Desire is Mimetic: A Clinical Approach

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What is the clinical expression of mimetic desire? *Rivalry.* What I see every day in my practice is not mimicking, nor copying, nor learning; it is rivalry.

Rivalry is recurrent, it repeats itself. The repetition syndrome identified by psychoanalysis is mimetic for two reasons: 1) because it is always the clinical expression of a rivalry and that rivalry is always mimetic; 2) because it reproduces itself, duplicates itself, imitating the circumstances of the first rivalry and always looking for an impossible victory. That victory is impossible, since it stems from a situation which mimics the circumstances of defeat. But those circumstances are the only ones of interest, since the only battle worth winning is the one that has every chance to be lost.

Mimetic rivalry (as I have tried to show elsewhere[1]) is always rooted in one of the two following claims: the claim of the self for the ownership of its own desire; and the claim of desire for its anteriority, its seniority over the other's desire, the other desire that has generated it, on which it is modeled.

Clinically, the self and the desire are going to develop various strategies to ascertain those two claims. The interdividual psychotherapy has to diagnose the nodal points of the mimetic conflict. It has to see

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[1] See Jean-Michel Oughourlian, *The Puppet of Desire: The Psychology of Hysteria, Possession, and Hypnosis,* trans. Eugene Webb (Stanford: Stanford University Press, 1991). *Ed.*

through the clinical variety of strategies and symptoms to the essential unity of the two claims underlying it. Let me give a few examples.

Vengeance

As we know, violence is mimetic. When violence cannot be immediately retaliated, imitated, duplicated, the energy for that retaliation is saved for later use. The more humiliating the violence, the greater the stored-up energy. Humiliation, in turn, stems from weakness: the humiliation of a child raped by an adult, of a civilian beaten up by soldiers, of a poor person insulted by a rich one, or, generally speaking, of the weak overpowered by the strong. If a weak person is the perpetrator of the first violence, it does not generate humiliation and, most of the time, does not entail vengeance. When an angered child kicks an adult, for example, this usually produces laughter rather than violence precisely because the child is smaller and weaker.

As time goes by, the energy of postponed or deferred violence accumulates and increases. Clinically, it manifests itself in two ways: as a feeling of *hatred;* and as a strength, a drive, a compulsive desire to destroy which will animate the offended and organize all his efforts in view of the vengeance that will set him free. The mimetic retaliation of violence will drive him until that retaliation is accomplished.

In my experience, all the young girls who were raped by their fathers could not restore their mental health and psychological balance unless they were able, in one way or another, to avenge themselves. In the absence of such revenge, the enormous energy built up throughout their childhood and adolescence produced psychological symptoms which last for a lifetime.

One such example is a patient, Miss L., 35 years old, who seeks treatment for alcoholism. It is a strange type of alcoholism: each time, she must enter a meeting and speak before a group of people—and especially if her boss is in the group—she goes to the bathroom and drinks white rum from a hidden bottle. She has been in psychoanalysis for the past 12 years with no significant results. The history of her malady shows that she has wide mood swings, ups and downs often labeled as manic-depressive. Very quickly I see that she has stored within herself an enormous amount of violence which is fairly well controlled, but which manifests itself through different types of aggressive behavior, especially towards men. A few sessions later, she finally tells me that she had been raped by her father and, as a consequence, that her parents had divorced. She was then obliged to remain with her father and take care of him. Psychoanalysis, of course, has

commented extensively on the actual achievement of her oedipal fantasies and this has only increased her feelings of guilt.

This patient was able to realize fairly quickly that since the rape by her father she has been oscillating between two extreme attitudes. One is an enormous violence, a hatred and a need for vengeance vis-à-vis her father —feelings that express themselves clinically by a state that is often labeled manic: agitation, anxiety, hyperactivity, and agressivity. She tries to modify those reactions by the use of alcohol. The other is the enormous feeling of guilt which she experiences when she realizes that this violence and hatred is directed towards her own father. She then finds herself in an impossible situation whose clinical expression is labeled depression. She tries to drown her sorrow in alcohol.

The realization of the interrelation between the two movements makes the patient feel better. She understands that her rapport with all men incessantly mimics those two movements, and that this is the reason she never was able to marry. She also understands that alcohol is used as a therapy in both cases, especially when she has to face her boss, who is a father figure.

Miss L. has improved but she is not cured. She remains in therapy. Her need for vengeance, which has not been satisfied, consumes her. My guess is that because her father has since died and vengeance is no longer possible, she is in fact incurable.

