

Anti-Mimetic Scapegoating: Mental Illness's Unaesthetic Pain

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In *Violence and the Sacred*, René Girard gives the following description:

The subject feels that the most intimate regions of his being have been invaded by a supernatural creature who also besieges him without. Horrified, he finds himself the victim of a double assault to which he cannot respond. Indeed, how can one defend oneself against an enemy who blithely ignores all barriers between inside and outside?¹

Although Girard is here portraying the stage at which mimetic violence morphs competitors into “monstrous doubles,” this description will resonate deeply with a group of people who could describe their own experience through the same words: the mentally ill. Indeed, like the monstrous double, mental illness attacks the “most intimate regions” of being and blurs the lines between what is “inside” and “outside.” Mimetic theory and mental illness have more in common than their descriptions of personal invasion, however; the former can provide us with useful insights into the latter and the way in which the mentally ill face stigmatization and mockery in our culture.

This paper will explore the way in which experiences of mental illness complicates Girard’s ideas of mimetic violence and scapegoating. It argues first that the mentally ill are indeed victims of “psychological violence,” which has, for the most part, replaced physical violence in this age.² Contrary to the standard scapegoating pattern, however, the mentally ill are “sacrificed” not because they compete in mimetic desire, but because their pain does not resonate with accepted cultural models of suffering. This argument leads to the second, which is that, wittingly or not, the mentally ill challenge what Gilles Deleuze refers to as the “machines” of desire that our culture has constructed. They thus threaten the tenuous stability that mimetic violence achieves; disruptors of societal norms, they become prime targets for scapegoating.

Before continuing, I would like to note that “mental illness” covers a wide gamut of conditions. Major depression, obsessive-compulsive disorder, schizophrenia, bipolar disorder, narcissistic personality disorder, and bulimia constitute a small sampling that demonstrates this variety. Mental illnesses vary in their origins: some are “endogenous,” resulting from biochemistry and requiring little or no outside

stimulus. Others are responsive, that is, they are triggered by one or by a series of life conditions.* They also vary in their severity; some mentally ill people are relatively functional without treatment and, treated, can be fully functional. Other mental illnesses, such as psychoses, can render a person utterly incapacitated unless she is treated. In this paper, I do not discriminate among various types of mental illness; rather, I include in my arguments all who suffer from any mental illness, regardless of its origin or severity.

Breaking the Molds: Mental Illness as “Unaesthetic”

In arguing that mental illness complicates Girard’s idea of mimetic violence, I first wish to expand on Girard by elucidating the particular aesthetic that mimesis fosters. We will then see that mental illness transgresses this aesthetic. Girard presents desire as a threshold of humanity, separating the human from the animal realm. Desire, he contends, comes after the fulfillment of natural needs; what we require and what we desire are distinct sets, for “The essence of desire is to have no essential goal.”³ Unlike instincts, desires will not save our lives. Precisely because desire does not have its root in utility, we cannot on our own discern our desires. “Truly, to desire, we must have recourse to people about us; we have to borrow their desires.”⁴ Thus Girard uses the phrase “mimetic desire.” That desire is mimetic means more than that a person wants what another has or wants; it means, as well, that to desire something changes its value. Our desire for an object, position, or status does not simply mean that the object is *desired*; it confirms that the object possesses *desirability*.

We can see, then, that desire has a certain aesthetic aspect. Our desires establish criteria for what we find attractive. Fashion fads, music crazes, and literary trends begin with an artist deemed “talented,” “established,” or “up-and-coming” producing a work that is acclaimed because of its creator (or, in the past and at times in the present, because of its patron). The work is then imitated because it is acclaimed.

* The distinction between endogenous and responsive mental illnesses is a theoretical one. In reality, we can speak of the relative influence of biochemistry and life events—“nature” verses “nurture”—but rarely is one or the other the sole factor contributing to mental illness.

