POSTMODERN REVERIES:
Expeditions to the Maladaptive Daydreaming World

by

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Thesis submitted to
the Department of Anthropology, Princeton University
in partial fulfillment of the requirements for the degree of
Bachelor of Arts

August 20th, 2022
I hereby declare that I am the sole author of this thesis.

/s/ Alexandra Marino
This project is in memory of my great-aunt, Nellie Rafaela Ruiz. In life and death, Aunt Nellie has shown me the inexorable power of daydreamers. Thank you for helping me making this dream of mine—an education—a reality, Aunt Nellie.
Acknowledgments

This project would not have been possible without the steadfast support of my dean, David Stirk. In the weeks before I graduated from high school, I was in-and-out of the hospital, roaming from specialist to specialist, trying to understand what was happening to my body. For years, I was misdiagnosed, prescribed harmful medications, and was in-and-out of Princeton like it was a well-oiled revolving door. If Dean Stirk had not received my illness narrative with compassion, grace, and open-mindedness, I could very well have missed out on the education of a lifetime. Because of Dean Stirk’s advocacy, I was able to earn my degree at my own pace and leave Princeton satisfied, knowing that I accomplished everything I set out to do. I am told that all incoming freshmen are assigned their residential colleges at random, but I know that Fate placed me in Butler College. Traversing Princeton would have been a doomed quest if it had not been for Dean Stirk clearing my path to the finish line. We did it, Dean Stirk!

I would also like to thank my thesis adviser, Professor Agustín Fuentes. When I was first assigned as Professor Fuentes’ advisee in Fall 2020, I was reeling from six months of food insecurity and bracing for the demands of senior year and post-graduate planning. Not knowing if my body would cooperate during this last leg of Princeton, it became clear that I needed to make new meaning out of my thesis. Under Professor Fuentes’ guidance, I was able to contribute to the Anthropology of Disability and also create the foundation for my own Disability World. In showing me the value of self-reflexive methodologies, Professor Fuentes helped me to cultivate my unique voice, perspective, and ethnographic location. I could not have asked for a better co-pilot on these expeditions than Professor Fuentes.

Of course, every Anthropology major shares the successful submission of their senior thesis with our Extraordinary Undergraduate Administrator, Mo Lin Yee. Tirelessly, Mo Lin keeps us all organized and on-track, by hand-delivering us copies of the Guide to the Independent Work in Anthropology and filling our email inboxes with post-graduate opportunities. Mo Lin has gone above and beyond for me in particular. Over the years, she has diligently coordinated with Dean Stirk, Professor Rouse, and Professor Elyachar to make sure that I had all the necessary accommodations to complete my degree. Thank you, Mo Lin, for always treating me with respect and for cheering me on!

Finally, I owe my sense of belonging in Anthropology @ Princeton to Patricia Lieb, our Wonderous Communications and Events Coordinator. It was such an incredible joy attending bubble tea socials with other Anthropology majors in pre-pandemic times. Whenever I taste Taro tea, I always think of kicking back on the couches in Aaron Burr Hall, getting to know graduate students and learning more about that dreaded senior thesis from upperclassmen. Patty also kept community connections strong during lockdown—I always wear the Anthropology @ Princeton mask whenever I feel fatigued about social distancing. Thank you, Patty, for all that you have given me during these extraordinary times!
Abstract

Maladaptive Daydreaming (MD) is a psychological phenomenon in which affected individuals compulsively retreat to vivid fantasy worlds. In the twenty years since MD was first identified by Dr. Eli Somer of Haifa University, there have been many hypotheses about the causes and functions of this neurodiversity—a coping mechanism to ease post-traumatic stress, a behavioral addiction, a symptom of a congenital neurological condition. Despite its prodigious research canon, MD has not yet been recognized by the American Psychiatric Association (APA). Without the APA’s recognition, it is virtually impossible for MDers worldwide to receive appropriate clinical help, whether that be tailored psychological tools or effective psychotropic medication. This thesis explores MD as a site of intersecting narratives—the personal and collective lived experiences of daydreaming, and one clinician’s struggle for acknowledgement. Envisioned as a contribution to Medical Anthropology, POSTMODERN REVERIES explores themes in cross-cultural psychiatry, post-structural theory, and disability studies.
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INTRODUCTION
My Daydreaming World
I was born and raised in New Jersey. But I truly lived in the infinitesimal and infinite space between pixels.

My passion for television began when I was an infant. I was mesmerized by both the national forecast and my Local on the 8’s. My mother captured a photo of me propped up against my polka-dotted boppy pillow, the technicolored continental US reflecting in my dark eyes. As a toddler, I watched Under the Sea over and over again, hanging onto the plastic blue fence in my playroom for balance as I aggressively head bopped to the soundtrack. After I saw The Matrix, my imaginary friends were clad in leather trenches. We would puncture the air above the swing sets with slo-mo flying kicks.

"What are you doing?" My mother asked me one morning.

I was sitting at the dining room table, a bowl of soggy Cheerios before me.

"You look like you were just talking to someone," she said.

When I became aware of my posture, I realized I had my legs splayed open, one elbow resting on the back of my chair, the opposite hand massaging my glass of milk. Only a moment before, I had been in the diner featured in My Cousin Vinny. Over plates of steaming grits, Vinny and I had been negotiating something very important and lawyerly. What we had been negotiating, I could not say. To be honest, I did not know what negotiating even meant at the time. But I did know what negotiating looked like—you scrunched up your face, you cocked your head to the side, you kept your eyes on the person across from you, nice and steady. I thought I had only been doing this in my daydream. Yet somehow my actions had spilled over into real life. On the way to school
that morning, my mother’s gaze flicked between the road and my image in her rearview mirror.

According to psychological literature, daydreaming is a normal phenomenon (Singer 1966) with as many as 96% of American adults daydreaming each day. This “basic human pastime” (Regis 2013) encompasses useful and beneficial functions (Hartman 1958). We can transform dull, uneventful moments into productive ones by visualizing our to-do lists and the fastest route home. Before drifting off to sleep at night, we can review the day’s key events, assessing what went well and what could have gone better. However, my “fantasy-prone personality” (Wilson and Barber 1981, 1983) allows me to engage in Immersive Daydreaming, which is far more vivid and extensive than what the average person is capable of (West and Somer 2020). Fantastical images have always made a deep impression on me, from animated movies to flashing billboards above the highway. For as long as I can remember, I have been in the habit of internalizing my favorite characters, universes, and lyrics for future exploration. Fantasy-prone persons like myself “live much of the time in a world of their own making” filled with “imagery, imagination, and fantasy” (Wilson and Barber 1981, 31).

Like most people with fantasy-prone personalities, my upbringing contributed to my overactive imagination (Wilson and Barber 1983). My parents are creative and idealistic people, like their parents before them. My family encouraged me to pursue the arts and humanities in school, play imagination games when I was home, and to take full advantage of their DVD collection, often at the expense of doing my math homework. However, my parents would assert that my fantasy-proneness could not be explained by nurture alone. After all, they could see when I was daydreaming. I would engage in
behaviors they deemed socially unacceptable, such as talking to myself, repetitively rubbing my hands along surfaces, and swinging my head in circles. It has been posited that the neurobiological basis for immersive daydreaming is a stereotypic movement disorder (SMD).

Stereotypies are “involuntary, patterned, repetitive, coordinated, rhythmic, and non-reflexive behaviors” (Freeman et al. 2010, 733). Just as everyone daydreams to some degree, everyone engages in stereotypies, such as finger-tapping or hair-twirling. However, those with SMD engage in more amplified stereotypies such as arm-flapping, pacing, bouncing, face-pressing and grimacing, tensing and untensing the body, and vocalizations. Children tend to have their own names for these movements, including “imagination game,” “exercises,” or “relaxing.” During their prolonged stereotypies, children with SMD are often replaying their favorite movies or TV shows. Overall, they enjoy their rhythmic movements and the resulting trance-like states (Freeman et al. 2010, 735). Yet these trances are often a source of concern for parents and teachers. As a result of social conditioning, daydreamers tend to isolate at a young age to avoid criticism, even punishment. In planned privacy, these daydreams acquire the function of increasing positive emotions (Freeman et al. 2010; Pietkiewicz 2018; Somer 2002). In this way, these fantasies are used to escape the very experiences that sustain them: loneliness, isolation, and marginality (Wilson and Barber 1981; Hilgard 1974; Rhue and Lynn 1987).

My childhood was defined by loneliness. Namely, I struggled with an undiagnosed chronic illness and I felt invisible in a social milieu fueled by distrust. In the second grade, I lost complete control over my body. I gained a significant amount of weight. Seemingly overnight, I became severely lactose intolerant, and could not stomach
foods that had been staples in my diet only days before. Every six weeks I developed a whopping sinus infection, with an accompanying migraine that was painful enough for me to see spots. Phantom pains started travelling throughout my body, causing unexplainable inflammation that would vanish before my mother could get me to the doctor. I started to disassociate from my body, which had become illegible to myself and everyone around me. My feelings of alienation were exacerbated by my lack of community. It was very hard for me to make friends, as all social activities were linked to sports that I could not participate in. I started taking long walks by myself at a young age. I would stare at the homes of my neighbors, wondering if any kids lived there. In the 2000s, suburban parents were cautioned against letting their children play out in the yard. Media outlets proliferated statistics about the high-rates of kidnapping and pedophilia—Elizabeth Smart and Jaycee Daugard were case in point.

And so, I built my own world, filled with friends and adventures that were unparalleled by soccer teams or scheduled playdates. In my fantasies, I was brave and bold, but always safe. There I had no uncertainty to contend with. I was in complete control of the universe, the storyline, and my body.

At summer camp, I would cannonball into an aqua chlorine pool, but when I opened my eyes, I was submerged in the eerie, shadowy Enchanted Lake on Hogwarts’ campus. I would swim around with Harry Potter on very important business, the details of which always lacked specificity. Nonetheless, the world depended on our success. I would dodge the cruel mere-people, their pitchforks glistening in my periphery. They would surely attack me were it not for Harry’s protective presence. Looking back on it, these “mere-people” were my fellow campers, who were excluding me from their pool
games. In this way, my daydreams with Harry Potter functioned as a “disengagement from stress and pain by mood enhancement” (Somer 2002, 203). However, my afternoons with Harry did not only make me feel happy and connected. Usually I felt excited, though stressed, worried, and on-guard. My plotlines were inspired by J.K. Rowling’s original writing, yet my imaginings were more intricate and far more graphic than a children’s book. My version of Harry Potter’s mission to save his classmates during the Goblet of Fire tournament were infused with themes of violence, “power and control,” and “captivity, rescue, and escape” (Somer 2002, 205). I was hiding in plain sight, my stereotypies going unnoticed in a crowded swimming pool.

As I approached pubescence, I coveted a different magic: white, feminine beauty. Harry Potter’s world would materialize before me when I repetitively swam in circles, whereas I needed a playlist to meet up with Taylor Swift. These kinesthetic elements allowed me to induce daydreaming, but also to sustain it, like the process of hypnosis (Somer 2002, 208). After listening to the opening chords of any given Taylor Swift song, my body would elongate and flatten until I looked just like her. My time with Taylor provided “companionship, intimacy,” and a “soothing” sensation, one that was both emotional and physical (Somer 2002, 204). My “idealized Self” and Taylor would gallivant in matching princess dresses across the English moors, safe from the paparazzi and the mean girls who did not understand us (Somer 2002, 203).

Although I took visual inspiration from her music video for “Love Story,” the true magic was in her deep cuts. I would make myself cry from the visuals I immersed myself in. The volatility of “The Way I Loved You” was balanced with the gentility of “Enchanted,” allowing for a seamless transition from a lovers’ quarrel in a parking lot to
a candlelit ballroom. “Mary’s Song” emplotted the seeming minutiae of my suburban existence into a tightly woven family saga set in a town that looked an awful lot like Stars Hollow, the setting of the popular television show *Gilmore Girls*. “Invisible” cued a different life in this storybook town, where I would silently float around the square in an ethereal dress when I was not writing poetry in solitude. In these various “wish fulfillment fantasies” (Somer 2002, 203), I was avoiding real friendships, which at this point in my life were attainable. As opposed to the dramatic conclusions to my swims with Harry, the playlist would end unceremoniously and I was relieved to be free from any commitment, demonstrating my “fearful-ambivalent attachment style” (Sandor et al. 2021). We see here how the fantasy-prone can try on lifestyles, jobs, and relationships for size with no consequences in the real world (Mooneyham and Schooler 2013; Regis 2013). Because these relationships and lifestyles were not real, the positive affect I was left with after each daydreaming session did not last more than twenty-four hours. At the end of each day, I became antsy, overwhelmed by my craving for privacy, darkness, and my iPod (Soffer-Dudek et al. 2020; Bigelsen et al. 2016).

I thought everyone lived like this—spending four-to-five hours a day daydreaming.

Slowly but surely, I stopped excessively fantasizing. I built a life worth living, a life that I wanted to fully participate in rather than escape from. I went to a new school district for high school, where I made friends and took classes that inspired me. I never did stop daydreaming, though, as one does not “grow out” of fantasy-proneness or a stereotypic movement disorder (Freeman et al. 2010). I just used my imagination in a more generative way. It was a vision board that I could summon at will. I would visualize
my success whenever the odds were against me. When my dad went to jail and my mom had no money to pay for college, I saw myself rushing to class on the Princeton University campus with the peace of mind only a full scholarship would allow. Through these visualizations, daydreamers can think out of the box and solve problems with resources that might not be available to them (Killingsworth and Gilbert 2010). Two years later, when I had to take a medical leave from Princeton, I envisioned myself walking at graduation, perfectly healthy. In this way, daydreaming gave me a positive outlook on life and kept my goals alive. For most of my young adulthood, I had been engaging in “positive-constructive daydreaming,” in which “creative, playful, planful thoughts” become vivid and detailed scenarios that one can act upon in real life (McMillan et al. 2013).

In 2020, my daydreams transformed into something quite different.

Solitude was the least of my worries when the Princeton University campus was evacuated. Now that COVID-19 was the top priority of the medical field (understandably so), my rare health condition and the recent advances made towards effectively treating it were put on hold. At this stage in my illness, my eyes had become the biggest source of concern. Hours of Zoom classes on top of typed writing assignments had precluded me from performing at my best and participating in social activities. Living in Emergency Residency on a nearly deserted campus restimulated memories of wandering around my neighborhood alone. With no family to rely on and no safety net other than Princeton, my life became defined by uncertainty.

Luckily, I had my daydreaming world to rely on, and I emplotted a future that showed me I had overcome the challenges of 2020. I had always been able to consciously
“set the theme” of my fantasies and they would unfold before me and around me, like I was both watching and participating in a movie (Wilson and Barber 1981, 142). Although I technically knew what was going to happen, I was still shocked when stimuli came zooming my way and excited when other characters spoke to me. However, when I would hit play on my “Quarantimes” playlist, I experienced a different daydreaming world altogether.