In my experience, vengeance is a crucial issue. The amount of energy mimetically produced by the other's violence is stored and urges to be released. If it is not released, it produces all kinds of psychopathological symptoms and shapes the life and destiny of the frustrated avenger.

How should our type of psychotherapy address this crucial issue?

Generally speaking, I think we must try to decrease the *humiliation.* This can be achieved by *devaluing* the aggressor and by *revaluing* the victim, by means, whenever possible, of comparing their destinies.

More specifically, three possibilities may be explored. First, through the *model* of sports and *sportive competition.* Original violence can be compared to a game that was lost, a game, however, that continues and thus affords the possibility that further competitions can be won. Second, by the technique of *substitution,* which is well known by all the specialists in vengeance. A substitute is offerred to replace either the offender or the avenger. The offender can be replaced by another force: "you have been physically abused, but you can come out on top in your class or in business or you can use the energy to work out and develop your body, etc. . . ." Or

the avenger can be replaced. In many cultures, a brother or a relative is substituted for the avenger. The recourse is, of course, whenever possible, to substitute God for the avenger: "vengeance is mine", says the Lord and vengeance should be left for His justice to deal with. A third possible way of decreasing humiliation is to try to stress the importance of *forgiveness.* Forgiving is the way to healing. It is the treatment of choice for the pain. Many patients will, however, challenge this. They will ask you to cure them first so that they will be able to forgive. One way to get out of such a "chicken and egg" situation is to tell the patient—if she is spiritually oriented—that God within himself, the divine part of his own being, has already forgiven and that this forgiveness should serve as a model for the patient's own forgiveness and the restoration of her health.

Jealousy

Jealousy is a very common clinical form of mimetic rivalry. There are, I would say, different forms of jealousy. The first is very simple. It is a rivalry that infiltrates a couple composed of friends, lovers, or marital partners, when one starts feeling envious towards the other: the other becomes the rival of the envious person and soon rivalry infiltrates the whole relationship. The second form of jealousy involves three people and is classically triangular. The jealous one in the triangle concentrates on the rival and, being preoccupied solely by mimetic rivalry, overlooks gradually, and sometimes completely, the inter-dividual rapport with the supposedly beloved one, who is now the object of that rivalry. Should the jealous person feel that he or she is loosing the battle, they may decide to kill the object if that solution appears to be the only way to prevent the rival from having the object. Such is the behavior of Othello or of the envious prostitute in Solomon's judgment.

In this type of triangle, the rival may be *real* or *virtual.* If the *rival is real, authentic, and present,* his or her presence makes the patient sick. This is how Mrs. H. came to me for treatment of an anxiety and depression syndrome that arose from marital problems. A few years before, she had been attracted by a man and had left her husband and two children. Her husband then realized how much he cared for her and did everything possible to get her back. She came back because she felt it was her duty to do so for the children.

Soon thereafter, Mrs. H. realized that her husband had a mistress, a Vietnamese. She was shocked and made his life miserable. The husband pleaded guilty but argued that the Vietnamese had helped him a great deal

while his wife was away, and that he could not abandon her now that she **had** grown very attached to him and needed him. He insisted, however, that he loved his wife and that his love was so great that it could not be altered by a few visits to the Vietnamese woman.

So Mrs. H. came to me for help. She expected me to cure her anxiety and depression and also to give her sound advice as to how to get rid of the other woman. She now wanted to eliminate that Vietnamese who was obsessing her because she realized how much she was in love with her husband.

In fact, Mrs. H. was amazed at herself. Tall, blond, elegant, full of charm and really beautiful, she had always been adored by her husband and all the men in Parisian society. She married her dark-haired, small, rather unattractive husband out of kindness, condescendence, and rationality, because he was madly in love with her and was very intelligent and very rich. And so she was astonished to see herself now: mortally jealous, exploring her husband's pockets behind his back, calling hotels and airlines to check on him, and desperately waiting for him to come home and make love to her, even though she had never been interested in having sex with him before.

Mimetic psychotherapy tried to make Mrs. H. realize that our most precious asset is desire, that desire is the very movement in psychology, that without desire one is inanimate, psychologically numb and therefore clinically depressed. I then told her that the presence of the Vietnamese woman—from this point of view—was a bliss and that jealousy in her case was a delicious feeling that made her life interesting and intense, that made her love her husband and allowed her to take pleasure in being with him. Mrs. H. soon began to discover that her suffering was delicious.

