The Idol Beneath the Altar

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Drawing on the imagery of a Mayan idol hidden beneath the altar of a Catholic mission church imposed on a Mayan city by Spanish conquerors, the author discusses the role of deeply rooted core beliefs that are not always evident on the surface—and the observation that, in clinical practice, things are not always as they seem. Psychotherapists may unconsciously be seen as invading cultural enemies. *(Journal of Psychiatric Practice* **2014;20:138–140**)

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On a sunny, steamy day in Belize, my wife and I surveyed the restored majestic temples and plazas of the ancient Mayan city at Lamanai Archaeological Site.[1] Our primary purpose for being there was to see the incredible array of spectacular birds that adorn the forests and fields of Belize. But on this day we stood in awe of the forbidding beauty and grandeur of these stone-age constructions—and tried to imagine the complex society that held these people together for over 3000 years. The deeply ingrained tenets of the intertwined religious and political structures of the Mayan culture must have been introduced to them from infancy. The resultant beliefs and convictions constituted the "received truth" that took root in the "transitional space" of each person's mental life where reside religion and other untestable convictions about the nature of things, as I recently discussed in these pages[2]—"transitional" between total immersion in self and a clear mental representation of outer reality.

Leaving the magnificent temples, our guide pointed out the modest ruins of a church. The conquering Spanish forced the Mayans to build it in their great zeal to bring the native Central Americans to salvation through belief in what the Roman Catholic missionaries viewed as the one true God. The church was built, but what the Spaniards did not know was that hidden beneath the altar was an icon of the Mayan god. When the Mayans worshiped, they could privately pay homage to the god who was rooted in their hearts. (They later rebelled, burned the two 16th century Catholic missions to the ground, and erected a stone *stela*, a monument renouncing all allegiance to Christianity.) The story captured my imagination as I trudged along peering at birds for the rest of the trip. Two lines of thinking emerged.

1) Our deepest convictions are unshakeable but not always evident on the surface.

What an example of how deeply rooted are our core beliefs! There are plenty of other examples in human history—the Jews, Catholics, Protestant Christians, Mormons, Muslims, or Hindus who held fast to their faiths and practiced them secretly through such outrages as the Holocaust, the Inquisition, the Crusades, the Taliban domination of Afghanistan, or many other forcible impositions of one culture upon another. Clear examples in our own history are the dehumanization and abuse of African-Americans during slavery and their mistreatment for over a century beyond it, systematic genocide of Native Americans and disrespect for their religions, and persecution of minority faiths. If one can be objective, one might suspect that the fervor of Jihadists comes not only from tribal hatred of Israel but also from their fear of the inexorable encroachment of modern Western culture upon their remote, agrarian, uneducated, ultra male-dominant civilization.

Untold humiliation, physical and mental abuse, torture, or threat of death cannot dislodge allegiance to core beliefs. Some of these beliefs have been political—national pride, Communism, or democracy—or related to philosophy or physical science—consider Socrates and Galileo—but many are in the religious realm that goes beyond verifiable reality to the ultimate nature of existence. This is where the mental image of a god resides. It is shaped by myriad impressions that a person forms from the moment the senses became active before birth, and it is molded by experience with parents or early caretakers (or sadly

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their absence). It may be further refined by subjective moments of a sense of revelation in worship or prayer, by the appearance of God's intervention in events of one's life, or by meaningful human relationships. But ultimately it is beyond human sensory proof other than a profound sense of conviction that it is real.

What is at the core may be much more primitive than what adults may express in formal religious practice. Therein may reside a wordless sense of a loving, all-embracing, benevolent presence or a seething hatred of what is not-me or fear of a harshly punitive outside force that exacts excruciatingly painful self-abuse or a profound sense of emptiness and abandonment. In other words, it has an affective core. Needless to say, that core affective tone is probably set very early in life through infants' preverbal experience of the world around them.

The practical implication of this for us as psychiatrists is that we should be alert to the hidden presence of each patient's core affects and beliefs—or apparent denial or rejection of them—even if they do not seem immediately pertinent to the condition for which the patient is working with us or to its treatment. They are seasoned by the cultural milieu from which the patient comes. One might say that the core belief system is the "idol beneath the altar" of what the person presents to us about how his or her mind works.

Naturally, each of us brings his or her own cultural milieu and core belief system into our work with patients. We can't avoid these influences that shape who we are and how we react to what the patient brings. The best we can do is make every effort to understand ourselves, know our core beliefs and affective tone, and be sensitive to what the patient draws out of us.

2) The corollary is: All is not as it seems

The idol beneath the altar was not visible to the conquering Spaniards. Nor are our patient's inner workings immediately visible to us. Usually there is a vested interest in keeping them hidden, which inherently creates a resistance to our interventions. As Freud put it, we are the disturbers of the peace, and our intrusions with a questioning but non-judgmental way of looking at things may be viewed with great suspicion and alarm. The idol stays hidden until the patient feels safe (or provoked) to reveal it.

A striking example occurred decades ago in a therapy group for men with alcoholism in a Northern city. I was taping the sessions for study and supervision. One participant was a courtly Southern gentleman whose politeness, benevolence, and good humor were unassailable, to the point of being frustrating and a bit annoying to the rest of the group. His defenses against connection or access to feelings were entrenched. Then one week he came to the group session drunk, foul-mouthed, and verbally abusive. The intensity of his vehemence was shocking, laced with hatred of blacks, women, and Northerners. Deep in his soul was the Old South and the War of Northern Aggression. At the next session he was his usual self. He couldn't recall his outburst and was astonished when we played back the tape. I felt then that we had touched something of his hidden core beliefs and their attendant affect, and I noted the exaggerated defenses of denial, reversal of affect, reaction formation, and isolation with which he had kept them in check before they were undermined by alcohol. I suspect that the disturbing outbursts of racism, homophobia, and misogyny that occur in our national public life have similar deep roots. They seem so incongruous with these same individuals' frequent strident assertions that the United States is a Christian nation, disregarding the constitutional separation of church and state.