This is not to say that the work is not authentically or objectively good or beautiful; but we all know that when we speak of luxuries, “objective value” is nearly impossible to define. (To be sure, sometimes trends begin by overturning a prior aesthetic and redefining the standard of beauty. We see this in campaigns that tell us that “ugly is the new beautiful” or “black is the new white.” In these cases, though, even these aesthetic reversals claim, through simile, to imitate what they oppose.) Instead, something is valued because it imitates other valued things; and people are successful when they create or possess valuable things. In short—and this statements sounds almost tautological—we are attracted to things that we can recognize as attractive; and we recognize them as attractive because we have been conditioned to do so.

“Mimetic aesthesis,” to coin a phrase in the Girardian spirit, governs more than our understanding of beauty; it influences our ability to feel pity and compassion, too. If we recognize something as beautiful because it conforms to our experience of beauty, we recognize a situation as one of suffering and a person as pitiable when they resonate with our experiences of suffering. Those who elicit from us this compassion are those we can identify as victims. Here, I depart slightly from Girard, who places the victim into the schema of mimetic competition, arguing that the victims who expose our competitors’ guilt bolster our relative virtue. “The victims most interesting to us are those who allow us to condemn our neighbors.”⁵ I would say, instead, that the victims most interesting to us are those whose experiences of suffering most resonate with ours. Whether we are drawn to victims for competitive reasons or for empathetic ones, we rely on particular markers to indicate to us that a person is indeed a victim, that she is suffering or has suffered. Again, I contend that our ability to recognize suffering, like our ability to recognize what is desirable, depends upon an established mimetic aesthetic of suffering and victimization.

Additionally, even if we are drawn to victims out of compassion rather than by a desire to condemn a victimizer, victims have utilitarian value in the scheme of mimetic competition. (That victims, or any person, should be valued in utilitarian terms is just another example of the violence wrought by mimetic desire!) Victims provide us with a theater in which to display our concern and compassion; they

give us opportunities to demonstrate our moral uprightness through helping them. Girard himself unintentionally suggests the utilitarian value of victims in his defense of the modern age as the one most concerned for victims:

To prove to ourselves that we are really neither ethnocentric nor triumphalist, we thunder against the bourgeois self-satisfaction of the last century, we ridicule the foolishness of so-called progress, and we...confess to being the most inhumane of all societies. Yet modern democracies can *defend themselves* by pointing to *a mass of accomplishments so unique* in human history that *they are the envy of the rest of the world* [emphasis mine].⁶

The accomplishments to which Girard refers are not of the technological, cultural, or economic variety; they are humanitarian ones. “Our society has abolished slavery as well as serfdom. Later has come the protection of children, women, the aged, foreigners from abroad, and foreigners within. There is also the battle against poverty and ‘underdevelopment.’ More recently we have made medical care and the protection of the handicapped universal.”⁷ How have we, as a society, helped the mentally ill? Do we, as a society, even *know* how to help the mentally ill? Certainly, if we have a mimetic desire to help other people and thus present ourselves as virtuous, compassionate, and respectable members of the human race, we can meet this goal more easily and more visibly if we help the hungry, or the aged, or the handicapped. Helping the mentally ill poses more of a challenge.

At this point, we can begin to see why it is so tempting to scapegoat the mentally ill: first, as we have just seen, they do not afford an efficient opportunity to advance ourselves through the pursuit of charitable activity. Additionally, their suffering does not fit neatly into our paradigms of what suffering is; nor do they seem to qualify, by common standards, as victims. Certainly, some people develop mental illnesses as the result of childhood neglect or abuse, or after experiencing a traumatic event like war or rape. In these instances, though, we tend to treat and help the person *as* a rape victim or abuse survivor rather than as a mentally ill person. Otherwise, given our culture’s dominant aesthetic of suffering, it is difficult, indeed, to recognize even these mentally ill as victims. Media of all sorts inundate us with stories and portraits of the impoverished, the hungry, the politically marginalized, and the tortured. These people suffer in ways that are very visible; their pain matches, and often exceeds, our aesthetic criteria for

suffering. While mental illness can indeed have physical symptoms, these are rarely as overt as the bruises associated with abuse, the distended bellies brought on by hunger, or the damaged dwellings resulting from natural disasters. With less visible and tangible evidence of pain, mental illness can be seen as less *real* pain.

