

**From adaptive fantasy to dissociative psychopathology:
On forms of daydreaming**

by
Eli Somer

A commentary on Young, W.C. (1988). Observations on Fantasy in the Formation of Multiple Personality Disorder Dissociation. *Dissociation*, 1(3) 13–20. ISSTDNews, Members Clinical Corner, June, 2013.

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I started Kindergarten at age 6 and, from what I understood from all the children (my Mom didn't really give me self esteem), I was ugly...so I spent many a lonely day at school without friends, sitting alone on the playground or not being chosen for games because everyone said "she's ugly"..... during those lonely times on the playground, I watched kids play...When I got home, I immediately went to my room, closed the door AND ROLE PLAYED ANY ONE OF THOSE CHILDREN (emphasis here and following by Randle, 2010) to get out of being "ugly" self and being one of them. If someone did knock on the door, I would instantly "snap" back into myself and carry on as usual. But leave me alone, it was like my ugly self would drop to the floor and I was into whomever I wanted to be. Right now, I've been in a role play fantasy for one character for over 3 years...How can I get rid of this problem? I don't take care of MYself, hate MYself and am only happy when I'm role playing or fantasizing being someone else. I only find comfort, control and esteem when I

am one of my many characters and would like to switch the character to be ME and find happiness in my life. No one knows (except now this forum) that I do this.....these characters (like my imaginary friends when I was a child) support the "character" me, make the "character" me feel important, sensual...EVERYTHING. The real me I hate ...
(Randle, 2010).

This excerpt is typical of numerous first person accounts posted on the internet describing apparently voluntary, conscious mental behavior that is reported by some to be compulsive and almost uncontrollable. These behaviors appear to be based on normal childhood tendencies that when providing an escape from aversive emotional experience can evolve into a rewarding coping mechanism against loneliness, rejection and abuse. Not unlike other addictive behaviors, an enjoyable recreative activity when used excessively to ward off distress can develop into a debilitating dependence.

In the excerpt above, normal childhood fantasy had probably eased the distress of social isolation but later developed into a maladaptive behavior, leading the writer to seek help from an on line audience. Readers of this column might wonder if this behavior belongs to the OCD spectrum of disorders, or is it a dissociative disorder? Along with those questions comes the problem of determining an appropriate approach to treatment. At present, our field does not have adequate answers to these questions, but as I indicated below, we hope to apply emerging knowledge to the solution of this puzzle in the near future.

Walter Young's article, published a quarter of a century ago, focused on childhood fantasy in cases where the child's unfolding imagery and ideas were used in service of wish fulfillment or wishful mastery over a severe reality. I returned to his early article recently because I thought he captured well the role normal childhood fantasies of mastery can play in the construction of dissociative identity disorder (MPD at the time) thinking that although the outcomes are distinct, clear parallels exist between the etiology described by Young and the (yet unclassified) psychopathology presented in the excerpt above.

Young's basic argument is that much of the clinical phenomena in DID arises when fantasies of restitution are repressed and then defensively incorporated into dissociative states. According to Young, derivatives of these repressed fantasies reappear as the clinical picture of DID emerges and as the structures shaped by the fantasies are developed. Young suggested that the clinical expression of DID in some situations represents the incorporation of early imaginary playmates, but may also represent a later use of a variety of other fantasies, all employed in an attempt to solve the child's unmanageable dilemmas. In these instances, he claimed, what begins as a conscious fantasy is gradually repressed, and becomes represented in an increasingly complex dissociated structure. This process can include the reemergence of a derivative of the fantasy form, which becomes part of the internal landscape of DID. Young asserted that at that stage the material of that prior fantasy life is forgotten by the patient and operates out of awareness as "a defensive structure with relative autonomy". He posited that newly split states of dissociation initially occur separately at moments of abuse and later incorporate fantasies of restitution for defensive purposes. Young termed the gradual evolution of alter personalities "the structuralization of fantasy" and maintained that this process is accompanied by dissociated activity not limited to fantasy, but including the dissociation of the entire traumatic memory with its affects, sensorimotor components, distortions and associations.

I came across this classic article recently, as part of a literature review on daydreaming, a topic I have been interested in for quite some time. I found Young's linkage of childhood fantasizing under duress with dissociative processes to be helpful.

