

The Micro-Politics of a New Mental Condition: Legitimization in Maladaptive Daydreamers' Discourse

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This study illuminates legitimization efforts in the discourse of individuals who suffer from excessive, uncontrolled daydreaming: a contested mental condition that has not yet been recognized by the medical establishment. It aims to explore the rhetorical maneuvers employed by these “Maladaptive Daydreamers” in 35 email exchanges with the second author and two petitions, submitted to the American Psychiatric Association and to the UK Parliament, with a demand for recognition. Our analysis, anchored theoretically and methodologically in Critical Discourse Analysis, identified several verbal strategies employed by the participants to persuade their interlocutors about the realness of their suffering. The main strategies were clustered into three dimensions: (1) professional—appealing to the audience’s professional identity as scientist-practitioner and presenting shared knowledge; (2) social—forming a joint consensus group, a coalition or a partnership; (3) psychological—appealing to the interlocutor’s emotions through gratitude, self-disclosure or humor. This bottom-up analysis, positions individuals’ claims as a starting point for knowledge-dissemination and institutional change and blurs the modern dichotomy between the objects and subjects of medical gaze. Keywords: Maladaptive Daydreaming, Medicalization, Discourse, Legitimization, Rhetoric

Introduction

In this article we focus on the voice of “lay” people who suffer from a contested syndrome and on their struggle for recognition and legitimation. “Maladaptive Daydreaming” (MD) is an absorptive and compulsive fantasy activity that causes distress because it interferes with social, academic, interpersonal or vocational functioning (Somer, 2002). The phenomenon was recently described as an excessive form of immersive daydreaming that produces not only a rewarding experience based on a created fantasy of a parallel reality, but also dysfunctionality and distress associated with persistent and recurrent fantasizing activity (Somer, Somer, & Jopp, 2016a). Internet users around the world have adopted this relatively new term to facilitate communication, confer collective identity and give meaning to their mutually distressing condition. Still, the existence of MD has yet to be acknowledged by the medical and psychological establishments. MDers have reported that their condition is often encountered with doubt or puzzlement by mental health practitioners (Somer, Somer, & Jopp, 2016b), and its descriptions and explanations are a matter of dispute (Zepps, 2015).

To this end, we consider and further develop the model proposed by Livnat & Lewin (2016) - usually employed for the analysis of public political speeches - to explore the rhetorical maneuvers¹, persuasive acts and verbal means used by individuals with daydreaming, (Maladaptive daydreamers, hence, MDers) to negotiate their viewpoint vis-à-vis claims emanating from skeptical authorities.

¹ The use of the term “rhetorical maneuvers” follows post-structural thinking and emphasizes the role of language and discourse in processes of subject positioning.

In this article, we examine the discourse of MDers by analyzing 35 email exchanges and two petitions submitted to the American Psychiatric Association and to the UK Parliament, demanding that MD be recognized as a mental disorder. Informed consent and ethics board approval were recruited. The main research questions are: What type of language do MDers use to certify their claims? How do they legitimize their subjective experiences and convince others that MD is a valid condition? In other words, we seek to examine the micro-political processes of medicalization - the bottom-up reification of MD and how it emerges from “lay” people’s accounts. By directing attention to the discourse of individuals and their demands for nosological classification and consequent treatment, we re-examine the social locations of medical knowledge and highlight the influence-possibilities of “lay” knowledge and its involvement in the construction of illness.

Maladaptive Daydreaming

The phenomenon of daydreaming is a highly prevalent mental activity experienced by almost everyone (Singer, 1966). It is thought to encompass almost half of all human thought (Killingsworth & Gilbert, 2010), with hundreds of daydreaming sequences experienced daily (Klinger, 2009). Maladaptive daydreaming, on the other hand, was first described as an extensive and distressing fantasy activity that causes dysfunction (Somer, 2002). The interviewees in Somer’s seminal paper constituted a small clinical sample of socially withdrawn and functionally impaired individuals who had sought help for dissociative and personality psychopathology associated with aversive early life experiences. MD seemed to have initially represented a preference for disengagement from life’s pains by means of mood-enhancing fantasies about an idealized self, companionship, intimacy, resourcefulness and power (Somer, 2002).

Seven years later, the next research publication on MD was a single-case study that described the successful treatment of excessive daydreaming with 50 mg/day of fluvoxamine, an antidepressant believed to influence obsessive-compulsive symptoms (Schupak & Rosenthal, 2009). The authors also reported that “the patient discovered a website containing a surprising number of anonymous postings on the topic of excessive or uncontrolled daydreaming. Numerous posters described patterns and tendencies that appeared remarkably consistent with the patient’s experience” (Schupak & Rosenthal, 2009, p. 291). This report is the first indication of the grassroots, consumer-driven action culminating in the process we analyze in this study. That India-based website addressed parenting concerns and featured an international interactive forum on daydreaming that has been part of a larger section on children’s behavioral problems (IndiaParenting.com; Jane Bigelsen, personal communication, March 6, 2016). Apparently, it was on this forum that the 2002 paper was initially mentioned and where internet users first adopted the term *maladaptive daydreaming* to communicate with each other about their nameless condition².