As for those people whose mental illness is endogenous, resulting not from any particular trauma but from biochemistry—when we recall Girard’s claim that we are most drawn to victims who allow us to hold our neighbor culpable, those with endogenous mental illness will certainly not attract our attention. There is no one we can condemn as responsible for causing the person’s suffering—unless the mentally ill person, himself, is responsible. Indeed, a significant portion of our society not only sees mental illness as not “real” suffering; it holds the mentally ill culpable for her own suffering. While skeptics may be able to acknowledge the pathological nature of severe psychosis, “Less dramatic mental orders,” writes Robert Kendell, “are commonly attributed to lack of willpower or weakness of character.”⁸

When Christians hold such misinformed views of mental illness, the burden that the ill carry takes on theological weight, as well. Kathryn Greene-McCreight writes that “Often [Christians]...feel guilty on top of being depressed, because they understand their depression, their lack of thankfulness, their desperation, to be a betrayal of God.”⁹ Unfortunately, some theologians confirm rather than contest the lie that to suffer mental illness is to live in a state of sin. Hans Urs von Balthasar contends that “...every reason the redeemed might have for fear [i.e., anxiety] has been invalidated.” Continued anxiety in the Christian indicates “bad conscience.”¹⁰ Balthasar condemns those who wrestle with anxiety “...about being in the world, about being forlorn, about the world itself...” as inadequately Christian: “If [a person] nevertheless is a neurotic and an existentialist, then he suffers from a lack of Christian truth, and his faith is sick or frail.”¹¹ Balthasar displays an inability to conceive of anxiety as a pathological issue rather than a moral one; and his contempt for those struggling with neuroses is matched, perhaps, only by his denunciation of “...their poisonous antidote, psychotherapy.”¹²

Please note that I in no way mean to excuse the mentally ill from all moral culpability. Except in the most extreme illnesses, they are capable moral agents (although the mental illness may impede their ability to act, and thus it may mitigate their culpability). We must not, however, hold the mentally ill responsible *for their mental illness*.

We see then, that the mentally ill are made scapegoats in the following ways: they are first alienated from their suffering by being denied the right to claim their pain as “real.” Next, they are held culpable for their suffering; their “fabrication” of or refusal to “snap out of” a pain that is “all in the head” demonstrates them to be morally questionable. Besides being sick, now the mentally ill bear the weight of condemnation. Moreover, when they mentally ill ask for our compassion, we interpret them as distracting our attention away from those who are “truly” suffering and who “really” need our sympathy. At this point, I would like to further my argument that the mentally ill are scapegoats by suggesting that, in addition to frustrating our ideas of suffering, they also provide a critique of mimetic desire. In doing so, they pose a threat to the culture established by mimetic desire—a threat that must be eliminated by scapegoating.

The Malfunctioning Desire Machine: Mental Illness as Critique of Mimetic Desire

Girard’s explication of mimetic desire underscores the social and cultural aspects of desire, pleasure, and ideas of “the good.” To be sure, the prohibition of covetousness in the Decalogue indicates our inherent proclivity toward imitation; it confirms that our wants are susceptible to suggestion. “Individuals are naturally inclined to desire what their neighbors possess, or to desire what their neighbors even simply desire...”¹³ While Girard’s primary concern is the violent competition, and ultimate scapegoating, that mimetic desire foments, one of his compatriots is interested in the process of desire-formation itself.

Gilles Deleuze speaks of desire arising from “assemblages” or “machines”: the constellation of social or economic constructs, ecological conditions, historical events—any factor that shapes the theater,

or “plane of immanence,” as Deleuze calls it, where desire is formed.¹⁴ While desire arises somewhat organically in response to the world situation, Deleuze highlights the way in which these assemblages are manipulated in order to render certain products or ideas desirable. At the height of such manipulation, these “desire machines” not only *inform* our wants; they dictate our wants. Deleuze’s “two regimes of madness”—capitalism and psychoanalysis—exemplify: in capitalism, the market and advertisers tell us what we should desire; and how well they succeed! Deleuze’s critique of Freudian psychoanalysis is scathing: he accuses Freud and Freudians, such as Melanie Klein, of essentially separating the subject of therapy from his actual desires and, in their stead, imposing on the subject the pre-fabricated desires provided by the Freudian canon.¹⁵ Instead of genuinely discerning the root of a subject’s disorder, Deleuze suggests that the Freudian analyst will listen for certain buzz-words or stock phrases and make a correspondingly stock diagnosis—for instance, that the subject must have an Oedipal desire to kill his father and claim his mother.[†]