About thirteen years ago, many years after Young's article had been published, I began noticing that a significant portion of my trauma practice had a rich inner world of fantasy in which they preferred to spend their time. Until then, it never dawned on me that this form of coping might be related to dissociation. I had regarded inner fantasy life as a normal mental activity akin to the tendency to drift off, get lost in thoughts, or daydream. My view of the process was influenced

by Jerome Singer's definition of daydreaming as the normal activity of shifting attention "away from some primary physical or mental task toward an unfolding sequence of private responses," or, more simply, "watching your own mental videos." (Glausiusz, 2011). In his seminal book Daydreaming, Singer (1966) reported that 96 per cent of presumably normal, fairly well-educated American adults engaged in some form of daydreaming daily. Most reports indicate that this mental activity occurs chiefly when a person is alone (e.g., in bed before sleep) and tends to focus on planning future actions and reviewing interpersonal contacts. However, while little research data exists regarding the amount of daydreaming in normal subjects, I had a growing suspicion that what some of my patients reported exceeded the normal bounds of daydreaming.

Were my patients "fantasy-prone"? This term was coined by Wilson and Barber (1981, 1983) whose study of excellent hypnotic subjects serendipitously revealed them to also be a group of avid daydreamers, later characterized as "fantasy-prone personalities." Wilson and Barber suggested that fantasy proneness was manifest in as much as 4% of the population, and that it represents generally adaptive experiences, fantasy abilities, and personality traits. However, they proposed another pathway to extreme daydreaming, that is, fantasy as a means of coping with loneliness or isolation and escaping from aversive environments.

Consistent with J. R. Hilgard's hypothesis that hypnotizability is related to a history of physical punishment (Hilgard, 1974, 1979), others have shown that a history of imaginative involvement is indeed linked with exposure to aversive childhood experience, including harsh physical and sexual abuse (Rhue & Lynn, 1987). Among individuals with a history of childhood abuse the incidence of fantasy-proneness ranges between 9% and 14% (Rhue, Lynn, Henry, Buhk, & Boyd, 1990). Nonetheless, I was not convinced that term *fantasy-proneness* adequately described the quality and quantity of daydreaming activity reported by some of my patients, many of whom would prefer to live in their alternate worlds for many hours a day.

Based on my observations, I coined the term "Maladaptive daydreaming."

(MD) (Somer, 2002) and defined it as fantasy activity so extensive that it replaces human interaction and/or interferes with academic, interpersonal, or vocational functioning. In a qualitative research paper I described 6 patients who demonstrated fantasy involvement sufficient to merit the label of MD. Four were diagnosed as suffering from a dissociative disorder and two were given the diagnosis of narcissistic personality disorder. Cross-sectional analysis of respondents' verbatim transcripts yielded nine themes that best captured the MD experience. The results suggested that for these patients of mine MD functioned to provide disengagement from stress and pain through mood enhancement and wish fulfillment fantasies, as well as ameliorating needs for companionship, intimacy, and soothing. All these functions could very well join with "simple" dissociation of traumatic memory and affect and augment its effect.

Recurrent themes in MD fantasies included violence, imagining an idealized self, power and control, captivity, followed by rescue and escape, and sexual arousal - themes that also typically preoccupy the minds of childhood survivors of neglect and trauma. My preliminary documentation of the characteristics of this pool of MD clients identified a normal childhood propensity for creative imagination, followed by aversive circumstances that appear to have contributed to the development of the degree of involvement characteristic of MD.

What followed the publication of that initial research was surprising. While the article seemed to have very little impact on the scientific community, I began receiving emails from individuals across the globe identifying themselves as MD sufferers, and seeking advice. What began as a moderate trickle developed into a barrage of communications. From these emails I learned about a growing and substantial number of online forums and web pages on which thousands of anonymous posters from around the world professed to have secretly suffered with these symptoms for years. Following are links to some of the internet websites and forums dedicated to discussions of and by maladaptive daydreamers:

Somer/Maladaptive Daydreaming

- <http://www.experienceproject.com/groups/Suffer-From-Maladaptive-Daydreaming/304795>
- <http://www.psychforums.com/obsessive-compulsive/topic76260.html>
- <http://voices.yahoo.com/maladaptive-daydreaming-11223240.html?cat=5>
- <http://wildminds.ning.com/>
- <http://www.daydreamingdisorder.webs.com/>
- <http://www.daydreamingdisorder.webs.com/>
- <http://www.revolutionhealth.com/forums/mental-behavioral-health/111247>
- http://www.indiaparenting.com/comments/124_890/day-dreaming.html

Someone (not me, I swear) even created a Wikipedia page on MD

(http://en.wikipedia.org/wiki/Maladaptive_daydreaming).

