual fathers and priests may provide some of the relational factors that facilitate the emergence of a relational self on the way to healing in the form of being able to be in the presence of another. Although efforts are sometimes made towards the establishment of an "Orthodox therapist," the assumption of such a uniform approach as if it were a method-ist path towards emotional and spiritual health may have its disadvantages. For example, the rigid application of an expected regimen may align with pathological defenses that are blocking the development of a healthy dependency on the Divine. Another approach may be more exploratory and appreciative of the healing wrought by the liturgical process. The benefits of empathic inquiry while steering the trauma victim towards the healing benefits of their liturgical faith practice appears to have considerable promise.

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[25] D. W. Winnicott. The Maturational Processes and the Facilitating Environment. *In the Theory of Emotional Development*. 64 (1965), 46-47.

Conclusion

By providing background on some of the elements of severe traumatic experience and their consequences, I have sought to illustrate some initial considerations for the work of the church and allied mental health professionals. An added dimension that seems pivotal for severe mental illness is the importance of the human subject, not centrally, for God is the object of faith, but when applicable, can be pivotal towards experiencing the great provisions of our faith. It seems important in cases of mental disturbances like in the case of Bill, that an in-depth healing relationship that helps him pick up the pieces of his life, and requires great attention, can be attended to by many potential sources of support, be it spiritual father, priest, parishioner, or mental health practitioner. Most important is probably not who, but when and how these relationships will emerge for severely traumatized individuals. Personhood, then, emerges from love, including importantly, the Divine Eros, and severe trauma can separate the person from this love. The Trinitarian response of clergy-clergy-parish may be pivotal if not crucial, in the restoration of the traumatized person to a loving relationship that "goes on being."