The synth-pop of Tame Impala carried me away into a dreamlike atmosphere, a setting I had not previously planned out. For the first time in my life, my daydreams were not cinematic, as there was no plot and no interactions between me and other characters (Wilson and Barber 1981). The psychedelic beats and soaring rifts built a new world for me, several years in the future. I was a graduate student in a library with a domed, stained-glass ceiling, not unlike Princeton’s Chancellor Green. However, this library was at least ten times the size, its carrels spiraling into the clouds, my friends seated at each of them, all of us typing away at our dissertations to the beat of the music. COVID-19 was merely a blip on our timelines. Although I enjoyed this dream-like atmosphere, I felt very disconnected from it, like I was in someone else’s daydream. It was as though the visuals had been cut from deep, disparate sections of my memory (my time at Princeton and fantastical images from my childhood, respectively) and now they were spliced into a world that was not meaningful to me. Logically, I knew that I was the architect of this new world— who else could it be? Yet somehow my agency as the world-builder had been obscured.

As the pandemic raged on, I continued to lose agency over real life as my health deteriorated. In Fall 2020, not only were my eyes inflamed again after another Zoom
semester, but my lung functioning had also weakened. With hospitals overflowing with COVID-19 patients, my prescription was more rest—lying down in a dark room, conserving as much energy as possible. This was a Herculean effort, as my to-do list was burning a hole in the back of my mind. I had coursework to complete, projects for various student jobs, internship and fellowship applications, not to mention my senior thesis. This was a make-or-break point in my Princeton career, and my inability to work towards my goals generated feelings of guilt, stress, and helplessness. Daydreamers like myself are prone to experience emotional distress more acutely than those who do not have such vivid imaginations (Rauschenberger and Lynn 1995; Giambara and Traynor 1978; Singer 1966, 1975).

My daydreams started enhancing my negative emotions rather than soothing them. During periods of prescribed rest, I found myself in a bright, airy room, sitting at a sleek desk, my senior thesis illuminated on my computer screen. It was as though my mind’s eye was taunting me, showing me what I could be doing if only I was in a different body. Pathological daydreamers do not have as much control over the nature of their thoughts as “normal” daydreamers do (Christoff et al. 2016). Like positive-constructive daydreams, pathological daydreams are also intense, all-encompassing experiences, but they require distressing levels of emotional involvement. When I emerged from this daydream, I felt worse than I had before. Pathological daydreams are always upsetting and for some they are intrusive, not unlike hallucinations.

I experienced such an intrusion in late June 2021 when I was invited to an outdoor reunion with a large group of friends, many of whom I had not seen in over a year. I debated whether I should go. Even after I committed to attending, the debate continued. I
envisioned scenarios in which I was ridiculed, my friends citing details about my life over the past year as evidence for their taunting. Why are you so lazy? my friends inquired in my daydream. Everyone else was far more productive this year. You’re going to flunk out of Princeton with this attitude. Here I was “rehearsing” what I “anticipated” were going to be “discouraging…dialogues,” which included “betrayal by seemingly trustworthy acquaintances” (Somer 2002, 207). Even when I would realize that I was daydreaming, it was difficult to detangle myself from these nightmarish scenarios. It was like playing mental Whack-A-Mole. As soon as I would swat at one friend with reason and logic, another would appear wielding another insult. My experience can be best described as “guilty-dysphoric daydreaming,” in which one obsessively fantasizes without enjoyment (Singer 1975). It is akin to a visual form of rumination, negative thoughts boomeranging throughout the day.

I was now caught in a “negative feedback loop” with my daydreams. Like other distressed subjects, the more I daydreamed and ruminated, the more evidence I had that self-bullying was warranted, which only sustained the cycle (Gold and Minor 1983; Starker 1982). My door handle seemed to be a trigger. Whenever I was about to leave my room, I would be roped back in. Once the scenario appeared in my mind’s eye, I was compelled to engage with it. On the day of the reunion, I got so worked up that I left my room later than I should have, and nearly turned around several times as I made my way through campus. When a woozy cicada torpedoed into my nose, I was brought back to the present. I was flooded with my real thoughts, which had been buried underneath the daydream: Would I ever be able to write fluently again? Would I get into graduate school? Did I still have a future?
When I finally arrived at the gathering, my daydream could not have been further from the truth. My friends showered me with love and socially-distanced affection. It was clear now that they admired, and always had, my determination and plasticity. They wanted to know how I had survived living alone during the pandemic, with a disability no less. They would have gone crazy.

“What is the secret to your greatness?” someone called from down the table.

I pitched them my senior thesis on Maladaptive Daydreaming.
CHAPTER 1
The Maladaptive Daydreaming World
It was not my intention to write my senior thesis on Maladaptive Daydreaming.

When I began my Senior Seminar in Anthropology, a workshop-based course designed to help students get their research off the ground, I felt like I was lost in space. It was September 2020, and for the past six months I had kept a series of journals titled, “Meditations from Planet Lockdown.” In my Senior Seminar, I pitched my fellow writers the three main topics and potential research questions I had been mulling over: 1) The normalization of disassociation during lockdown; the abstraction of physical place, the overcrowding of virtual spaces, and our collective lived experience of absence. Where do we draw the line now between mental health and illness, neurotypicality and divergence? Who has the power to validate subjective distress and/or psychological difference in such extraordinary times as these? 2) Living with a rare disease during a pandemic. How well does my lived experience translate? What story are my friends, professors, supervisors, and deans able to receive from their perspectives as able-bodied individuals? Is my lived experience legible to others? 3) Disability and belonging. What is disabling—the body and/or mind of the person deemed disabled or the societal contexts that bar certain bodies and minds from full participation?

As an afterthought, I mentioned to my Senior Seminar that I recently learned about this phenomenon called Maladaptive Daydreaming and I’ve been doing it for as long as I can remember. Out of all my potential topics, my fellow anthropologists were most stimulated by my doorknob confession. The linguistics alone could be its own thesis topic, several classmates expressed, A word like maladaptive had such a moralizing valence. At the same time, daydreaming is such a relatable experience, but what I was describing seemed foreign to my peers. They wanted me to defamiliarize the familiar.
What is daydreaming, anyway, and how can you do it for hours on end? What does it look, sound, and feel like? How can a doctor diagnose it? Do they have to know how to daydream too?

That night I wrote the first draft of the Introduction to this thesis on Maladaptive Daydreaming, in part answering my cohort’s questions while also exploring the themes from my time on Planet Lockdown. Without fully realizing it at the time, I had crafted a performative account of my fantasy life. Here I define performative as a series of “meta-actions,” in which I was giving a creative account of my daydreaming world through a psychological lens, and in doing so I was offering a “critique of taken-for-granted assumptions” about psychiatric diagnoses (Martin 2009, 59, 80). I argue that our conceptualization of a diagnosis needs to be reframed. A diagnosis is not a physical reality that exists within a person, but rather it is a narrative tool, a means of providing language for an otherwise incommunicable experience. In short, a diagnosis makes an illness legible.

I, like almost all Maladaptive Daydreamers, had had to turn to the internet in order to diagnose myself with this mental disorder. Although this phenomenon of “excessive fantasizing activity” was identified in 2002, Maladaptive Daydreaming (MD) is still not included in the Diagnostic and Statistical Manual of Mental Disorders (Somer 2002). Published by the American Psychiatric Association, the DSM sets the global standard for categorizing and treating discrete psychological disorders. In 2013, Maladaptive Daydreaming was excluded from the DSM-5, the most recent edition, but this was not for a lack of trying. Dr. Eli Somer, the Father of Maladaptive Daydreaming, has devoted the last two decades of his career to MD. Somer trained as a clinical
psychologist, specializing in trauma and dissociative disorders. In 1992, he joined the faculty at the University of Haifa’s School of Social Work, where he continued to work with trauma survivors. Ten years into his tenure there, Somer published a series of case studies about his patients’ compulsive daydreaming.

For some time, excessive fantasizers had been sifting through Google, searching for a sign that they were not alone—“Maladaptive daydreaming: A qualitative inquiry” was the first adequate description of their lived experience. Somer’s inbox became flooded with people who needed help and he answered their call. Although retirement was in sight, Somer began his second act. Since 2002, Somer has remained at the vanguard of MD research, often listed as the first or second author on publications.

The International Consortium for Maladaptive Daydreaming Research, an open-source website, contains Somer’s cannon. Here I found the psychological literature I cited in the previous section. In addition, I availed myself of Somer’s Maladaptive Daydreaming Scale (MDS-16), which I used to diagnose myself. Like scores of MDers before me, I recognized my story in Somer’s writing. There are many ways to describe the relationship between Somer and MDers—a grassroots movement, a patient-directed research niche (Casaflores 2017). As an anthropologist, I would describe the relationship between MDers and Somer as a co-production of narrative. MD research has been sustained by the rapport between MDers and Somer—Somer takes their fantasies seriously and in turn MDers trust that he will properly represent their stories in his research.

In my own experience of writing the Introduction to this thesis, I found that the clinical diagnosis of Maladaptive Daydreaming served as a narrative framework onto
which I could emplot my lived experience. As a fantasy-prone person, I am naturally gifted with robust and prodigious world-building capabilities. However, Maladaptive Daydreaming research has made my experience legible to other MDers and vice versa because we have a common narrative framework onto which we can emplot the idiosyncrasies of our inner worlds. I argue that this diagnostic emplotment—the translation of an incommunicable lived experience into a legible narrative—is a form of world-building all onto its own. Moreover, this common narrative framework provides an opportunity to belong to an international community of people who identify as MDers.

The matter of belonging was one of my primary misgivings in committing to this thesis topic. Although I reached the diagnostic threshold of MD, I did not identify as an MDer. But if I wasn’t an MDer, then what was I? In order to fully understand my relationship to MD, I utilized Anthropologist Marilyn Strathern’s definition of hermeneutics, the process of understanding The Self by defining The Other (1987). I understand myself as a fantasy-prone person, someone who has greater imaginative capabilities than what Western culture deems appropriate for an adult. I am a Fantasy-Prone Self because there is a Maladaptive Daydreaming Other, a fantasy-prone person who has integrated Somer’s diagnostic criteria into their identity. At the same time, the concept of fantasy-proneness only exists because there is the Non-Daydreaming Other. Furthermore, there is the Immersive Daydreaming Other who has far more control over their fantasy life than I or MDers do. In short, I am both an insider and an outsider in the Maladaptive Daydreaming community, straddling the boundaries it shares with other populations. Although it is perfectly appropriate for an anthropologist to study a
community where they are an insider, an outsider, or something in between, I was uneasy in this liminal space I occupied.

This uneasiness spoke to my own bias, which was the other impediment I faced before I could commit to this topic. I reasoned that daydreaming was not real and, therefore, it was not as important, relevant, and scholarly as other topics I could explore. I viewed my own life through this neurotypical lens as well. I was simply embarrassed that I still had a fantasy life as an adult. I shielded myself with a socially acceptable, concretized reality—my somatic illness, Princeton’s deadlines, my doctors’ diagnoses—only to have this defense dissolved by my imagination. I worked diligently to define the Maladaptive Daydreaming World for my own purposes, placing it aside in the hopes that I could keep it separate from The Self and The Real I had constructed. However, the more distance I tried to put between myself and The Maladaptive Daydreaming World, the more it collided into me, until I found myself totally immersed in it. In this world, I simultaneously had the perspectives of an omniscient architect, a veteran local, and a newcomer unsure of my next move. In other words, I was in a more fascinating ethnographic location than I could have ever planned for. When I wrote the proposal for my virtual ethnography on the Maladaptive Daydreaming World, I realized I had not chosen this research topic, rather it had chosen me.

I knew from the first draft of my Institutional Review Board (IRB) application that this project necessitated a methodological intervention. I was puzzled by how I was going to conduct my ethnographic research and where my field site was\(^1\). Online? Would this purely be a literature review? An autoethnographic study? Before I could fully

\(^1\) Although Princeton allowed students to travel domestically for their senior thesis research during Summer 2021, I chose not to travel due to my immunocompromised status.
develop my methodology, I had to become a cartographer and map out the Maladaptive Daydreaming World. In breaching this uncharted territory, I utilized Anthropologist Emily Martin’s “expedition” methodology. In her semi-autoethnographic book *Bipolar Expeditions*, Martin set out to learn about both the lived experience of those diagnosed with Manic Depression and the American mythos of bipolarity.

As a Manic Depressive herself, Martin had an insider’s take on psychopharmacology and the patient experience. In addition, she lived the paradox of balancing a severe mental illness that implied irrationality with a demanding professorship that connoted rationality. Rather than conduct a “deep dive” participant observation in one setting, she went on short “excursions” to a variety of settings, both physical and imagined ones. By comparing expressions of mania in outpatient support groups in California’s affluent Orange County with those among patients locked in one of Baltimore’s infamous psychiatric wards, Martin was able to identify a paradox that affects every Manic Depressive. Each patient is deemed as “unique,” yet the common diagnosis “neutralizes” difference in socioeconomic status and race.

Martin also attended pharmaceutical conferences to compare the scientific explanation of mania with the commodification of mania in advertising campaigns and medication branding. By analyzing images and slogans which are displayed on billboards, featured during commercial breaks, and printed on free pens given out at doctors’ offices, Martin offered a new definition of mania. Mania is not merely an unexplainable fit of insanity that “overpowers a person entirely”, but rather it is a culturally meaningful way of being that is key to survival in a highly competitive and individualistic capitalist state. Although Martin describes her methodology as a “modest
sampling” of several field sites, clearly this is an effective tool for identifying cultural narratives that fuel tacit agreements in physical places and necessitate the creation of third spaces (Martin 2009, 30-31).

On my virtual expeditions, I aim to plot the cultural narratives that sustain the Maladaptive Daydreaming World. The International Consortium for Maladaptive Daydreaming Research (ICMDR) not only helped me to map out my own MD World from a psychological perspective—charting its various themes and functions, remissions and triggers—it also presented me with the landscape of what I define as the Maladaptive Daydreaming World at large. The Maladaptive Daydreaming World straddles the terrains of the real and hyperreal, and its topography is composed of three intersecting axes: the Personal, the Social, and the Clinical. The Personal Axis is the negotiation between the individual MDer’s lived experience and the MDS-16. The Social Axis defines the parameters of belonging in the MD World, a now ever-changing threshold dividing MDers, Immersive Daydreamers, “normal” daydreamers, and those who want to appropriate the MD identity. The Clinical Axis elucidates the power-imbalance between the American Psychiatric Association and Somer, calling into question why the DSM sets the global diagnostic standards at all.