However, a few months later, she came back to me. She was sad and complained that her husband was not as passionate anymore, that he seemed to be more interested by his business than by their relationship. She was wondering whether that evolution was due to her husband's increased attachment to the Vietnamese woman.

The mimetic psychotherapy showed her that her husband was not more deeply attached to the Vietnamese woman but that he was drifting away from her because she loved him too much and was beginning to take her for granted. I therefore suggested to awaken her husband's desire by creating an "equivalent" to the other woman. Mrs. H. began hanging up the phone for no reason and going out suddenly without any explanation. Her husband very soon took her out for dinner and asked what was going on. He said he

suspected she was having an affair. Following my advice, Mrs. H. answered that this eventuality would only be fair, that since she was coping with the existence of the Vietnamese woman, her husband could cope with the existence of N. Mougins. (Mougins is the name of a small city in the south of France, where Mrs. H. had spent her childhood and that we had selected together in order to create a fictitious affair).

Since that time, Mrs. H. and her husband, aged 56 and 61, experience a passionate relationship with a delicious and reciprocal jealousy.

The type of triangle that involves a rival who is *virtual, unreal, imaginary* is, of course, different. Here the rival is created and produced by the sick brain of the jealous partner. Here jealousy is psychotic. In such cases, the jealous person should be treated with neuroleptic and the spouse should enter psychotherapy to learn how to avoid all details that may trigger the other's suspicion, all attitudes that may be interpreted as clues. Psychotic jealous patients are very dangerous.

Possession

Mimetic rivalry can turn into possession in certain cases. I have already stressed the mimetic nature of the possession phenomena, which are not only observed in Africa but also in clinical practice. Micheline, an airline hostess, was brought to me by her girlfriend Sandra. Sandra is 52 years old, married, has three children, and is madly in love with Micheline, with whom she has discovered love and who has revealed her lesbian nature. Sandra complains that Micheline is being sadistic to her: she refuses to make love to her, takes a lot of money from her, treats her badly, and drinks too much alcohol, which makes her aggressive and depressed. Sandra is therefore bringing Micheline to me for alcoholism and depression.

Mimetic psychotherapy very soon unveils Micheline's story: She was madly in love with a Creole girl, Marguerite, who was beautiful, charming, *free,* who was having affairs with boys as well as girls. Marguerite revealed Micheline to herself and led her to discover life, love, and desire. But she also took all her money and even her house, and abandoned her pennyless. Micheline still sees Marguerite from time to time when she has been able to take enough money from Sandra to afford Marguerite.

Mimetic psychotherapy helps Micheline realize that she is desperately imitating Marguerite, that she is trying to get her by identifying with her, that she is even trying to achieve a metamorphosis of herself into Marguerite. Clinically speaking, Marguerite possesses Micheline, making her do

to Sandra everything that Marguerite would have done to her. It is not, as it were, Micheline who is being sadistic to Sandra and inflicting pain onto her; it is Marguerite herself, through Micheline whom she possesses.

Micheline then is able to understand that her rival is not Sandra. By being sadistic to Sandra, she is choosing the wrong enemy; by being sadistic to herself and by destroying herself with alcohol, she is again hurting the wrong enemy. She understands that her sole enemy is Marguerite and that she should try to free herself from that possession. This mimetic analysis has so far helped Micheline. She is drinking less and is treating Sandra somewhat better.

The Rivalry in Hysteria

As the reader knows, I have discussed the mimetic aspects of hysteria at length. I will just remind you here very briefly that the hysterical patient comes to us with a physical symptom or complaint and uses it in a rivalrous way: "Can you help me, can you cure me?" really means "I am going to prove once again that I am stronger than doctors and medicine. The doctor, like all the others, will not be able to cure me. He or she will fail and I will win." In other words, the rivalry is there at first sight. Therefore, the mimetic approach should avoid that rivalry as much as possible by keeping a low profile: "I am not sure I can help you. . . . I am going to suggest a treatment to you, but I am not sure at all it will work." By taking this attitude, the psychotherapist turns the challenge 180 degrees: if the hysterical patient wants to prove the therapist wrong, he or she has to respond positively to the medication and get better. Should that happen, the therapist must look amazed and manifest serious doubts about the maintenance of that improvement in the future.

One last word in conclusion. Clinically, there is a constant antagonism between *interest* and *desire.* Desire, being mimetic, constantly works against the objective and best interests of the patient. Drawing the patient's attention to that reality is one of the most difficult things to do.