My communication with MD sufferers world-wide assured me that such a problem indeed exists, that it is unrecognized and rarely addressed professionally when people with MD seek help. I also learned that there might be more than one path leading to MD. An illustration of the diversity of the phenomenon was provided in a peer-reviewed case-study (Schupak & Rosenthal, 2009). The 2009 article was titled: *Excessive daydreaming: A case history and discussion of mind wandering and high fantasy proneness*. It described a patient with MD which has caused her distress but was not incident to any other apparent clinical psychiatric disorders or childhood adversity. The patient was successfully treated for over 10 years with fluvoxamine therapy, that reportedly helped to control her daydreaming. The fact that this patient responded to a medication that influences serotonergic tone, implied neurochemical irregularity and the possibility that some compulsive daydreaming might be related to obsessive-compulsive spectrum disorders. The possibility of more than one pathway is leading to MD was further reinforced by Bigelsen & Schupak (2011) who presented data from 90 individuals who self-identified as “excessive” or “maladaptive” fantasizers. Participants shared a number of remarkably specific behaviors and concerns regarding their engagement in

extensive periods of highly-structured, immersive imaginative experiences, including the use of kinesthetic activity which accompanied the fantasies of 79% of participants. Kinesthetic activity was also described in my 2002 article where I interpreted it as trance-inducing. Participants in the Bigelsen & Schupak study (2011) reported distress (88%) and shame (82%) stemming from difficulty in controlling the need to engage in fantasizing and concern that the quantity of daydreaming interfered with social functioning (24%), all hallmarks of potential psychopathology. However, only 27% of their participants reported early trauma and/or childhood abuse, again suggesting that this apparent addictive cluster of behaviors might stem from divergent etiologies. The data also imply that some 12% of excessive daydreamers are not distressed by it, suggesting that for them, this indulgence in fantasy was mostly enjoyable. Reports of maladaptive, compulsive daydreamers among individuals with no reported trauma history suggest MD can be extremely gratifying. Not unlike consciousness altering mechanisms such as psychological or chemical dissociation, that can be enjoyed recreationally or spiritually; or cause dysfunction when used excessively; daydreaming too have potential merits, but can become harmful if used excessively.

Young (1988) correctly identified the soothing or empowering properties of fantasy, particularly when utilized successfully as buffers against impossible dilemmas or uncontrollable stress. An abused child can profit immensely from fantasizing that her violated body is not hers, that she is not in that body, that she is someone else, that she is strong or safe because she is a boy or an adult or that her beloved abuser is actually a monster. When such fantasies are developed, relationships between imagined characters and elaborated plots can help victims create alternative realities to their unbearable circumstances. Portions of what begins as a conscious fantasy may be dissociated out of conscious awareness and can later evolve into autonomous alters with an active inner life or delusions of complete separateness. That is, normal childhood propensity for vivid imagining, can be utilized as a psychological buffer against childhood adversities. The gratification experienced following a relief in suffering

motivates some victims to develop their natural childhood ability into DID or MD, two related but distinct processes. In one the focus of alteration is the sense of identity, in the other the focus of change is the experienced reality.

I hope that data I am currently collecting with American colleagues will help determine the validity of the concept of MD, its inner structure, the prevalence of MD and its relationship to dissociative disorders. Beyond the theoretical implications of this concept, its main utility would be the correct identification of a group of individuals who are struggling with a plight with neither a name nor a remedy.

Call for Participation

Together with researchers from Fordham University, New York, I am presently working on a large study of MD sufferers. Our intention is to create screening tools to help identify MD, to more fully understand how it differs from more typical daydreaming, and to learn more about its relationship to other mental health issues. As part of that effort, we hope to recruit both maladaptive daydreamers and people who do not have MD. You are invited to complete the following confidential online survey and to encourage others to do so (<https://www.surveymonkey.com/s/daydreaming>). We expect that it will take between 20 and 50 minutes. We plan to collect data through the month of May and we hope to report our preliminary results in the ISSTD 2013 conference in Baltimore.

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