I was inspired to divide The Maladaptive Daydreaming World by this triad after reading the work of Medical Anthropologist Arthur Kleinman. In his seminal book *The Illness Narratives*, Kleinman argues that the doctor-patient paradigm in individual medicine fails to effectively treat illness. Kleinman describes illness as personal experience. Symptoms do not only affect the body, but also the patient’s psychological life by hindering the fulfilment of vocational commitments. In response to falling out of
step with societal expectations, the ill person experiences a variety of psychological states: “grief,” “shame,” and “dangerously declining self-esteem.” These “illness problems” are presented to a doctor, but practitioners are not trained to receive the nuances of these narratives. Doctors specialize in disease, which is the “biological rendition” of illness.

From the biomedical perspective, disease is merely “an alteration in biological structure or functioning”. This very “narrow” view of symptoms can sometimes be an “enormous success,” mainly when symptoms correlate with an acute problem that can be fixed, such as a broken bone or an arterial blockage. Yet, when illness is chronic, the disease model is a “failure.” The patient’s psychological anguish, their family’s frustration, and the “conflicts” and “crises” generated in their community’s perception of illness goes “undiagnosed and unaddressed” (Kleinman 1988, 5-6).

Just as Kleinman’s definitions of illness and disease are inextricably interwoven while simultaneously existing as asymptotes, I believe that the three axes of the Maladaptive Daydreaming World demonstrate that a diagnosis has everything and nothing to do with the lived experience of illness. An MDer cannot make their lived experiences legible to others without diagnostic emplotment tools. MD communities are built upon the agreement between fantasizers that the MDS-16 is the appropriate narrative framework. Of course, there would not be any MD communities without Somer’s research, and Somer’s research would not be so robust without fantasizers advocating for him to be their storyteller. The diagnostic criteria of MD circumnavigate this globe, though it is unable to fully elucidate the singularity of each individual MD
world. The lived experience of MD existed long before there was a common language for it; the diagnosis gives this phenomenon form, not birth.

This is why Maladaptive Daydreaming needs an anthropological perspective. While the discipline of Psychology is more concerned with what makes one form of psychological difference discrete from other forms of difference, Anthropology is more concerned with how those who deviate from established normative behaviors make meaning out of their difference. As an anthropologist, I can ask questions that a psychologist cannot. While in the Personal Axis, I want to learn more about how MDers’ make meaning out of their ability. Specifically, what does the word “Maladaptive” mean to them? Once in the Social Axis, I want to understand what it means to belong to the MD sub-community on Reddit. How do these MDers relate to neurotypicals? How has “social distancing” affected how they relate to the various worlds they belong to, are stranded in, or are trying to return to? Finally, from the Clinical Axis I hope to determine whether Somer is an insider or an outsider. What is the motivation in seeking recognition by the APA? How do other MD researchers conceptualize this phenomenon?

At the same time, I maintain that the discipline of Anthropology will be enriched by research on Maladaptive Daydreaming. This topic provides an opportunity to augment the intersection of the Anthropology of Disability, Medical Anthropology, and Psychological Anthropology. Disability Studies and Cross-Cultural Psychiatry have often been subsumed within Medical Anthropology. I believe that this subject will allow for these literatures to build upon each other, but also stand taller in their own right. Specifically, through performativity I am demonstrating the value of disabled ethnographers. As a disabled anthropologist who is studying one of her own disabilities, I
am able to enter field sites that are illegible to neurotypicals, filling a scholarly gap and social blind spot.

I envision this map as a springboard for a monograph where I debut a methodological intervention, Participant Daydreaming, which would allow me to utilize traditional ethnographic methods while co-daydreaming with my interlocutors. This thesis can also be viewed as a theoretical toolkit, the Maladaptive Daydreaming World demonstrating the functionality of narrative in individual medicine, collective disabilities, and the psychopharmacological powers that be.

In the following chapters, I will explore each of these axes and their intersections, using visual data, personal narratives, and case studies as my guides.
CHAPTER 2
The Personal Axis
The mission of the International Consortium for Maladaptive Daydreaming Research (ICMDR) is “to promote scientific knowledge on MD” primarily through psychological and epidemiological research (“Our Mission”). However, Somer also considers the MDer’s lived experience to be empirical evidence. As a result, the ICMDR’s website is a balance of science and narrative. In exploring the visuals in the two poles of this site, I will establish the relationship between this clinical diagnosis of MD and its various narrative forms.

The Maladaptive Daydreaming Scale (MDS-16) is a 16-item questionnaire, each question pertaining to a key symptom of MD. Figure 1, the latent structural model of the MDS-16, demonstrates how the four main factors of MD interact with and build off each other, culminating in sixteen typical behaviors. The “Yearning” symptoms speak to the addictive quality of MD. “Impairment” demonstrates how these cravings cause dysfunction in the MDer’s life by interfering with necessary tasks and other preferred activities. The “Kinesthetic” elements reflect how MDing is a robust physical activity. “Music” was most recently added (transforming the MDS-14 into the MDS-16). Music often initiates and sustains daydreaming sessions, yet, as we can see from the structural model of the MDS-16, there is not one clear trigger of MD (Soffer-Dudek et al. 2020).

This is why I argue that the MDS-16 is a frame narrative. Each MDer has a unique experience of these four universal factors, culminating in vastly different daydreaming worlds. A virtual gallery on the ICMDR’s website showcases drawings and essays produced by MDers, which contain intimate details of their inner worlds, their metaphors for daydreaming, and their personal manifestations of the four factors on the MDS-16 (“Maladaptive Daydreaming Art”).
Figure 1. The Latent Structural Model of the MDS-16

Figure 2, “The experience of movement during MD” represents this anonymous artists’ Kinesthetic Elements. We can see how embodied daydreaming takes on many forms: laying prostrate on the floor; leaping through the air; curled up in a fetal position; playing for an invisible mezzanine; standing motionless, rigid yet contorted — here the figure’s torso, arms, and feet face in different directions. I found this depiction of Kinesthesia to be noteworthy because the artist utilized multiple perspectives. Here we view MDing through a Neurotypical Gaze (an outsider’s evaluation of a body MDing) and we also get a glimpse into the lived experience of daydreaming. The sprinkling of disembodied heads and appendages demonstrates how this MDer lives at a distance from their body.
The artist of Figure 3 describes this as a “Dissociated Experience.” We can see how the artists embodies several Ideal Selves in her daydreams—very fashionable women with a variety of haircuts and outfits, each exuding a distinct persona. However, a young girl, perhaps a younger version of the artist, is suspended at the intersection of these daydreaming worlds, staring hauntingly at the viewer. This artist’s “Dissociated Experience” is inextricably linked with Yearning—for material wealth and a multiplicity of lifestyles, for connection with others and an integration of the Self.

“Grey reality vs. colorful fantasy” (Figure 4) demonstrates other facets of Yearning. This artist uses her daydreams to escape the limits of reality, finding community with Tinkerbell and the Seven Dwarves. We can see why this fantasy is preferable over real life, where the daydreamer is depicted as a walking shell, in drab clothes reminiscent of a prison uniform.
Maria Elena Sampietro, one of the few artists who chose to identify herself, also grapples with Yearning in “A representation of MD” (Figure 5). Sampietro’s MD Self, a small woman with noticeably less sensuous features (thinner eyebrows and lips), serves as her third eye. Through this third eye, Sampietro can see a world that sends her corporeal form into a trance. With eyes closed, lips slightly parted, and head tilted, we can see how she is moved to sway rhythmically. This is a key depiction of the craving for the transcendent and spiritual experience of daydreaming.

“Blind to the outer-world” (Figure 6) shows a much darker representation of the all-encompassing daydreaming experience. The daydreamer is trapped in a liminal space, unable to claw their way out because they do not have fingers. We can see how their body’s energy, represented by stripes of color, pulses around them, confined in a tight orbit. This daydreamer is unable to take action in the outer-world, which they cannot see,
but they know it exists beyond the veil. This is a depiction of Impairment due to MD. MDers often find it impossible to stop daydreaming, even when the stakes are high and vocational, educational, and interpersonal responsibilities are on the line.

Warisha Khan describes her Impairment in verse. The only poem published on the ICMDR, Khan depicts how she is no longer able to control her daydreams now that her personhood has become inextricably linked to her daydreaming Selfhood. Khan plays with the various connotations of the word “Characters” by demonstrating how she feels disconnected from her personal values (her character) yet her daydreaming Selves (her fictional characters) are always present. After years of “Running from reality” she wonders, “…how do I escape/From my escape?”
The three original factors of the MDS-14—Kinesthesia, Yearning, and Impairment—covered the metaphysical and physical aspects of daydreaming. The drawing, “How the song ‘Somewhere over the rainbow’ triggers my MD” (Figure 7), demonstrates how Music plays a key role in MD. The artist does not merely hear “Somewhere Over the Rainbow”, rather they experience it. The feelings elicited by this song provide them with a blueprint for a daydreaming world that is fantastical like the classic film *The Wizard of Oz* from which the song originates. However, this daydreaming world, like any other, is ultimately a unique mixture of various forms of imagery the daydreamer has consumed throughout their lifetimes.

Although “Tranquility” (Figure 8) does not explicitly mention Music, this artist’s depiction of their daydreaming world hazes like an impressionistic soundscape. While no Idealized Self is portrayed here, the daydreamer’s consciousness is implicit throughout.
This daydreaming world is not only an escape from the real world, but also an escape from one’s orientations to the real, allowing for complete unity with an affect. This is how many MDers experience music— a third space where they can just be.

In addition to works of these largely unknown artists, the ICMDR showcases Maria Casaflores’ 2017 BuzzFeed essay, “I Lost Decades in a Daydream,” which has since then become a seminal work in popular MD discourse. Casaflores, a Toronto-based artist and MDer, demonstrates how she was emotionally and socially crippled by MD. She spent most of her thirty-four years in a reality where her wildest dreams of becoming a Hollywood star, a memoirist, and a bakery owner had already come to fruition.

With unabashed candor, she describes how she manifests the four factors of MD— the catalytic role of music; the vigorous kinesthetic elements; the yearning for connection that outweighed her interest in real people; and the impairment that led to inaction to advance her goals, even as opportunities abounded (Casaflores 2017).
I was struck by how much I saw myself in the ICMDR’s virtual gallery.

The artists and writers featured above appear to be cis-gender women, and most, if not all of them, are white-bodied. Our daydreams have been heavily influenced by the Disney corpus throughout the 20th century—equal parts Western fantasy tropes and heteronormative romance. We are also well-educated, evidenced by our writing capabilities and gestures to various artistic movements in our work. We are not afraid to be emotionally vulnerable, openly admitting to being lonely and self-aware, as well as nostalgic and expectant.

We not only utilized the MDS-16 as a frame narrative to tell our stories, but it appears we represent a prototypical illness narrative.

In “Culture and Psychopathology: Directions for Psychiatric Anthropology,” Byron R. Good argues that the DSM’s diagnostic criteria and prototypical illness narratives are equally important in clinical settings. Good draws upon Roy D’Andrade’s research demonstrating how our “cultural organization of knowledge” is based upon prototypes, the most general or common form of any given concept. Professionals in psychology might argue that they diagnose based on the objective criteria listed in the
DSM, which has been vetted through an arduous peer review process. Nevertheless, a clinician’s cognitions, like anyone else’s, is steeped in prototypes. Prototypical narratives allow us to make connections between our a priori knowledge and the current information before us, helping us to feel confident in our decisions and judgements. Yet we are often not fully aware that the cultural narratives that surround us—advertising campaigns, political slogans, fictional characters—heavily inform our subjective experiences and the resulting knowledge we hold to be true (Good 1992).

Good illustrates how the prototypical illness narrative for Panic Disorder was constructed by Dr. David Sheehan’s 1983 book, *The Anxiety Disease*. Sheehan, a psychiatrist then based at Harvard Medical School, provided questionaries to help readers determine if their anxiety was the result of “normal” stress or if they were suffering from the genetic, chemical imbalance called Panic Disorder, which had recently been inducted
into the DSM-III. Sheehan included a case study to illustrate how panic disorder develops suddenly and unprovoked, like a heart attack or stroke. After all, Maria, the prototype, had everything a young woman her age could want: a college degree, a boyfriend, good physical health, and enough financial security to eat at restaurants, plan vacations, and regularly shop at the mall. Therefore, her spontaneous spells of terror and dizziness met the primary criteria listed in The Diagnostic Interview Schedule—feeling “frightened, anxious, or very uneasy in situations when most people would not be afraid.”

Good argues that this diagnostic criterion contains “an ideological construct” in its assumption that there is a normative human experience, as implied in the wording “most people.” A prototypical illness narrative is not only a list of symptoms, but also a belief system that “reproduces conventional knowledge about social relations in American society,” in which everyone is white, heterosexual, able-bodied, and, at the very least, middle-class (Good 1992, 193). In his own ethnographic research, Good interviewed patients at a clinic that served residents of a low-income, urban neighborhood who met some of the symptomatic criteria for Panic Disorder. However, their paralyzing attacks of terror did not appear spontaneously like they did for Dr. Sheehan’s Maria. Their histories of physical and sexual abuse, childhood neglect and abandonment, as well as familial cycles of addiction and passive suicidality, provided context to their hypervigilance and sensitivity to threat. In addition, several interviewees were currently homeless and regularly experienced feeling afraid for their lives. How the APA would expect Most People to respond to such situations is unclear.

Here we can see how the APA’s ideological constructs are exclusionary norms that simultaneously create The Other and silence their lived experiences. Although Good
does not specify, his interviewees were most likely persons of color, as his field site was a classic setting for American racial imaginaries—inner city neighborhoods filled with halfway houses and Medicaid clinics, where crime and drug use abounds (Washington 2006). This is not the setting where Most People like Maria are working hard to maintain their wellness and despite their best efforts, they succumb to a sudden spring of disease. However, for those who have been systemically oppressed, their psychopathology exists within the community, not the individual. Therefore, they are excluded from individualized medicine, and all too often are moralized for the same behavior that expressed in Most People elicits compassion and necessitates treatment.

I can foresee a similar clinical scenario playing out for MDers. Suppose Maladaptive Daydreaming was included in the upcoming DSM-VI. If I were to describe to a psychiatrist how I, a white-bodied, Ivy-League educated woman, have compulsively fantasized about being a famous singer, a mermaid, and doing my homework in a levitating library, I would fit both the diagnostic criteria and the prototypical illness narrative of Maladaptive Daydreaming as it stands today. However, if another young woman were to describe to the same psychologist how she spends eight hours a day fantasizing about “kill[ing] scores of people” and “taking great pleasure in tormenting them, both mentally and physically,” she may fit the diagnostic criteria of Maladaptive Daydreaming, but her narrative is not prototypical for this condition.

Because she feels “so powerful” in these “sadistically violent” fantasies, the content of her fantasies might overshadow the fact that she is fantasizing at all—like the proverbial missing of the forest for the trees. Based on her grandiose beliefs and homicidal urges, diagnoses of bipolar mania or narcissistic personality disorder could be
justified, though they would entail a far different treatment protocol, not to mention
social stigma, than MD.