What Girard and Deleuze have in common is their recognition that, in our culture—in *any* culture—desires, at least the desires we use to gauge our success and happiness, are oftentimes fabricated. Both scholars indicate that in order to discover what one desires, the person does not perform rigorous self-examination, but looks instead at her neighbor or blindly accepts the desires that society thrusts upon her. By bringing Deleuze into conversation with Girard, I suggest that we are able to discuss with greater sophistication mental illnesses’ relationship to mimetic desire; for what we see in mental illness is a failure to embrace mimesis, a rejection of what society labels “good.” In mental illness, the desire machines have malfunctioned.

To be sure, in virtually all forms of mental illness, from anorexia nervosa to agoraphobia to antisocial personality disorder, the subject displays a profound disruption of her appetites and a severely

[†] It is important to note that Deleuze’s diatribe applies to Freudian psychoanalysis, only. He does not, like Balthasar, dismiss all forms of psychotherapy—only the one that he believes imposes desire onto the client, rather than tracing the origins of the client’s desire back into the client—and even beyond the client, in society.

reduced ability to experience pleasure. In his “memoir of madness,” *Darkness Visible*, William Styron describes how his depression renders him unable to celebrate receiving a prestigious French cultural award; indeed, in his depression, he is not only unable to enjoy the award, but also socially crippled at the reception ceremony. “Instead of pleasure—certainly instead of the pleasure I should be having in this sumptuous showcase of bright genius—I was feeling in a my mind a sensation close to, but indescribably different from, actual pain.”¹⁶ Kathryn Greene-McCreight, likewise, speaks of how, in depressed episodes of her bipolar disorder, “The blue sky, which normally fills my heart, stung my soul. Beautiful things like oriental rugs and good food like bean soup absolutely exhausted me.”¹⁷ Things normally appealing become bland or even repugnant.

Greene-McCreight demonstrates how, in mental illness, the disruption of desire takes place at a very base level; the sufferer does not only disengage from more advanced stages of mimetic desire, where we crave increasing opulence, but also from very simple sensual pleasures like a good meal or a hot bath. The mentally ill unravel the thread of mimetic desire long before it culminates in mimetic violence. In doing so, they deny the trajectory of mimetic desire: deification. Girard writes, “Desire clings to violence and stalks it like a shadow because violence is the signifier of the cherished being, the *signifier of divinity* [emphasis mine].”¹⁸ Human willingness to desire unto the point of violence indicates our obsession with becoming gods. The mentally ill, on the other hand, indicate that we should not aspire toward divinity; it is difficult enough to be human—difficult enough, even, to *desire* to be human. Both Styron and Greene-McCreight discuss how, at the worst moments of their depression, they can understand the temptation of suicide and must constantly struggle to choose to live.¹⁹

The mentally ill, then, have a prophetic relationship to our society. They demonstrate to us that we are not gods; we are human, and being human is task enough for us. I do not mean to ascribe to the mentally ill some sort of automatic virtue—to suggest that they always, or even often, desire rightly. Indeed, their desires can be incredibly warped. Kay Redfield Jamison relates how, in her mania, she “...bought precious stones, elegant and unnecessary furniture, three watches within an hour of one

another...” and, besides these, “twelve snakebite kits.”²⁰ Kathryn Greene-McCreight, whose bipolar disorder first surfaced as postpartum depression, notes her failure, at times, to take joy in her new daughter.²¹ I am also not suggesting that the mentally ill are outside the influence of mimetic desire and mimetic violence. Through no virtue or volition of their own, though, but by the very fact of their affliction, they point us to what right desire *is*, even when they themselves desire so wrongly. Right desire is that desire which confirms our human state and does not grasp after divinity through the exercise of violence. (How ironic it is that desire, which, we recall, Girard claims distinguishes humans from animals, all too often evolves into a desire for divinity marked by violence! Desire can thus both confirm and destroy humanity.)