In 2011, Bigelsen and Schupak retrieved data from members of a MD cyber community and reported that “a host of online forums and web pages began to proliferate on which thousands of anonymous posters from around the world professed to have secretly suffered with these symptoms for years” (Bigelsen & Schupak, 2011, p. 1634). This global interest in MD was also translated into coverage in the print and electronic media³, which according to

² IndiaParenting triggered the term’s viral spread on the World Wide Web and the subsequent sprouting of numerous other online platforms disseminating knowledge about and providing peer-support for MD.

³ Examples include an article in *Scientific American* (Glausiusz, 2014), a newspaper article in *De Standaard*, a Flemish daily newspaper published in Belgium (Le Blanc, 2015), a magazine article in *The Atlantic* (Bigelsen and Kelly, 2015), a Canadian Broadcasting Corporation radio show (Tremonti 2015), and articles in *Men’s Health* (Bonaguro, 2015), *The Wall Street Journal* (Reddy, 2016), the Israel daily newspapers *Haaretz* (Efrati, 2016) and

Kroll-Smith (2003), has growing significance in creating and conceptualizing medical phenomena by shaping public perceptions.

In light of broad consumer interest in MD and its wide-ranging media coverage, *The Huffington Post's* online television network, HuffPost Live, aired a scholars' discussion on MD (Zepps, 2015) featuring Eric Klinger, Emeritus Professor of Psychology, University of Minnesota, a leading daydreaming scholar; Scott Barry Kaufman, Scientific Director, Imagination Institute, University of Pennsylvania; Jayne Bigelsen, a former maladaptive daydreamer and co-author of several papers on MD; and Eli Somer, an MD scholar. The show was titled "Is Excessive Daydreaming a Psychiatric Disorder?" and presented substantial disagreements. Klinger, for example, questioned the classification of MD, saying: "I feel very uncomfortable about pathologizing it... It is the underlying problem that really is the key here." In an interview in the *Wall Street Journal*, Klinger reiterated his skepticism that MD should be its own separate mental condition: "I'm very reluctant to create a category for a mind-wandering disturbance. Once you start psychopathologizing these things you can get yourself in trouble, because often normal mechanisms account for this" (Reddy, 2016).

Skeptical views on MD were also voiced by experts in two other prominent news media. A recent *Wall Street Journal* story on MD featured Jonathan Schooler, a professor in the Department of Psychological and Brain Sciences at the University of California, Santa Barbara. Schooler stated:

Whether it deserves its own distinct diagnosis and the degree to which it's not just anything more than the extreme end of the distribution of mind-wandering is not clear to me. Frequent mind-wandering can be a symptom of a variety of other mental conditions, such as attention-deficit disorders and depression. (Reddy, 2016)

A CNN report on MD recently quoted clinical psychologist Peter Kinderman of the University of Liverpool who said, "MD is a good example about wanting to apply the medical disease model to elements of the human experience... I would not create a new category of mental disorder for daydreams" (Pequenino, 2016).

After publication of the second and third papers on MD (Bigelsen & Schupak, 2011; Schupak & Rosenthal, 2009), two major interactive processes ensued: (1) Email traffic from members of the global MD community to the authors of the three published papers increased. The writers provided personal testimonies about their MD experiences, requested advice, urged the authors to promote research on MD and volunteered to take part in future MD research. (2) Scientific collaboration began between researchers who had independently been writing about MD: Jayne Bigelsen and her colleagues in the USA and Eli Somer and his research associates in Israel. This collaboration began with a series of in-depth Skype interviews that examined the nature of the MD experience (Somer, Somer, & Jopp, 2016a; Somer, Somer, & Jopp, 2016b). It progressed to the development of an MD scale (Somer, Lehrfeld, Bigelsen, & Jopp, 2016) and the presentation of data indicating that MD is a distinct mental disorder (Bigelsen, Lehrfeld, Jopp, & Somer, 2016)⁴.

This brief history of MD is characterized by tensions between MDers' distress on the one hand and experts' bafflement on the other and by the interest of the media in this intriguing

the *Jerusalem Post* (Siegel-Itzkovich 2016), Radio New Zealand's *The Wireless* (Kamm 2016), *New York Magazine* (Tsoulis-Reay 2016) and CNN (Pequenino, 2016) (sample retrieved from goo.gl/tZMEIY on January 6, 2017).

⁴ The latest developments in this nascent field include the presentation of suggested diagnostic criteria for MD, the development of a structured clinical interview for MD and the demonstration that it can reliably differentiate between MDers and non-MDers and a study on the comorbidity of MD.

mental phenomenon. We described unique grassroots pressure on scholars to reify MD scientifically. We believe the initial micro-political processes associated with the emergence of a new psychological disorder are worthy of scientific exploration. In this article we examine how individuals struggling with an unknown mental condition work to obtain recognition and legitimization from the medical-scientific establishment.