This is rather ironic because the latter example I described was one of Somer’s
original research participants (2002, 204-205). At the age of nine, she was raped by a
family member and uses daydreaming to cope with the trauma. Although this woman’s
story laid the groundwork for the MDS-16, her lived experience as an MDer might very
well be illegible to a clinician who has thoroughly perused the ICMDR’s art gallery and
read Casaflores’ essay on BuzzFeed. First and foremost, this MDer’s survivorship
contradicts the innocence and childlikeness connoted with daydreaming. In addition, she
challenges gender roles by taking on a position of power in her MDs.

This underscores how prototypical illness narratives are “far more powerful
rhetorically than are diagnostic criteria” (Good 1992, 191). Casaflores echoes a similar
sentiment when she writes that the APA “will soon recognize MD as a disorder and list it
in the DSM” because of “positive voices like Dr. Somer’s and the online communities
that are building around this condition” (2017). However, as we can see from the above
examples, diversity rather than quantity of voices will be key in assuring that all MDers
are recognized.

Following Casaflores’ trail, I pivoted from the Personal Axis to the Social Axis
and set my sights on the MD communities on social media. I returned to the ICMDR’s
website to get my bearings and to make an informed decision about which virtual
platform would be most pertinent for my map.
CHAPTER 3
The Social Axis
By providing links to several virtual MD communities, Somer and the ICMDR team have made it possible for an MDer to diagnose themselves and find peer support all in one sitting. MDers are represented across a wide-range of sites catering to a variety of demographics—from the classic Facebook to the ever-increasingly popular Discord. There is even a chatroom that is exclusively devoted to MD, Wild Minds Network. For the purposes of this project, I chose to explore the MD sub-community on Reddit because I believe that in today’s social media landscape, Redditors are the most concerned with cultural narratives, identity politics, and the tension between subjugated knowledge and official knowledge.

Founded in 2005 by two college students, Reddit was envisioned as the “front page of the internet”, a snapshot of current events. The name is “a play on the phrase ‘I read it,’” the elision of syllables meant to demonstrate the warp speed at which Redditors can become up to date on the news. However, Reddit is ultimately a “social news site,” meaning that the headlines are meant to be interacted with (Schmidt 2010). The allure of spending time on Reddit is not so much about reading the news. Rather, the appeal lies in the consumption of world views, in surveying other users’ subjective interpretations about the causes and effects of objective events (Proferes et al. 2021). Sub-communities allow like-minded Redditors to construct their own realities based on shared subjectivities (Niezgoda 2018). In subreddits, agreed-upon cultural narratives dictate who belongs to one subreddit as opposed to another.

At the outset of my expeditions, I expected that the MDS-16 would be the common narrative framework stitching the MD subreddit together. After my expedition to the Personal Axis, I hoped that this subreddit would be a diverse and inclusive
platform, but I was prepared to find a prototypical narrative that erased difference. In
addition to my data on MD and narrative, there were other historical, social, and political
contexts to consider before I embarked for the Social Axis.

The MD subreddit, formally known as r/MaladaptiveDreaming, was created on
October 14th, 2013. Nearly a decade later, the mission statement has not changed: “We
are a community support sub dedicated to individuals suffering from Maladaptive
Daydreaming and helping them cope with the condition.” As of July 2022, this
community is now encroaching upon 90,000 members. Since the start of the COVID-19
pandemic in March 2020, Google searches for Maladaptive Daydreaming have
skyrocketed. Researchers posit that lockdown orders triggered higher rates of compulsive
fantasizing, even among those who previously had no problem controlling their
daydreams (Somer et al. 2020). In light of these circumstances, I hypothesized that the
community dynamics of r/MaladaptiveDreaming changed significantly during quarantine.

However, I suppose the same could be argued for all social media platforms
during this unprecedented time. Due to social distancing practices, timely conversations
about social justice were relegated solely to online spaces. Such conversations concerned
health disparities and other forms of structural inequalities in wealthy nations, namely the
United States. Although these hierarchies have existed for centuries, the COVID-19
pandemic only served to underscore them (Merriman 2020). As a result, a cultural shift
went into effect that placed political matters at the epicenter of virtual gathering spaces
and entertainment forums that were once deemed apolitical or neutral territory (Conger
2021). Social media became a central platform for the new civil rights movement, the
dismantlement of heteronormativity and gender binaries, and the normalization of self-
disclosures about mental health struggles (Davies 2022). The pandemic also marked the coming of age of Gen Z, the first generation to have grown up immersed in social media.

Generation Z encapsulates those who were born between the years 1997 and 2012. Broadly speaking, Gen Z is very politically minded. Their left-of-center views define their interests across a range of materials, from the popular culture they consume to the social media content they create. Furthermore, their political mindsets both contributed to and also were informed by the cultural shift described above (“Boomers, Gen X, Gen Y, Gen Z, and Gen a Explained”). During this period, Gen Z made a name for themselves in cyberspace, particularly in how they embody the blurring of the line that once divided the political and the social, raising questions about why we spend time on social media in the first place (Parker and Igielnik 2020). Is creating and engaging with content on social media only about mindless entertainment and fun for its own sake? Or should social media be seen as a political arena, an opportunity to create the change we want to see in the world by representing what could be and to correct those who still hold onto exclusionary beliefs? Such questions are particularly salient for medical-themed sub-communities on Reddit.

Medical subreddits are peer-support driven, allowing for Redditors to share their personal experiences with illness and to receive validation from others with the same condition (Niezgoda 2018). These spaces are also distribution sites for pirated, peer-reviewed scientific studies, an attempt to close the knowledge gap between patients and doctors. Overall, subreddits that cater to somatic illnesses have been characterized as positive and generative environments. Conversely, subreddits devoted to mental illnesses have been characterized as sites of controversy. Such communities have been known to
incite “group think” and to “perpetuate…toxic ideological views” (Niezgoda 2018, 173). For instance, r/2meirl4meirl was created for those who use grim humor to cope with their Major Depressive Disorder. However, the ironic content posted here has been criticized for inducing suicidal ideations, particularly amongst its younger members.

Furthermore, r/incel, one of the most infamous subreddits to date of any genre, began on the premise of providing peer support for men struggling with loneliness and depression. Yet this community has focused very little on discussing depression and far more on promoting violence against women. In this space, “frigid” women have been blamed for purportedly creating this population of involuntarily celibate men. Finally, r/Morgellons proved to be a breeding ground for conspiracy theory and hypochondria. Members of this now abandoned subreddit believed they had been infected with the highly contagious Morgellons virus, which manifests as itchy, red skin lesions (Niezgoda 2018, 173-174). Allegedly, the Centers for Disease Control was aware of Morgellons but was not warning the public about this epidemic for political reasons. The Mayo Clinic ran a study on those who were convinced they had Morgellons and found that their skin lesions were a result of compulsive skin picking, a behavior induced by spending time on the subreddit (“Morgellons Disease: Managing an Unexplained Skin Condition”).

The above literature underscores and broadens a key lesson I learned in the Personal Axis: the medical is inextricable from the social and the political. Feeling equipped for the task of charting r/MaladaptiveDreaming, I embarked for the Social Axis in Summer 2021.
MEET THE MODERATOR

On my first day in r/MaladaptiveDreaming, I was greeted with the imperative, “Read before posting” (Figure 9). Supreme_Leader, one of the subreddit’s moderators, recently pinned this post to the top of the feed. I inferred that this post makes explicit what were once implicit social mores before lockdown.

Therein, Supreme_Leader admonishes community members for creating content that contributes to the “glorification and romanticization of MD.” In addition, Supreme_Leader cautions against willfully inflaming one’s MD by “providing or asking for trigger material,” such as a stimulating song or movie. Furthermore, no one is allowed to invalidate another’s lived experience of daydreaming, as “it is no one’s place to tell another if they do or do not have” MD. Supreme_Leader maintains that the ICMDR is the definitive source on this condition and embeds a link to the MDS-16. Above all else, this subreddit should be a “supportive” environment for those who are truly “suffering” from MD. Those who are not distressed by their daydreaming are referred to the subreddits for Immersive Daydreaming and general fantasizing.

I was struck by Supreme_Leader’s post for several reasons. Firstly, I was impressed by how unabashedly long it is in an age where the cynicism of “Tl;Dr” qualifies most written content of this size. “Tl:Dr” is an abbreviation for the phrase “Too long, didn’t read,” speaking to the fact that lengthy writing in virtual spaces is considered to be a nuisance (“Tl;Dr Definition & Meaning”), no matter how critical and layered its content may be. When formatting Figure 9 in this thesis, I debated whether or not to crop Supreme_Leader’s message into smaller chunks, wondering if the message would be
This post is going to explain the sub and some of its policies.

First and foremost we are a "community support sub dedicated to individuals suffering from Maladaptive Daydreaming and helping them cope with the condition."

As the description implies this sub is focused on providing a space for people who are struggling with Maladaptive Daydreaming. If you do not feel that you need support or would like to share content related to daydreaming which doesn't fit the scope of this sub /r/ImmersedInDaydreaming offers a space free from these limitations. Here is a helpful post by u/shimmeres describing the terms. We do not attempt to define or set parameters on what these struggles are or how mild or severe they need to be.

Here you will see posts with complaints you might personally find silly or easy to deal with, or you may see posts detailing severe circumstances and feel your struggles are nothing in comparison. Please remember when you are reading these posts; it does not matter what you need support with, there is no threshold for suffering you need to break before being worthy to post here, there is no issue too big or small that you should not speak up.

Keep in mind the people replying to you are just fellow MDers going through similar struggles. There is no professional advice here and we cannot guarantee that comments you receive will be helpful. But they should be supportive. Report abusive or dismissive comments.

That's not to say all comments must contain helpful advice. Support comes in many forms and it's ok to simply let OP know they are not alone by relating to their post. Additional guidelines for posting:

MD is a complex issue that varies wildly from person to person. People will be coming to this sub from all stages of life, all stages of their understanding of MD and with very different views, resources and circumstances. It is no one's place to tell another if they do or do not have Maladaptive Daydreaming.

Posts which are providing, or asking for, trigger material will be removed (eg. "My daydreams have gotten stale, recommend me to jumpstart some new plots!" "This song makes the most amazing flight scenes, try it out!).

Glorification and romanticization of MD is against the rules. These terms are taken to mean posts or comments which idealize MD and/or depict it, or aspects of it, as admirable or desirable. We do understand that it can be helpful for MDers to "find the silver lining" or to address their negative symptoms through a positive outlet like creativity, these are not considered glorification but without proper explanation might be confused for it. Help the mods, and fellow users, by providing context with topics like these.

Now, let's talk about the memes.

Community discussion has shown us that most users like having the memes around, people find comfort in their relatability, so for now they are allowed. Memes DO need to follow community rules and fit the scope of this sub. They should be on-topic and not promoting a romanticized version of MD and not suggesting inspirational material. If you wish to share an image post which does not fit here /r/MaladaptiveDDMemes is available.

The nature of memes makes these rules tricky to enforce uniformly, they are subjective and it often comes down to a judgement call by whichever mod happens to be online. Providing additional context for image posts through your title or a text comment will be helpful in making those judgements; this is not required but it will improve your chances of not being misunderstood or removed.

All users should avail themselves of Reddit's upvote and downvote (and possibly report) features to express what you believe is and is not appropriate to the sub as outlined above.

We will continue to revise this post as things change.

Lastly, a note about the auto mod. It sends a message reminding you to flair your post to everyone. If your post is flaired you can ignore this message. If you're not sure what to flair your post as just pick one and mods will change it if it's too far off-base.

For newer members here is a link to the sub wiki which explains what MD is, answers a few FAQs and lists some resources. https://www.reddit.com/r/MaladaptiveDreaming/wiki/index

Here are studies on MD: https://daydreamresearch.wixsite.com/md-research/publications

Here is a link to the Discord: https://discord.gg/96eM4PapM5

Figure 9. "Read before posting," Supreme_Leader
more digestible for my readers in this way. However, when I realized that this way of thinking was in the vein of “Tl;Dr,” I decided that I wanted my readers to have the same visual experience I had when first encountering this post. Before I even had a grasp of the specifics, I was moved by the sheer sight of “Read before posting” because its form exhibits how important the idea of community is to this community.

The post’s tag, “Meta,” signals that this is a commentary on community life. This tag was the second key detail that struck me because it denotes that this post accomplishes two aims: it provides the community with ground rules, and at the same time it is a series of meditations on what this community could be, getting to the heart of what we owe each other. Supreme_Leader proves themselves to be not only a prolific writer, but also a thoughtful moderator. Finally, I was impressed by Supreme_Leader’s research and rhetorical skills. By citing scientific studies and providing perspectives from other community members, Supreme_Leader demonstrates that they are not an unchecked, absolute ruler. Rather, they are a highly conscientious community member with a facilitator role, one that is neither greater than nor less than anyone else’s role. With every comment posted, each member of this subreddit holds equal power to change this community for the better.

Despite the impact this post had on me, it was not clear to me when I first encountered “Read before posting” that it would become primary source material for my thesis. When I looked up from my fieldnotes journal, I was shocked to see that the two hours I had set aside for this inaugural excursion were nearly over. I had not intended to spend this much time analyzing an introductory note. I chalked that afternoon up to necessary surveying work that would perhaps be useful once I captured more salient data.
However, after several proper forays into the subreddit, I began to feel overwhelmed by the dialectics that zigzagged throughout this community—the local and the global, the personal and the political, sameness and difference, official narratives and counternarratives, the real and the commodity. I had no idea where to begin my map because I could not visualize the landscape. I was in need of a guide. I circled back to Supreme_Ledger’s post because it was the only landmark that had been instantly legible to me. I now viewed “Read before posting” with a new perspective. It had transformed into a series of guideposts illuminating the path ahead.

Each of the following guideposts grew out of my analysis of “Read before posting.” At the time of publishing the post in question, Supreme_Ledger appears to be moderating the tensions among various factions of MDers—both between those who want to glorify MD and those who want to validate the inherent suffering of MDers, and also between those who want to share their subjective distress and those who want to keep this community rooted in objective knowledge.

By contextualizing Supreme_Ledger’s key points within the portions of the Maladaptive Daydreaming World I had previously charted and the scholarly literature on social media I had reviewed, I was able to understand the stakes these Redditors face in agreeing upon a cultural narrative for their community. Each guidepost speaks to a crisis of definition community members are currently grappling with, namely delineating between the MD narrative and counternarrative, creating a metric for an MDer’s suffering, and establishing the parameters of belonging in r/MaladaptiveDreaming.

In the following section, I will walk you through each of the guideposts I co-created with Supreme_Ledger.
GUIDEPOST 1: Defining the Counternarrative

This first guidepost grew out of Supreme_Leader’s primary concern about the faction of community members who are intentionally glorifying MD. I argue that Supreme_Leader’s warnings against the romanticization of MD speak to the quandary posed by producing a counternarrative without a preexisting, widely known-prototypical illness narrative.