That primitive rage is never far away is demonstrated daily by incidents of road rage. We may look on that with contempt, but the nearness of rage was strikingly demonstrated by distinguished psychiatrists at the Convocation of the American Psychiatric Association meeting in Washington in 1971.[3] It was during the Vietnam War, and demonstrations were going on in Washington; Benjamin Spock, the noted pediatrician, had been arrested and was in the news again in his three-piece dark suit and Phi Beta Kappa key behind a chain link fence. Dressed in tuxedos as they were about to be elevated to being Fellows (it would be "Distinguished Fellows" now), several hundred worthy psychiatrists were awaiting the introduction of Ramsey Clark, former U.S. Attorney General, as the Convocation speaker. "By design or incredible coincidence," essay contest awards were being presented by the Task Force on Aggression and Violence when the doors burst open on either side of the podium and about 30 demonstrators in two groups swarmed around the stage.

In a brief scuffle with some APA officials, a few climbed onto the dais. One group, "Gay Liberation" led by Franklin Kameny, PhD, was protesting the

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"oppression of homosexuals" by psychiatry; the other, a "Radical Caucus" of APA members, was protesting the war. Most of the demonstrators were reportedly not APA members. Watching in horror, what struck me then was the outburst from many of the new Fellows: they became what felt like a mob, standing, shouting, and gesticulating in an enraged, menacing surge. Dr. Charles Pinderhughes, who had been presenting the awards, took charge: each group of protestors was given a few minutes to present its case from the podium. People calmed down and then the regular agenda proceeded. I knew then how close civilized people can be to erupting into a mob.

All is not as it seems when we encounter a new patient. As we meet a hallucinating, paranoid, disorganized psychotic patient, it doesn't come easily to sense the confused, terrified human being with a history and a life of his or her own inside. Recently a second-year psychiatric resident argued with the psychodynamic instructor in a case conference in which a patient had been presented with an intense phobia for cockroaches. The resident was adamant that there was nothing more to it than a fear of cockroaches. The instructor agreed that cockroaches were ugly and disgusting. But they are not dangerous, so that this kind of a panicky fear was a displacement and externalization from something internal of much greater significance that wasn't yet apparent or understood. The challenge is to help the patient recognize the defenses of repression, displacement, and avoidance and come to grips with what has been hard to face inside. Meaningful and useful diagnosis must go far beyond mere categorization of symptoms. Eventually therapist and patient can pull together an understanding of the feared affects and the devious and unconscious ways in which people control them to reduce the internal conflict and anxiety they would otherwise cause. This is not just a psychodynamic construct: cognitive behavioral and interpersonal psychotherapies also focus on discerning unrecognized patterns, schemata, automatic thoughts, effects of life changes and losses, and so on, although they may not go so deeply into the underlying dynamics and genesis of problems in earlier life. Change is gradual and requires working through.

Two cases in my own practice demonstrated the dynamics of freeway phobia—a phobic anxiety about driving on a freeway. When elucidated down to the causes, each was unique. In one case, the patient was avoiding going to her parents' home because of guilt about deep resentment toward her mother and father and fear of rejection for reasons too complex to elaborate here. As she understood that and worked through it, and found more mature and self-confident ways to relate to her parents, her fear of driving on the freeway faded away. We titrated the dosage of exposure—one freeway exit at a time.

The other patient's problem was entirely different. Being rather flirtatious was part of her style, but her sexual morality was very strict. She was chronically unhappy with her rather insensitive husband. Her phobia began after she had been stuck in a traffic jam caused by an accident on a freeway. She and a man in an adjacent car had flirted with each other during a long wait while the freeway was cleared, and she had a powerful impulse to have an affair. When she initially presented for treatment, she had repressed that incident. It turned out that the phobia was a way of avoiding that longed for, forbidden temptation, and the guilt, loss of her husband, and ostracism that would have resulted from yielding to it.

Neither of these cases was easy. Recognizing transference manifestations was part of the process: projection of guilt and judgment in the first case, flirtatiousness and fear of being rejected and abandoned in the second. There were many complexities and the process of treatment took months, but it worked and the symptoms did not return on long-term follow-up with both patients. Systematic research has borne out the hypothesis that unconscious processes related to childhood separation anxiety underlie adult anxiety disorders.[4] These must be addressed if the longstanding pattern is to change.

So, as we as psychiatrists contemplate the altar, we had better be thinking about what might be hidden beneath it.

References

1. http://www.belize-vacation.com/belize/lamanai.htm accessed February 15, 2014.
2. Clemens NA. Current psychoanalytic views on the mental representation of God. J Psychiatr Pract 2013;19:495–7.
3. Gant H. Annual meeting runs smoothly while protests hit Washington. Psychiatric News, June 2, 1971 (with follow-up Letters to the Editor June 16 and July 7, 1971). The author is grateful to Gary McMillan, Director, Melvin Sabshin Library & Archives, American Psychiatric Association for obtaining these articles.
4. Milrod B, Markowitz J, Gerber A, et al. Childhood separation anxiety and the pathogenesis and treatment of adult anxiety. Am J Psychiatry 2014;171:34–43.

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