To a culture that revolves around material accumulation, social advancement, and violent competition, simple desires such as wanting to be able to take pleasure in bean soup or ones children, or wanting to be able to sleep at night, pose serious threats. These simple desires expose the humanity-denying, divinity-aspiring craving at the root of our more sophisticated mimetic desires. Returning to Gilles Deleuze, we can claim that these sorts of desires, which lead to patterns of violence, are products of manipulative assemblages of desire. These assemblages stymie healthful desires by prioritizing desires propagated through uncritical mimesis, even when these desires result in personal or societal harm. In calling these types of assemblages “regimes of madness,” Deleuze points to the fact that it is not only the mentally ill who are mad; society, when it surrenders to mimetic desires at the expense of its own health or the health of its members—and this is certainly the case in mimetic violence—is even madder than the mentally ill. What we see, then, is that mental illness exposes the madness of “sane” society; and, moreover, in the competition toward real health, the mentally ill may be further along than the “sane.”[‡] The only option society has, if it wishes to avoid this exposure and threat, is to “sacrifice” the mentally ill. Their inability to participate in dangerous “machines” of mimetic desire necessitate their scapegoating, if our violent society is to be preserved.

[‡] It is useful to recall the etymology of “sane”; *sanus* means “health,” either physical or mental.

Conclusion

We have seen, then, that mainstream culture lacks the ability to recognize mental illness as suffering because it does not imitate patterns of suffering which we are taught to recognize as painful. Mental illness confounds the established “aesthetic of suffering.” In addition, mental illness is a cog in the wheel of our culture’s desires machine; and the breakdown of this machine threatens to topple a society built on mimetic desire, as ours is. For these reasons, the mentally ill all too often fall victim to scapegoating in the form of stigmatization, mockery, and withholding of sympathy. If we as a society and, in particular, we as Christians, are to take seriously the call to overcome violence, we must strive to treat the mentally ill with compassion instead of suspicion and with care instead of scorn. Until that time, the mentally ill person will continue to feel himself invaded not only by his disease, but also but the antipathy of our violent culture.

¹ René Girard, *Violence and the Sacred* (London: Continuum 2005), p. 175.

² René Girard, *I See Satan Fall Like Lightning* (Maryknoll: Orbis Books 2002), p. 157.

³ *Ibid.*, p. 15.

⁴ *Ibid.*

⁵ *Ibid.*, p. 164.

⁶ *Ibid.*, p. 165.

⁷ *Ibid.*, p. 166.

⁸ Robert E. Kendell, “Why stigma matters,” pp. xxi-xxiii, in Arthur H. Crsip (ed.), *Till Every Family in the Land* (London: Royal Society of Medicine Press 2004), p. xxi.

⁹ Kathryn Greene-McCreight, *Darkness Is My Only Companion* (Grand Rapids: Brazos Press 2008), p. 13.

¹⁰ Hans Urs von Balthasar, *The Christian and Anxiety* (San Francisco: Ignatius Press 2000), pp. 82, 83.

¹¹ *Ibid.*, p. 86.

¹² *Ibid.*, p. 36.

¹³ Girard, *I See Satan Fall Like Lightning*, p 8.

¹⁴ Gilles Deleuze, “Desire and Pleasure,” pp. 122-134, in *Two Regimes of Madness* (New York: Semiotext(e) 2007), pp. 124-125.

¹⁵ Gilles Deleuze, “Four Propositions on Psychoanalysis,” pp. 79-88, in *Two Regimes of Madness* (New York: Semiotext(e) 2007), p. 84.

¹⁶ William Styron, *Darkness Visible* (New York: Vintage Books 1992), pp. 16.

¹⁷ Greene-McCreight, p. 20.

¹⁸ Girard, *Violence and the Sacred*, p. 160.

¹⁹ See Greene-McCreight, p. 45 and Styron, p. 32.

²⁰ Kay Redfield Jamison, *An Unquiet Mind* (New York: Vintage 1996), p. 74.

²¹ Greene-McCreight, p. 25.