In the Personal Axis, I revealed how Dr. Sheehan constructed the prototypical illness narrative for Anxiety Disorder. Dr. Sheehan’s prototype, Maria, obscured The Other’s lived experience of persistent hypervigilance in response to systemic oppression. In this frame, The Other’s lived experience presented a counternarrative to Dr. Sheehan’s official narrative. In my review of the scholarly literature on medical subreddits earlier in this chapter, I learned that r/2meirl4meirl utilizes irony to parody the absolutism of the DSM’s Major Depressive Disorder. I argue that r/2meirl4meirl’s relationship to the diagnosis of Major Depressive Disorder is also that of counternarrative to narrative.

In the case study of Anxiety Disorder, The Other remained voiceless. Conversely, the r/2meirl4meirl community reversed the narratorial powers by creating alternative pathways for conceptualizing depression other than the disease paradigm. Here we can see how social media platforms give a voice to those who have been silenced in generations past.

However, Maladaptive Daydreaming does not fit neatly into this narrative/counternarrative model primarily because MD does not have a widely known-prototypical illness narrative. Although I did identify a prototypical MDer while I was in the Personal Axis—a white bodied woman who has an all-consuming craving for
heteronormative romance and Western fantasy—this prototype has not yet seeped into
the popular consciousness. This is in part because MD has not been recognized by the
APA, which also means there is no official diagnostic category for
r/MaladaptiveDreaming to subvert. In light of these circumstances, MDers do not have an
easily accessible narrative to counter when constructing their own cultural narrative.

Glorifying MD could perhaps counter the current prototype, which is predicated
on a gendered portrayal of romantic loneliness and vocational impairment. Yet glorifying
MD could also threaten to nullify the link between MDers and Somer. Historically,
MDers have campaigned for an official diagnosis and without their grassroots advocacy,
there would be no MDS-16. In preventing the creation of a counter-prototypical MDer—
one who works to inflame their compulsive fantasizing rather than manage it—I believe
that Supreme_L_leader is acting as gatekeeper of the relationship between MDers and
Somer.

This guidepost complicated my understanding of prototypical illness narratives.
Before arriving in the Social Axis, I had considered prototypes to be indicative of an
unchecked system of power and the internalization of exclusionary norms. Now, I viewed
prototypes as both opportunities for community engagement and also threats to patient-
directed advocacy. Going forward with my expedition, I knew to keep an eye out for the
balancing act between needing the APA’s official recognition, adhering to the traditions
of the Medical subreddit genre, and establishing a cultural narrative solid enough to serve
as a community foundation for years to come.
GUIDEPOST 2: Defining Suffering

The second guidepost required me to consider what makes Reddit and its subcommunities unique in the ever-expanding universe of social media. Facebook, the other major social media platform that grew to prominence in the mid-2000s, was marketed to those who wanted to keep up with current friends and to make new ones. From the outset, Reddit was marketed to a much different demographic, one that was more concerned with ideas and world events than they were with the minutiae of their peers’ lives (Schmidt 2010; Proferes et al. 2021). The profile pages on Facebook and Reddit underscore the key difference between these respective platforms. On one hand, Facebook focuses on curating a Self-image. A Facebook Timeline displays personal milestones such as graduations, vacations, and anniversaries. Photo albums serve as evidence that these events occurred in real life (Niezgoda 2018). In short, a valued member of Facebook is one that Self-mythologizes.

In contrast, a Reddit profile page curates what I call a nonself. A personal profile page on Reddit contains little other than one’s screenname, avatar, and awards. Redditors have the ability to grant awards to other community members who post noteworthy content. When a Redditor wins an award, they are granted currency which allows them to in turn “purchase” an accolade for another Redditor. Each award speaks to the particular flavor of the conversation sparked by the Original Poster or commenter. For example, the Spit-Take Award is granted to a Redditor who has made another community member “feel seen,” so much so that the awardee was moved to spit out the proverbial water they were drinking while scrolling through the feed (“What are awards and how do I give them?”). Ultimately, a valued Redditor is one that contributes knowledge and fresh
perspectives to the collective, forging connection among people who may very well live worlds apart. I argue that Reddit fosters the cultivation of a nonself because one’s profile page on Reddit speaks to how useful they have been to the collective rather than how unique and interesting they are as an individual.

Supreme_Leader highlights an inherent tension within the genre of Medical subreddits, one which pits expressions of individual illness against a Redditor’s duty to the collective. Although Supreme_Leader maintains that this subreddit is supposed to be a supportive environment where community members hold space for each other’s suffering, this ground rule appears to be in conflict with the role of a Redditor. It is a Redditor’s job to discuss and to parse through topics, not necessarily validate another’s subjective distress. Although Supreme_Leader has envisioned a supportive environment like other medical subreddits have modeled (Niezgoda 2018), it appears some community members of r/MaladaptiveDreaming are only doing their duty as Redditors by questioning whether self-disclosures are useful contributions to the collective.

As opposed to the MDers described in the first guidepost, it appears that this faction of the subreddit upholds the MDS-16. I argue that these community members are working to create a metric of suffering, one for evaluating whether self-disclosures are beneficial to anyone other than the poster themselves. Such a metric could potentially be this community’s informal addendum to the MDS-16, one that expands the Impairment factor from an individual’s problem to a community’s knowledge. I could foresee such a metric creating a more cohesive community by establishing clear expectations for modes of expression.
This guidepost complicates its predecessor because it broadens the question from who has the right to tell stories about illness to what a community’s obligations are in receiving such stories. Is it the individual’s responsibility to emplot their MD experience within the MDS-16’s narrative frame? Does the collective have a right to refuse the individual’s experience if they fail to partake in traditional diagnostic emplotment?

GUIDEPOST 3: Defining the Parameters of Belonging

The third guidepost speaks to the political undertones of Supreme_Leader’s writing. As previously reviewed, politicizing diagnoses is a common practice on Reddit. This politicization is exemplified in r/incels and r/Morgellons use of the disease paradigm to promote neo-conservative views. Specifically, Major Depressive Disorder upheld a gender hierarchy in r/incels, while the Morgellons parasites stoked a preexisting mistrust of science. By directing community members to the ICMDR, Supreme_Leader is both gatekeeping the pivotal relationship between Somer and MDers and also aligning r/MaladaptiveDreaming with liberal-leaning viewpoints.

In politicizing this space, I argue that Supreme_Leader is implicitly defining the parameters of belonging. In order to belong to this subreddit, it is clear that one must believe in science and in the wider constellation of liberal orientations. Such orientations include dismantling hierarchical structures and creating safe, inclusive virtual spaces. Supreme_Leader’s implicit political moves pushed me to reflect on the relationship between believing and belonging.

I realized that r/incels and r/Morgellons utilized diagnoses as advertisements of sorts. In becoming a member of these respective subreddits, one was buying into a belief system that nonconsenting women cause depression, and that the CDC was willfully
suppressing information about an epidemic. It appears that these subreddits were clear on what they were selling from the outset. In contrast, MDers are still negotiating. Are they selling a counternarrative or an addendum to the MDS-16? This ongoing negotiation is creating friction among community members because it is unclear who belongs here and who does not.

With a firm grasp of the third guidepost, I now understood why I could not find my footing in The Social Axis: I was not visualizing r/MaladaptiveDreaming as a marketplace. Now I understood the community tensions addressed in “Read before posting” to be the result of heated negotiations between producers and consumers. In illustration, each Original Post, whether it be a meme or a video representing MD, is a commodity presented to a crowd of consumers. The resulting comment thread is a bartering process, the commenters having the purchasing power to decide if this piece of content should represent the collective. As moderator, Supreme_Leader is both refereeing the negotiations between producers and consumers, and also regulating the kind of narratives that can be sold here. I argue that politicizing this space is an act of regulation rather than one of censorship. If all producers and consumers hold the same general constellation of beliefs, then they are free to compete, allowing for the best narrative to win.

In the following sections, I will provide a theoretical framework for working with intangible commodities. Then, I will explore two pieces of content from r/MaladaptiveDreaming that produced heated negotiations amongst community members.
THE MARKETPLACE

The commodification of that which was previously uncommodifiable, such as a narrative, is one of the hallmarks of a postmodern society. The other key factors in postmodernism include 1) the reign of corporations, 2) globalization as Western dominance, 3) the ephemerality of human relationships, 4) the widespread use of irony, and 5) the abstraction of space (Borchard 1998). Postmodern theory speaks to the collapse of societal structures that once directed economic systems and social mores in the United States and Western Europe. Georg Simmel, a late-19th century structural theorist and sociologist, provides historical context to the rise of postmodernism.

In his seminal work *The Metropolis and Mental Life*, Simmel grounds us in the aftermath of The Industrial Revolution, which lasted from the mid-1700s to the mid-1800s. Before The Industrial Revolution, Simmel describes how life in the West was sustained by agriculture and handicrafts. In rural communities, there was a strong bond between producers and consumers. Each community member knew the person who cobbled their shoes and the person who baked the bread on their table. Simmel argues that the exchange of these commodities fostered feelings of warmth, connection, and natural belonging. When the Industrial Revolution transformed local, agrarian economies into global manufacturing systems, communities and mental lives were transformed as well.

Rural communities became increasingly depopulated as in-demand manufacturing jobs were located in various urban centers. Simmel refers to these urban centers monolithically as “the metropolis.” In the metropolis, belonging was no longer a natural state, but rather something that had to be earned by accumulating capital, prestige, and
status markers. The “purchasability” of belonging made metropolitans feel personally “valueless,” which they expressed outwardly as a “blasé attitude” (Simmel 1971, 330). The disaffection and loneliness of the metropolitan blasé attitude required a remedy. Semiotician Ferdinand de Saussure, a contemporary of Simmel’s, demonstrates how the theory of signs both remedied and sustained metropolitan blasé. For the purposes of this project, it is helpful to view a sign as a cultural narrative in commodified form.

The creation of a sign— or, the commodification of narrative— is a two-fold process. The signifier is the product we are presented with, whether it be words, images, or a combination thereof. In consuming the signifier, we are also consuming the cultural narratives it signifies. For example, an image of a tree is a sign. Lush, green leaves swaying over a solid trunk that is firmly rooted into the earth conveys a constellation of Western cultural narratives. Such narratives include the act of “putting down roots” and starting a family. In addition, a tree signifies Spring’s promises of rejuvenation after a barren Winter. By extension, the Easter holiday assures us of the possibility of resurrection— but only for the righteous, as Eve’s cautionary tale of forbidden fruit reminds us.

Trees in and of themselves are neutral circumstances that occur all around the world, but the Western Christian tradition has applied the aforementioned narratives onto them. These narratives inform various Western constructs such as the nuclear family structure, time, morality, and the gender binary. In short, signs — whether they be on billboards, on the cover of a book, or on a film set — offer an opportunity to sell stories about community life to the alienated, lonely metropolitan (Saussure 2011; Simmel 1971).
Signs are the vehicles for conveying prototypical illness narratives. In the Personal Axis, I described such signs as ideological constructs, which obscure the structural inequalities and widespread disillusionment created by capitalism. However, in the Social Axis, I found that negotiations over signs were opportunities to create structure and belonging in an otherwise abstracted virtual space. I argue that this virtual marketplace is a reimagining of Simmel’s rural community, wherein fostering connection is the primary aim of transactions.

Upon my return to r/MaladaptiveDreaming, I browsed through numerous exchanges between producers and consumers, knowing that it would not take long for something to catch my eye. A TikTok video (Figures 9-12) piqued my interest. Established in 2018, TikTok is a social media site that exists separately from Reddit, and it is famous for its 15-second videos, which are also referred to as TikToks (Janes 2021). TikToks are hallmarks of Gen Z’s cultural milieu, and they feature a range of topics, from exercise routines to cleaning hacks to comedy skits. I would categorize the following TikTok within the comedic genre.

This TikTok follows a common structure in which the content creator plays two characters, who I will call The Insider and The Outsider. There is an implicit understanding in these videos that the material has been inspired by real life events, The Insider being a lightly veiled version of the content creator. This TikTok is representative of tiresome conversations the content creator regularly has with persons who hold radically different viewpoints than they do. In this example, The Insider is a Maladaptive Daydreamer, and The Outsider epitomizes the Non-Daydreaming Other.
The title of this TikTok sets the scene: “When I try to explain it to someone who doesn’t have it”, “it” being Maladaptive Daydreaming. Figure 9 shows The Outsider prompting the conversation in scene, by asking: “what do mean you can just turn your f-- head off? How the hell do you do that?” The Insider responds with a montage representing their MD World. What follows is the current prototypical illness narrative for MD, filled with fantasy and swashbuckling adventure. The stage is set in a grand castle (Figure 11). Just inside the castle walls, a sweeping, period romance ensues (Figure 12). However, a hoard of dragons approaches from above (Figure 13), and the battlements can do little to protect the unsuspecting lovers. The swift editing creates a
suspenseful, whirlwind effect. When we cut back to the present of the story, we find The Insider waking up from their reverie. By moaning “Woo,” they are conveying the dizzying experience of having just traveled through their daydreaming world. The Insider then concludes that their MD world is a manifestation of “trauma.” Ironically, The Insider delivers “trauma” in a bouncy, lighthearted tone (Figure 14).

In the top corner of my fieldnotes, I scribbled “SOLD,” doodling an auction pad around my declaration. Guidepost 1 helped me to appreciate this TikTok in full. Despite Supreme_Lleader’s misgivings, this content creator demonstrates how a prototypical illness narrative and a counternarrative can coexist. Unlike the rhetorical technique of r/2meirl4meirl, this ironic ending does not counter the MDS-16. Rather, here irony serves as an effective vehicle for diagnostic emplotment. We can see the four main factors of the
MDS-16 clearly exhibited in this TikTok. It is implied that there is social Impairment, as there is friction between the Insider and the Outsider. Music carries us through the MD World. The Insider’s delivery of “Woo” conveys the experience of vigorous Kinesthesia. Finally, The Insider Yearns to escape their traumatic memories.

I was not surprised to read that the commenters also unanimously bought into this TikTok’s narrative. Most got right to the point by proclaiming this TikTok as, “Brilliant!” and that, “Lol, this is amazing!” Some commenters related to specific details of the TikTok. One MDer was thrilled to recognize a film clip from the short-lived television program, *The Legend of the Seeker*, which has also been a source of inspiration for their own MD World. Here we see a connection fostered between The Producer and The Consumer. Another found “The Woo Trauma bit” impactful because of its tongue-in-cheek delivery.
Guidepost 2 helped me to understand the following comment by Old_Cardigan:

Wow that last line. How have I never clued into the fact that this is all a coping mechanism I developed as a child to distract me from feeling scared all the time?"

Clearly, Old_Cardigan came away from this TikTok with more self-insight and knowledge than they had before. Although this TikTok portrays an MDer’s individual experience, it was still beneficial to the collective. Here we can see how the content creator has infused their Redditor nonself with a creative flare. This nonself creates a self-mythology that is both accessible to others, and also provides psychosocial awareness, peer support, and validation in its ironic packaging.

Furthermore, the content creator also addresses Guidepost 3 by defining the parameters for belonging in this space. In portraying The Outsider, the content creator deepens their voice and adopts a gruff tone, particularly when delivering the expletive,
signifying to me that The Outsider is supposed to be a cis-gender man. Upon watching the TikTok again, I realized that I also could have named The Outsider “The Patriarch,” and that this choice of diction would not have drastically changed my analysis of the video. I found this characterization of an uncouth and unimaginative white man to be very apropos of Gen Z’s politically minded media, as they are chiefly concerned with representing non-dominant groups in a positive light.

However, “The Malasexual Flag” (Figure 15) demonstrates that while this commitment to representing non-dominant groups is critically important, even the best of intentions do have their limits. A_redherring, found The Malasexual Flag on the LGBTQIA+ Wiki site and presented it to r/MaladaptiveDreaming with a simple
Malasexual is a term where one’s orientation is influenced by one’s maladaptive daydreaming or another similar condition. For example, a malasexual individual might feel pansexual normally but may feel asexual when maladaptive daydreaming. Malasexual can be an orientation on its own or it can be combined with other terms. For example, a malabisexual individual is someone who is only bisexual when daydream or in their daydreams.

According to this flag, Malasexuality is a sexual orientation attributed to MDers who have a different sexual orientation in their daydreams than they do in real life. Truth be told, I was not sure what to make of this. Malasexuality did not ring true for my experience as a MDer. In addition, I had neither read about Malasexuality in the scholarly literature, nor had I encountered it on my previous expedition. I decided to research the
LGBTQIA+ Wiki from which the flag originated. I learned that this wiki has two primary aims: to represent the LGBT+ experience in media, particularly in fan fiction, and to provide peer-produced educational resources about sexuality (LGBTQIA+ Wiki).

Overall, I found legitimate and helpful information on this wiki.

I was far from the only one who took my time researching and mulling over the Malasexual flag. Its resulting comment thread on r/MaladaptiveDreaming generated almost 250 comments and it was archived for posterity. Furthermore, the Original Post was bestowed three different honors: the “Crab Rave Award”, given to posts that spark collective outrage; the “Wholesome Award”, given to posts that strengthen community bonds; and the “Take My Energy Award,” given to posts that generate heated discussions. I identified three overarching themes in the comments: indignation over the appropriation of LGBT culture, criticism of Gen Z’s politics, and concern about misinformation influencing outsiders’ view of MD and its relationship to sexuality.

Most responses were terse, though adamant. “No,” “…this is ridiculous,” and “wtf” were sprinkled throughout the thread. Armchairexpert_01 aimed their critique directly at the LGBTQIA+ Wiki:

*I just think this makes the LGBTQ community look like a big fat joke...* Hell I even saw a flag [on the wiki] for people who are attracted to bees or are star sexual.

Applepied-a-terre, however, took Gen-Z head on in their critique:

*This... is why people don't take the lgbtq community serious you don't need to keep making shit up to feel special and othered. it's okay to be average and ordinary. everyone doesn't have to be some unique special nonsensical string of made up shit... this just sounds like some stupid shit a straight person made because "being the norm" is boring now.*

*...this generation is just regressing and pushing back the lgbtq movement...*
Armchairexpert_01 and Applepied-a-terre engaged with Guidepost 1 by pointing out that creating counternarratives just for the sake of countering is not all that unlike the work of Dr. Sheehan. In other words, constantly underscoring power imbalances only serves to neutralize the experience of those who live in nondominant identities.

Armchairexpert_01 and Applepied-a-terre argued that in applying a political lens where it is not warranted, well-intentioned LGBT+ advocates are undermining high-stakes situations and are potentially creating a widespread blasé response to inequalities.

These commentators helped me to wade through the thorny territory Guidepost 3 speaks to. I can confidently assert that everyone who participated in this thread is committed to dismantling heteronormativity. However, these MDers were not willing to blindly purchase a narrative they disagreed with because it gives the appearance of being in line with their views. This is an illustration of Supreme_Leaders political regulation of the marketplace. Because there is a tacit understanding that all community members support LGBT+ rights, this is a safe place to parse through the various implications of the Malasexual flag without fueling homophobic beliefs and inciting hate speech.

For example, some commentators revealed that they are also members of the LGBTQ+ community, and that Malasexuality writes over their intersectional identity. G1_Jane explained how she technically fits the description of a Malasexual. In real life, she is a lesbian, though her daydreaming Self, who she calls “Para,” is bisexual. Yet, G1_Jane did not view the difference in sexual orientation between her true Self and Para-Self to be indicative of a sexuality all onto its own:

\[
\text{You don’t just switch sexualities because of a daydream. Your para can be differently sexually or romantically oriented than you, YOU cannot be differently attracted than YOURSELF.}
\]
sherlockhomie also technically fit the description of a Malasexual, but argued that Malasexuality misconstrues a key function of MD:

*Though I am asexual, I'm sexual in my daydreams (because I always wish I was sexual and fitted in with the rest of the world). But it doesn't mean my sexuality has changed, it's just a safe way for us to explore other sexualities without any of the consequences. At the end of the day, that's what MD is all about, isn't it?*

Guidepost 2 illuminates the value of these comments. GI_Jane and sherlockhomie did not express their personal outrage for the sake of it. Rather, they provided evidence for their outrage, and in doing so, they also provided the community with helpful definitions and widely applicable insights.

AMitskyFan engaged with Guidepost 2 by epitomizing the Redditor nonself. They pointed out that the Latin prefix ‘mal’ signifies something that is “bad.” By adding the prefix “mal” in front of “sexuality,” the author of this wiki post created a neologism that literally means “bad sexuality.” AMitskyFan went on to explain what the phrase Maladaptive Daydreaming means from a linguistic perspective:

*Maladaptive is not providing adequate or appropriate adjustment to the environment or situation.*

*[M]aladaptive daydreaming describes a condition where a person regularly experiences daydreams that are intense and highly distracting — so distracting, in fact, that the person may stop engaging with the task or people in front of them.*

AMitskyFan followed up several hours later to mention that they had joined the LGBTQIA+ Wiki just so that they could edit the Malasexuality post to include the etymology of the word. AMitskyFan’s comment catalyzed a shift in this thread, demonstrated by dailyGrace’s subsequent comment:

*Yes!! I could not agree more. This is an obsessive-compulsive addictive disorder.*
Afterwards, commenters began to explore how MD is far more akin to a neurodiversity than it is to a sexuality. I found this topical shift to be rather ironic, as this is a mental health subreddit, where most conversations revolve around the obsessive-compulsive nature of MD. Yet the Malasexual flag created such a frenzy that members had to reorient to speaking in the language of diagnostic categories.

Although r/MaladaptiveDreaming resoundingly declined to purchase the Malasexual narrative for their community, I argue that we nonetheless still bought into it. We researched the wiki from which it came and even edited it, we shared our personal experiences of MD and sexuality, we voiced our political views, making this one of the most popular threads of the year. I argue that the paradoxical nature of this thread indicates that the Malasexual flag violates Saussure’s law of signs. In short, the flag does not reference a reality any of us MDers recognized. Yet we entertained this piece of fiction as though it did signify something real.²

Sociologist Jean Baudrillard’s theory of postmodern signs provides some insights to this quandary. Baudrillard published his seminal work *Simulacra and Simulation* in the 1980s, almost a century after Simmel and Saussure provided a language for the mechanics of the modern capitalistic society. As opposed to a modern society, a postmodern society is capable of producing signs without a preexisting signifier. The Malasexual flag is a postmodern sign because the signifier was generated out of thin air. It did not signify anything until we as a collective entertained what it could possibly signify, such as Gen-Z’s politics and current cultural divisions on social media.

² Although the cultural narratives explored in this project are not technically “real” because they are societal constructs, they still reference a reality, such as lifestyles and kinship systems.
Baudrillard would describe our collective state of consciousness as a hyperreality in that we were unable to distinguish between reality, references of reality, and postmodern signs without a referent. Baudrillard describes hyperreality as having a “refractory” quality to it, as though we are living in a house of mirrors (Baudrillard 1998, 179). As a subreddit, we engaged in simulating a potential reality in which Malasexuality could exist—a reality where the monolith of Gen Z has abstracted liberal views, where reactionary beliefs linking sexuality with psychological difference inform nosology, where we have forgotten what this subreddit is devoted to in the first place.

When I left The Social Axis, I was reminded of the TikTok’s ending—*Aha...woo*... I jotted this phrase down in my fieldnotes. I too felt as though I had just returned from a tumultuous journey, yet I had not left my room. This sensation demonstrated to me that Maladaptive Daydreaming itself is a symptom of postmodernism, each MD world being a personal hyperreality. By extension, I argue that a virtual MD community references our collective hyperreality. In other words, *r/MaladaptiveDreaming* references our pathological inability to distinguish between reality and simulations of it.

Knowing this, I was confident in the map I had produced of *r/MaladaptiveDreaming*, and at the same time I was entirely convinced that I had accomplished nothing. Which of course, speaks to the power of prototypes, signs, and simulations—they all promise structure, stability, and a remedy for our collective grief over the erosion of community life and a certainty of who we are, where we are, and what is real. For a cartographer of The Maladaptive Daydreaming World, I realized that simulacrum is both a treasure trove and fool’s gold.
I anticipated that it would be extremely difficult transitioning from the Social Axis to the Clinical Axis. I could not have been more wrong. A firm understanding of postmodernism was just the theoretical grounding I needed to understand the power dynamics between Somer and the APA.
CHAPTER 4
The Clinical Axis
As an anthropologist, I view a diagnosis as a form of narrative, a story that we tell ourselves to create structure and mutual understanding out of the ephemerality of illness.

At the outset of my expeditions, I hoped that the Clinical Axis would reveal to me what the purpose of a diagnosis is from a psychologist’s perspective. Specifically, I wanted to understand Eli Somer’s motivation in seeking recognition by the APA and why it is imperative that MD be included in the next edition of the DSM. I also wanted to understand how the concept of a diagnosis mediates the relationship between Somer and MDers. Is he considered an insider in the Maladaptive Daydreaming World because of his MDS-16?

In many ways, my respective expeditions to the Personal Axis and to the Social Axis answered the initial research questions I had set aside for the Clinical Axis. In the Personal Axis, I learned that an official diagnosis could help MDers who are at risk of being labeled as psychotic or given another equally stigmatizing diagnosis. This realization demonstrated why it is imperative that clinicians have a variety of discrete, diagnostic lenses through which to view their patients. In the Social Axis, I learned that disease categories are the foundations upon which collective illness narratives are built. In turn, collective illness narratives can foster a mutually beneficial relationship between patients and clinicians, one that is predicated upon patient advocacy.

In short, I already captured data demonstrating how and why a diagnosis is important, from both narratorial and clinical perspectives. Even so, I still did not understand what it was exactly. There was a circularity to the way I was conceptualizing the diagnosis— a diagnosis is important because current systems need it in order to
function— and, by extension, Somer’s relationship to MDers— patients and clinicians need a diagnosis because they would have no relationship without one.

In preparation for my third and final expedition, my central task was two-fold: I had to first deconstruct the diagnosis and then rebuild it from the ground up. By defamiliarizing the diagnosis, I knew I would be able to see it clearly within the landscape of the Clinical Axis.

THE DIAGNOSIS: Defamiliarized

Before I embarked on my expeditions, I briefly touched upon the “awkward relationship” Disability Studies has with Anthropology (Strathern 1987). Although there technically is an Anthropology of Disability, this sub-discipline is often subsumed within Medical Anthropology (Ginsburg and Rapp 2020). Because this project is concerned with a psychological disability, the canon at my disposal becomes even more muddled, as Psychological Anthropology is also all-too-often subsumed within Medical Anthropology (Good 1992). According to the current paradigm, it appears that any form of impairment, whether it be physical or psychological, cannot exist outside of the Medical Gaze.

For this reason, the interdisciplinary field of Disability Studies has long held medicine to be hegemonic force. According to Tom Shakespeare’s social model of disability, impairment is not located in the body, but rather in the societal contexts that bar certain minds and bodies from full participation (1998). In other words, able-bodiedness and neurotypicality are constructs. There is no universal, natural law that dictates what a normal, healthy human is. Therefore, the very concept of health, whether
it be physical or mental, is an exclusionary and arbitrary norm, like whiteness or heteronormativity. Historically, Western biomedicine has both created and reified the binaries that allow Most People to participate in social structures such as the public transportation systems, the workforce, and educational institutions. In this view, a diagnosis is an exclusionary label.

The Individualized Education Plan (IEP) is a prime example of the exclusionary and hegemonic powers of medicine. An IEP is a diagnostic passport that allows children who need academic accommodations to participate in educational institutions. In order to procure one, neurodivergent children must first receive an official diagnosis from a clinician. Based off of this diagnosis, the student’s parents, teachers, and school district must negotiate what the most reasonable academic accommodations are for such a diagnosis, in accordance with the Americans with Disabilities Act (ADA). The resulting IEP is a legal document mandating what accommodations the student has a right to, whether that be extra time on exams or a notetaker in class. In theory, an IEP is both a passport and a road map, clearing the way for disabled children to finish school and, ideally, make the transition to college and/or job training programs, eventually leading them to the workforce.

However, not everyone wants their difference to be medicalized. For children who are neurodivergent, they are essentially forced into psychiatric treatment if they want an education and a career someday, as earning a clinical diagnosis is the first step in generating an IEP. In a way, forced psychiatric treatment is the best scenario for neurodivergent children, as many underserved communities do not even have access to specialized clinicians, leaving these students without accommodations altogether. Rayna
Rapp and Faye Ginsburg, forerunners in the Anthropology of Disability, have used IEPs as case studies for exploring the push to “demedicalize” neurological and psychological disabilities. As parents to children with Learning Disorders themselves, Rapp and Ginsburg grapple with the current systems that necessitate IEPs and ponder futurities in which there are other pathways for neurodivergent children (Ginsburg and Rapp 2013b).

In defamiliarizing the IEP, we can view it through the lens of “common-sense ableism” (Ginsburg and Rapp 2013a). This ableist paradigm puts the onus on the divergent individual to “seek help” and “become cured” before they can fully participate in normative educational systems. Not only does common-sense ableism characterize neurodivergent persons as deviant, as though they are criminals in need of reform, but it also securely locates disablement within the individual. This ideology leaves no room for collective reflections about how to make educational systems more structurally competent. Structural competency would allow neurodivergent persons to move freely throughout the world without needing to be qualified by a diagnosis.

In illustration, the Deaf community has made great strides in advocating for a more inclusive society that would do away with common-sense ableism. The Deaf community considers themselves to be a language minority rather than a disability collective, meaning that the impairment lies in the fact that hearing people do not know how to sign, not that the Deaf do not know how to hear. By making American Sign Language a requirement in schools, the Deaf could fully participate in the able-bodied world without a diagnostic passport (Ginsburg and Rapp 2013a).

This same logic can also be used to justify including “autistic socialities” into our current way of life. Rather than viewing autistic persons as disabled for being
overwhelmed by bright lights and noises, we can view the metropolitan environment as in need of adjustment. By reducing sensory overload in public spaces, we could lower the barrier for participation for autistic persons. In this way, we are seeing autistic divergence as valuable, helping us make public spaces more inviting and less overwhelming for everyone (Ginsburg and Rapp 2015b).

Through the lens of Disability Theory, the diagnosis remains a narrative and clinical tool. However, we see that its importance and functionality hinges upon exclusionary beliefs, in which Most People naturally belong in society and The Other must jump through hoops in order to be accommodated. Because we know that neurotypicality is merely a contingency, we have the power to make different choices in the future, making our society more inclusive and diverse.

THE DIAGNOSIS: Simulated

Although he does not employ Disability Theory, Historian of Science Charles Rosenberg also views the diagnosis as a social construct rather than natural law. Rosenberg views the diagnosis as evidence of our collective hyperreality. In short, a diagnosis is a simulacrum that does not reference the realities of illness. Here Rosenberg engages with Kleinman’s definitions of disease and illness, though Rosenberg does not fully agree with Kleinman’s paradigm. While Kleinman argues that illness and disease are mutually exclusive concepts, Rosenberg offers that illness and disease are “mutually constitutive and continuously interacting worlds.” In short, ill persons require diagnoses in order to “assimilate” in the “larger system of institutions, relationships, and meanings in which we all exist as social beings” (Rosenberg 2002, 257-258).
Rosenberg goes on to explain that even though the diagnosis is not technically real—like the lived experience of illness is—we still grapple with the diagnostic entity as though it is real, creating a language for it, building knowledge around it, and erecting a multitude of structures in its honor. In light of these circumstances, Rosenberg argues that we live under “The Tyranny of the Diagnosis.” In many ways, Rosenberg describes my findings from the Personal Axis and the Social Axis when he characterizes the diagnosis as a powerful, personified entity.

Rosenberg demonstrates that a diagnosis has two key functions that dictate how we communicate and provide structure to the systems we move through. A diagnosis’ Social Entity has a dialogic quality to it. Essentially, it is a script to follow upon the disclosure of a diagnosis. For instance, one does not express the same level of concern and sympathy for someone who has eczema as opposed to someone who has cancer. In the Social Axis, the thread concerning the Malasexual flag demonstrated how important the Social Entity of the diagnosis is. If the general public is unsure about what a diagnosis signifies and what it does not, it is nearly impossible for the divergent person to get their psychosocial needs appropriately met by friends, family, and coworkers.

The Functional Entity of a diagnosis is also a script. However, this script is reserved for clinical as opposed to social settings. My time in the Personal Axis provided a case study for the Functional Entity of a diagnosis. Upon receiving their patient’s account of spending hours conversing with imaginary people, the psychiatrist would follow up with more questions in order to discern whether the patient is exhibiting the Positive Symptoms of Schizophrenia or the Manic Symptoms of Bipolar Disorder.
However, if MD were included in the DSM, then the MDS-16 would also be a prop in this Functional script.

Although Rosenberg deconstructs the diagnosis like disability scholars do, he deems its existence and its extensions, such as the IEP, as necessary, given the “indispensability” of the diagnosis. I argue that Rosenberg is employing the same circular logic I had when pivoting from the Social Axis to the Clinical Axis—we need the diagnosis simply because we do. While Rapp and Ginsburg are more concerned with what the world could be like without the existence of the diagnosis, Rosenberg grapples with the world as it operates now under the diagnosis’ tyrannical rule.

In the process of deconstructing and then rebuilding the diagnosis using two different scholarly lenses, this entity not only became clearer to me, but I also viewed Somer in a different light. Although the diagnosis is by no means ideal, we must first work within its bounds if we are serious about ever reforming the systems that make this entity so powerful. This is why I now viewed Somer more as an alchemist than as a clinician. Here I am using the word alchemist figuratively, referring to someone who has the “power to transform things for the better, real or imagined” (“Alchemist Definition & Meaning”). In getting MD included in the DSM, there are potentialities to reform both the APA’s recognition process and the current power dynamics inherent in the making of a diagnosis.

As I set out for my third and final expedition, I had far more modalities in my toolkit than ever before. Even still, I knew that I was venturing into the Clinical Axis blindly, as Somer himself had not yet blazed the trail that I was attempting to map. More so than ever before, this expedition was purely imaginary in the sense that I was scouting
potentialities rather than realities, simulated or otherwise. Before embarking, I knew full well that I would trip often during this expedition. Yet I chose to interpret my stumbles as opportunities to inspect the barricades that impeded me and also Eli Somer on his twenty-year quest for APA recognition.

The following sections will describe the roadblocks I encountered while traversing the Clinical Axis, and I will also offer potential solutions for the MD community to overcome them, making the recognition process more egalitarian.

**ROADBLOCK 1: Buried Genealogies**

The first roadblock I encountered was the entanglement of the APA with the pharmaceutical industry, as evidenced by the DSM’s publication process.

Before I even started this project, I had a general understanding that the APA publishes the DSM and that the pharmaceutical industry produces medications to treat the disorders categorized in the DSM. However, the mechanics of the revolving door between these three power structures—the APA, pharmaceuticals, and the DSM—remained a mystery to me and also most likely to Somer himself, as he has not been able to breach this triumvirate. In order to uncover this roadblock, I needed to understand more about the historical underpinnings of this closed circle.

When the *Diagnostic and Statistical Manual of Mental Disorders* was first published by the American Psychiatric Association in 1930, it was only ninety pages long. It was envisioned as a guidebook for clinicians treating veterans of World War I who had succumbed to the mysterious “shell shock,” which we know today as Post-Traumatic Stress Disorder (Rosenberg 2002; Good 1993). Shell shocked patients were
like live wires, restimulating memories of combat every time they moved their bodies. As a result, many veterans had become bedridden, unable to work and to take care of their families. Their neuroses had robbed them of their masculinity, a construct which dictated that male-bodied persons were not only to be the heads of household and bread winners, but also unfailingly hardworking and stoic.

The first two editions of the DSM unabashedly reified gender, race, and class through its diagnostic categories (Rosenberg 2002; Healy 2006; Good 1992; Martin 2009). Although I will not delve too deeply into the DSM’s history in this project, I will say that even commonly used diagnoses today like schizophrenia began as a means to disqualify and silence oppressed members of society, namely housewives and African American men (Martin 2009). In addition, homosexuality and gender dysphoria were also included in the DSM as psychiatric diagnoses, serving as a symbolic promise to society that there was a way to return white men to their naturally dominant, masculine states.

By the 1970s, when the DSM-III was being drawn up, the APA was under pressure from two fronts. On the one hand, social justice advocates were campaigning for the removal of sexual and gender-based disorders and for the addition of more objective, scientifically backed protocols for psychiatrists. At the time, psychiatrists were criticized for being too arbitrary, the granting of a diagnosis considered to be more reflective of a clinician’s personal views than their professional training (Healy 2006). On the other hand, long-term psychiatric hospitals had been closed as a part of the “deinstitutionalization” movement. This movement was in part supported by social justice advocates who wanted more humane treatment for the mentally ill, which included safe housing and job training as opposed to psychiatric treatment.
Deinstitutionalization also spoke to the restructuring of the insurance industry, which was expanding in outpatient settings, decreasing the amount of state and private funding for inpatient treatment centers (Rosenberg 2002).

The pharmaceutical industry was also in a precarious position because of deinstitutionalization. Psychiatric institutions had been a key distribution site for atypical antipsychotics, the greatest advancement in psychotropic medication to-date (Good 1992). At the same time, these long-term care facilities had also served as fruitful sources of data for improving drug efficacy. As a result, the pharmaceutical industry needed new sites and funding sources for their research. In order to remain viable, the APA and the pharmaceutical industry both needed to adapt to cultural shifts and bureaucratic restructurings. Their mutually beneficial solution continues to thrive today: “the marketing of disorders.”

In “The New Medical Oikumene,” David Healy explores how the publication of the DSM-III in 1980 solidified the relationship between the APA and pharmaceuticals, marking a drastic shift in clinical and social understandings of psychopathologies. As a British social scientist and practicing psychiatrist, Healy has witnessed “the marketing of disorders” in both of his professions (Healy 2006, 64). He describes this initiative as a two-pronged approach to meeting the respective needs of the APA and the pharmaceutical industry.

On one front, the APA was able to improve their public image. By nearly tripling the length of the third edition of the DSM, the APA was able to debut new, “scientifically backed” data that warranted the creation of new disease categories. Research provided by the pharmaceutical industry was critical in expanding the monolithic category of anxiety
into several discrete disorders, including Anxiety Disorder, Panic Disorder, Social Phobia, and Obsessive-Compulsive Disorder. These refractions made the DSM appear to be more scholarly and respectable, and psychiatry itself gained a new reputation for being a progressive and innovative specialty (Healy 2006, 61). On the other front of “the marketing of disorders,” pharmaceutical companies crafted cultural narratives about new diagnoses and their respective medications. In crafting these narratives, the industry found a new home and funding sources for their research, as well as an outpatient market for their drugs. These narratives were also focused on the Personal, the Social, and the Clinical nature of illness.

The practice of “direct-to-consumer” advertising allowed for psychopharmacological narratives to seep into the popular consciousness, not unlike catchy jingles for candy bars. TV commercials and advertising campaigns for anti-anxiety drugs such as Ativan gave Americans a language for their “panic attacks,” a new term popularized by pharmaceutical companies (Healy 2006, 62). Furthermore, it became common practice for writers and editors of lay publications such as Vogue to receive commercially backed research articles describing the rampant spread of Major Depressive Disorder. As a result, psychiatric illnesses were featured in magazine articles alongside images of other stylish objects, saturating the fashion industry and other parts of the social sphere where diagnostic categories had once been irrelevant (Healy 2006, 66). Perhaps one of the most well-known sites for pharmaceutical advertisements is the doctor’s office. Pens, calendars, and other office supplies brandishing the names of specific drugs demonstrate how new diseases and their remedies are marketed directly to clinicians (Healy 2006, 81).
In short, the DSM as it exists today—a ever-expanding nexus of disease categories with unchecked influences on the public—would not have been possible without the combined efforts of the APA and the pharmaceutical industry.

It would be impossible to conceptualize the DSM’s rise and current global reach without postmodern theory. To reiterate, one of the key tenants of postmodern theory is the Globalized West, a colonialist legacy which allows for power structures such as biomedicine to flourish in Western countries (Borchard 1998), while advancements made in other parts of the world are often obscured. After all, the DSM is published by the American Psychiatric Association and major pharmaceutical companies such as Lilly, GlaxoSmithKline, and Solvay are located in the United States and the United Kingdom. Furthermore, the most prestigious and well-funded research institutions exist primarily in the Continental U.S. and Western Europe. With these resources, the APA and the pharmaceutical industry are self-sustaining, not needing to look to other countries or regions for help. Because of the unbreachable power structure surrounding it, the DSM unilaterally sets the global standard for diagnostic categories and treatment protocols.

Philosopher Michel Foucault would describe the DSM as an example of “global, totalitarian theory” (1980, 80). In his paradigm of power/knowledge, Foucault links widely known information to the systems of power that have produced it and disseminated it. Foucault argues that there is no universal, objective reality which validates that such common knowledge is the absolute truth. Rather, there are equally valid forms of knowledge that have been “disqualified” simply because they were not produced by powerful, Western institutions (Foucault 1980, 82).
As previously stated, Somer and his team are based in Haifa, Israel. The other key contributors to the ICMDR are located in Italy, Poland, and Romania. Over the last twenty years, the ICMDR has produced almost eighty peer-reviewed articles, which validate the existence of MD as a discrete disorder as well as the efficacy of the DSM-16 in diagnosing it (“Publications on Maladaptive Daydreaming”). However, I argue that the primary roadblock to APA recognition lies not in the size of the ICMDR’s research canon, but in the geographical location of its researchers. For this reason, Foucault would describe the ICMDR as “a subjugated genealogical discourse” (Foucault 1980, 85).

Culture also speaks to the ICMDR’s subordinated position. As explored above, the DSM has a rich history that is solidly grounded in American norms and politics. Yet I believe that MD has also been shaped by American culture. In the Social Axis, I explained how MD is inherently a postmodern disorder with global implications, as it stems from the overuse of technology, the legacies of metropolitan blasé and loneliness, and the international propagation of Western media. However, it could be difficult for the APA to receive Somer’s narratives if he and his patients appear to be The Other rather than Most People simply because they are located outside of the U.S.

The next roadblock I encountered was chiefly concerned with the exclusionary logic and limitations of cross-cultural psychiatry.

**ROADBLOCK 2: Cross-Cultural Illegibility**

I can infer that Somer has a thorough understanding of this roadblock. In order to be included in the DSM’s global, totalitarian theory (Foucault 1980, 80), the ICMDR must prove MD is a global phenomenon.
In 2020, Somer and one of his protégé’s, Nirit Soffer-Dudek, designed a study to test if the MDS-16 translated accurately across cultures. By demonstrating that MDers from different countries had the same understandings of the four factors of MD, Somer and Soffer-Dudek could prove that this was not a localized disorder. The self-diagnosed study participants were pooled from the United States, the United Kingdom, Turkey, and Italy. While all participants had the same understandings of MD’s Kinesthetic elements, social Impairment, and functionality of Music, it was clear that Yearning and its relationship to personal Impairment did not translate cross-culturally.

In the study, Yearning was presented to participants as “the extent to which one consistently feels drawn to daydreaming and has a strong, addictive urge to engage in daydreaming” (Soffer-Dudek et al 2020, 1060). Here we see Yearning synonymized with addictive cravings. Moreover, one of the questions in the MDS-16 gives addiction a positive connotation: “Some people love to daydream. While you are daydreaming, to what extent do you find it comforting and/or enjoyable?” The indefinite relationship between Yearning, personal Impairment, addiction, and enjoyment revealed the cultural divisions among participants.

Overall, the participants from the UK did not correlate enjoyment with their addictive urges. In other words, British participants did not necessarily believe that they were addicted to daydreaming because they enjoyed it. Somer and Soffer-Dudek further explored this finding by referring to a British study conducted on smart-phone addicts. Here participants described their time spent on social media and online shopping as compulsive and wasteful (Andreassen et al. 2013; Lopez-Fernandez et al. 2017; Laconi et al. 2018). I argue that this cultural belief about behavioral addiction stems straight from
capitalistic practices in the UK. If the ideal metropolitan is constantly productive, then anyone who engages in idle activities like checking Facebook is engaging in an errant behavior.

As a result, Somer and Soffer-Dudek’s study participants from the UK viewed their Yearning to MD as a sign of their personal Impairment. Conversely, the MDers from Italy had an entirely different conception of addiction. Italian MDers considered their addiction to daydreaming to be strongly correlated with how much they enjoyed their fantasy worlds, making personal Impairment totally irrelevant to Yearning. Clearly, idle time is much more positively valanced in Italy than it is in the UK. I also understood this finding through an economic lens— if one’s worth and belonging does not rest on consummate productivity, then overindulging in fantasy is not necessarily problematic.

Although this study did prove that MD exists across different cultures, it also demonstrated that the MDS-16 itself might not translate perfectly to all MDers around the globe.

The cross-cultural translation of diagnostic categories has long been a key issue for the pharmaceutical industry, specifically in the arena of direct-to-consumer advertising. One of the best examples of such a marketing predicament was advertising American anti-depressants in Japan in the 1990s.

If the 1980s was the heyday of disseminating Anxiety Disorder and panic attacks to the public, then the 1990s was the pinnacle of Major Depressive Disorder. The publication of the DSM-IV in 1994 marked another major paradigm shift for the APA, further entangling it with the pharmaceutical industry. Psychopathologies had now morphed into brain diseases, meaning that psychotropic drugs did not merely numb
repressed memories in the subconscious, but rather corrected “chemical imbalances” in the brain (Good 1992).

However, Japanese culture did not view psychological distress as a chemically-driven brain disease. Rather, depression was considered a taboo topic, one that generally lay outside the purview of medicine. When the British company Solvay wanted to market their serotonin-uptake inhibitor Luvox in Japan, they were targeting the same depressive symptoms exhibited in Westerners, but they had to present a more culturally competent narrative in order to make a profit. As a result, Solvay created an advertising campaign that rebranded depression as a “soul cold,” as opposed to a chemical imbalance. Billboard advertisements for Luvox invoked drivers: *Does Your Soul Have A Cold?* (Martin 2009, 15).

This roadblock demonstrated to me how the diagnosis is equally concrete as it is malleable. While the making of a diagnosis is an exacting process that requires significant peer-reviewed data, anything goes when it comes to marketing a diagnosis to the public. The case study of marketing Luvox in Japan demonstrates how the pharmaceutical industry was willing to compromise the DSM’s neurobiological paradigm in order to expand its international presence. While the burden of proof currently rests on Somer to demonstrate MD is a global disease, twenty years of work might mean little when presenting MD and its medications to international markets.

This roadblock speaks to illegibility in several ways. Firstly, inclusion in the DSM ultimately remains a mystified process as it is difficult to predict the APA’s next moves because profits ultimately have the final say. Secondly, clinicians cannot control how their research is read. Essentially, researchers in Somer’s position have to simultaneously
prove that their diagnosis is global and that it is also representative of the universal, normative Westerner. It is then up to pharmaceutical companies to “translate” the Western psyche to the Other.

When uncovering the third and final roadblock I realized that in his own way Somer has had to market MD and the MDS-16 to the APA. In order to be included in the DSM-VI, Somer must not only prove that MD is a global phenomenon, but also that it is discrete enough from existing disease categories to have its own diagnostic tool and its own medications.

**ROADBLOCK 3: Competing Pharmaceutical Selves**

This roadblock required me to return to the beginning of this project. In the Introduction, I presented a self-reflexive, performative literature review of the ICMDR’s canon and related psychological accounts of daydreaming. Although I wrote truthfully about what my daydreaming world looked, felt, and sounded like, I emplotted my subjectivities within objective descriptions of fantasizing. These peer-reviewed, objective descriptions of fantasizing were meant to simultaneously represent all daydreamers and also very specific kinds of daydreamers.

Based off the scholarly literature, I realized that there were four kinds of Daydreaming Selves that I employed while writing. I began as an Attention-Deficit Daydreamer, in which the majority of my thoughts as an elementary schooler were concerned with recreating film scenes as opposed to engaging in my schoolwork. A few years later, when I first began to struggle with my physical health and, by extension, forming meaningful relationships with my peers, I became a Dissociative Daydreamer.
As opposed to my Attention-Deficit Daydreaming Self, my mind would now flee into my fantasies. Dissociative Daydreaming served as a means of escaping a reality that was too painful for me to bear at the time.

By the time I reached middle school, I had become an Addict Daydreamer. I realize now that I embodied both the Italian and British conceptions of behavioral addictions, which I explored in Roadblock 2. At first, I kept up my daydreaming habit simply because I enjoyed it. However, eventually my addiction became distressing and impairing because I no longer had a choice in whether I daydreamed or not—fantasizing was now a compulsion. After years of remission, the stresses of the COVID-19 pandemic showed me that I had become a Discrete Daydreamer. My former Daydreaming Selves all resembled disorders that had already been recognized by the APA, namely Attention-Deficit Hyperactivity Disorder, Structural Disassociation, General Behavioral Addiction, and Obsessive-Compulsive Disorder. I argue that my experience during lockdown demonstrated that MD is a unique disorder that has symptoms which resemble other diagnoses, yet the presentation and experience of these fantasies’ merits recognition.

The concept of discreteness became increasingly important to the APA in the 2000s when preparing the DSM-V. While the addition of more disorders into the DSM-III made the APA appear more reputable in 1980, this praise did not age well. In the new Millennium, the DSM’s plethora of disorders were now considered to be overlapping and repetitive. Was there a need to keep Social Phobia, General Anxiety Disorder and Panic Disorder as discrete entities when they were all treated by the same class of medications?
As a result, the APA was less open to adding new disorders into the DSM-V, unless researchers could prove that they had identified a disorder that did not significantly intersect with preexisting categories.

I would argue that discreteness is an equally critical factor for the pharmaceutical industry as it is for the APA.

Anthropologist Janis Jenkins explains that we all live in a Pharmaceutical Imaginary. In The Pharmaceutical Self: The Global Shaping of Experience in An Age of Psychopharmacology, Jenkins is chiefly concerned with how “magic, science, and religion” play a role in postmodern life (2011, 3). According to Jenkins, the imaginary is “the dimension of culture oriented towards conceivable possibilities for human life.” In particular, the Pharmaceutical Imaginary is the portion of our culture’s potentiality where pharmaceuticals are critically important. In this space, we are able to imagine how we can be changed, improved, even perfected by consuming psychotropic medications (Jenkins 2011, 6-7). Specifically, it is our Pharmaceutical Selves who are oriented to who we could be in this imagined space.

I contend that the DSM facilitates the creation of two different Selves in psychiatric patients. Another way to view the APA’s recognition process is to see it as an approval of a Diagnostic Self, one we can try on for size in an intake meeting with our clinician. However, we engage with the potentiality of our Pharmaceutical Selves when watching TV commercials and flipping through magazines.

The Pharmaceutical Self calls into question not only how MDers will be portrayed in advertisements, but also what medication for MD would do exactly. In a few years, will we be consuming advertisements that show a hyperactive dreamer who must be
tamed? A dissociative dreamer who must be snapped back to reality? A discrete dreamer whose imagination has been destroyed altogether?

As an MDer, I think the beauty of this neurodiversity is in its vastness. In my MD World, I have been magical and all-powerful, downtrodden, and exiled. In orienting to my imaginary space, I have both idly passed through it and clung to it with the same intensity of my cravings; I have fled to it seeking a safe haven, only to desperately try to break free of its captivity. While I argue that my personal imaginary demonstrates that MD is a discrete disorder, I do not know how palatable it would be to our collective Pharmaceutical Imaginary—a space where we all embody discrete diagnoses that neutralize our personal differences.

This final roadblock best demonstrates Somer’s potential to be an alchemist. Twenty years ago, no one considered fantasizing to be a pathology. In his time as the Father of Maladaptive Daydreaming, Somer has created a language for dreamers who have become ensnared by their imaginations. Now that he is nearing his ultimate destination, there are a variety of traps that could befall MD in its marketing process. However, after spending the last two years following his footprints, I have no doubt that Somer will continue to do everything he can to make the DSM’s power dynamics benefit his dreamers.

**DAYDREAMING POTENTIALITIES**

If anything, Somer has already equipped MDers with the necessary tools to hold their own against the APA and the pharmaceutical industry.
By creating a platform for MDers’ personal and collective stories in the ICMDR, Somer has given his patients a head start in marketing their disorder. In the Personal Axis, I witnessed adult women who were unafraid to be publicly vulnerable about their daydreaming habit. In the Social Axis, I saw how virtual communities balance validating the individual MDer’s suffering with preventing an exclusionary narrative from taking hold that posits there is a Universal Daydreamer.

I predict that the rich narratorial legacy of MDers has largely co-opted the work of the pharmaceutical industry. If anything, powerful pharmaceutical companies must either comply with the narratives MDers have already disseminated in the form of personal essays, videos, and memes. Or, these companies must counter with a marketing narrative of their own—and be prepared to defend it. MD might very well mark the beginning of a true reversal of the narratorial powers long held by the APA and the pharmaceutical industry.

Indeed, we might be on the precipice of a cultural imaginary where official diagnoses are merely one way of conceptualizing illness among many. In such a Daydreaming Potentiality, we could imagine structuring work and school days to allow for idle time, destigmatizing fantasy proneness in adults, and valuing the limitless potential of young daydreamers.
CONCLUSION
A Cartographer ‘s Reflections
Nothing about this thesis— the process of writing it and the final product itself—turned out like I imagined it would.

In Chapter 1, I wrote about a series of notebooks I kept over Summer 2020. After “Meditations from Planet Lockdown” concluded, I started a new series of journals called “The War Books.” Like a general orchestrating an all-or-nothing mission, I was intent on eradicating my physical illness once and for all, knowing that it would be impossible to finish my senior year in good standing and advance my professional goals if my symptoms progressed. I treated my body as though it was harboring insurgents, intent on sabotaging my ambitions.

In Spring 2021, I titled my journals “The Nature of Lists.” Therein, I enumerated every aspect of my life— when I was required to submit my COVID tests, what I ate that day, the intermittent deadlines for my senior thesis. I was experiencing the beginnings of memory loss at the time, though I did not realize it.

In the Summer and Fall of 2021, I kept “Fieldnotes from Virtual Expeditions.” Not only was I conducting research on the ICMDR’s website and r/MaladaptiveDreaming, I was also conducting ethnographic interviews on Zoom. I had the honor of interviewing Dr. Eli Somer and Dr. Igor Pietkiezwicz, two of the most prominent MD researchers of our day. In addition, I also had virtual “deep hangouts” with four MDers who had responded to my “Call for Research Participants” post on r/MaladaptiveDreaming.

Although I was technically immersed in the Maladaptive Daydreaming World, I felt as though I was elsewhere. I could not remember the readings I had done in preparation for this thesis. It was difficult for me to remember the content of field notes I
had written only the day before. When I would get my meals at one of Princeton’s dining halls, fellow students would sit down next to me with such eagerness and familiarity that I simply could not reciprocate. Although I recognized their faces, it was as though an ominous absence had replaced my capacity for connection.

Growing up, I watched several of my family members lose their memory, but I always imagined that they too felt grief for their loss of Self, a mourning that mirrored my own. Now that I have inherited the same illness, I now understand what lay behind the blank stares I used to receive.

I wrote the Introduction to this thesis in Fall 2021, around the same time when I should have produced a full draft. A few weeks later, when I began “Brief Inquiries Into My COVID-19 Isolation,” I was two weeks away from my last class at Princeton. It was then that I realized that the Self I thought I was—a full-time student, diligently working towards my degree—had dissolved some time before without my noticing.

In the last eight months, there were two instances when I swore that my former Self had returned. In March 2022, I produced Chapter 2 of this thesis, The Personal Axis. In June 2022, I wrote Chapter 1, in which I elucidated the expeditions methodology I employed in the Introduction, the first draft of which I had produced almost two years previously. The summer of 2022 proved to be a period of rejuvenation—I wrote The Social Axis in July and The Clinical Axis in August. With the unfolding of this project, a new Self had emerged.

Anthropologist Paul Rabinow had a similar experience when penning Reflections on Fieldwork in Morocco. This short text is a series of meditations on the making and unmaking of the ethnographic method he had utilized for his 1975 monograph, Symbolic
Domination: Cultural Form and Historical Change in Morocco. Rabinow published his Reflections two years after publishing his full-length ethnography—only when looking back on his fieldwork experience did his companion project come into view in the present. Rabinow describes this as phenomenological hermeneutics, a process in which he understood his current Self only by understanding his former Other. From his present location, he could reflect on his fieldwork and reconstruct a map which would guide future students as they navigated their ethnographic methods course (Rabinow 1977).

When I first read Rabinow’s work in Fall 2019, I had a hard time grasping how he understood his ethnographic Self only when looking back on his fieldwork. Isn’t an anthropologist supposed to know their location before they embark? Furthermore, aren’t anthropologists supposed to plan out their projects down to the letter so that everything goes as planned? My experience of living through lockdown and surviving a COVID-19 infection equipped me with the experience to not only understand phenomenological hermeneutics, but to employ it in my own work.

One could argue that this thesis is a complete redesign of my original project proposal. After all, I included only a small fraction of the ethnographic data I had collected. However, I view POSTMODERN REVERIES as an absolutely necessary step in the process of writing the monograph I had envisioned. With this project, I have created the three different maps my future ethnographic Self will need to see this dream come to fruition.

The first map is the only one plainly presented in this thesis—an exploration of the Personal, Social, and Clinical Axes of the MD World. The second map is a latent one with dissimulating properties. The ethnographer I was in 2020 was not the ethnographer
who could write the project I had envisioned. Back then, I could not see beyond The 
Tyranny of the Diagnosis, which obscured other possibilities for conceptualizing 
disability, impairment, and accessibility from view. The third map, however, exists only 
in my imagination.

Over the years, Rapp and Ginsburg have written extensively about the concept of 
“disability worlding.” This concept “supersedes a framework that too easily 
pathologizes” the differently abled as “suffering subjects.” As a writer, ethnographer, and 
aspiring disability scholar, I have now mapped out an inner world where I “embrace [the] 
challenges” I face every day as I navigate a world that was designed for the able-bodied 
and the neurotypical. In my personal disability world, the “creative solutions” I have 
crafted to finish my degree and to embark on my career are celebrated for their ingenuity 
(Ginsburg and Rapp 2020, S6-S7). From this imagined space, I can harness the natural 
resources to write an autoethnographic account of (dis)ability, human plasticity, and the 
inexorable power of Maladaptive Daydreamers.
Bibliography


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I pledge my honor that this thesis represents my own work in accordance with Princeton University regulations.

/s/ Alexandra Marino