The Politics of Medical Knowledge

When exploring the core literature on the social aspects of clinical knowledge, one cannot avoid noticing the dichotomous distinction between the “subjects” and the “objects” of the “medical gaze” (Conrad, 1992; Foucault, 1973, 1975, 1978; Freidson, 1972; Zola, 1972). According to these scholars, the ability of modern medicine to name diseases, label and classify people, and prescribe or proscribe patient behaviors bestows great social power upon professionals, setting them apart from “lay” people and confirming their greater knowledge and status. This given authority to define persons, conditions or problems in medical terms can turn people into objects to be controlled or treated by prevailing forms of knowledge owned by a few delegated subjects (Conrad, 1992; Conrad & Schneider, 1980; Foucault, 1973, 1975, 1978; Freidson, 1972; Zola, 1972). The dominant medical framework clarifies and explains what people experience, validates their pain or distress and makes sense of the body (Clarke & James 2003; Lafrance & McKenzie-Mohr 2013). It identifies treatment options and predicts outcomes, enables access to services, provides structure to a narrative of dysfunction and also imposes official order. A diagnosis gives the individual permission to be ill and reflects what society is prepared to accept as “normal” and what it feels should be treated (Conrad, 1992; Jutel, 2009).

Still, alongside these suggested modes of objectification by which humans become subjected to the medical gaze, Foucault (1982) notes that power can also be manifested in patients’ capacity to resist the attempt to master their forms of knowledge. Thus, power can also turn them into “subjects” who resist medicine’s monopoly over the right to define health and illness. Although institutional clinical psychology and medicine remain potent factors in the day-to-day lives of ordinary people, we are witnessing a permeative process in which the psycho-medical authorities, with their hierarchical procedures of observation, categorization or judgment, are now unavoidably being democratized and at times challenged (Conrad, 2005; Douglas, 2017). This process marks the end of the era of mutual engagement between the supervisors and the supervised (Bauman, 2000).

These fundamental changes in the organization of medicine are not articulated in a vacuum, separated from other social concerns. First, we have been witness to a growing distrust of established experts, which is magnified by our culture’s ambivalent attitude toward the institutions of science and medicine. Postmodernist perspectives have raised troubling questions about the role of science in a world stripped of the old warrants of reason and truth (Lyotard, 1984). Second, in an era characterized by neo-liberal values, “lay” people become “buyers of health services” or “informed consumers,” while physicians are now regarded as employees or service providers who are expected to deliver satisfactory work performance. Under such circumstances, patients are on a more equal footing with their doctors, who are more prone to acknowledge their limitations and are both aware and critical of the proliferation of psychiatric categories (Conrad, 1992; Epstein, 2007; Halpin, 2016). Finally, expert knowledge is now procurable. Information previously restricted to medical authorities is currently available to “lay” web surfers, who can acquire knowledge and change the way they experience themselves or grasp the world around them (Conrad & Barker, 2010; Cotten, 2001). The doctor-patient relationship has become a meeting of experts, with patients more willing to

challenge their doctors, dispute their findings or seek advice from alternative services outside the doctor's office (Lupton, 1997; Nettleton, 2004).

These "educated patients" can also use the web to join advocacy groups that challenge medical authority, demand a say in how health professionals conceptualize their illness and battle for recognition or funding (Brown & Zavestoski, 2004; Langdrige, 2016). A growing number of internet communities form the grounds for social membership and the basis for staking citizenship claims (Epstein, 2007). These communities offer a means of survival for sufferers of medically unexplained symptoms and provide alternative networks of support (Dumit, 2006). They confer collective identity and create their own separate and distinct medical culture, one that assigns primary importance to the role of subjective experience (Goldstein, 2004 cited in Jutel, 2009). Furthermore, influential health consumer interest groups that have developed globally, such as the website of the Britain-based "Experts by Experience," provide the NHS, hospitals, universities, professional bodies or third sector organizations with a range of services with respect to best practices in mental health Experts by Experience, n.d.).

In this new era of distribution of knowledge, it will be interesting to explore the discourse and resistance practices of MDers when a diagnosis is absent, thus impugning the medical legitimacy of their complaints. Instead of focusing on large-scale struggle, we use a micro analysis model to examine the verbal means and rhetorical maneuvers through which individuals position themselves within the frame of medical discourse and claim recognition and rights.

Persuasive Acts and Legitimacy Struggles for a New Diagnosis

Clinical psychology and medicine are indeed more likely targets of "lay" intervention than are other more private and remote domains of scientific practice. It is a site of debate and critique as long as its implications are relevant to the public and to policy-making (Douglas, 2017). The health of one's mind and body is an issue of considerable salience to most people, and there is a substantial history of political struggles around the nature, causes and treatments of disease (Bury, 1991; Epstein, 1996; Rose, 2001).

According to Epstein (1996), organized groups of patients differ in how they approach medical discourse. Some groups are essentially negative and distrustful, rejecting medical knowledge outright and advancing their own claims and different epistemological standpoints. Others ultimately just want to show that science and truth are on their side, seeking to acquire the cachet of medical authority for themselves by finding the expert who will validate their given stance. Other groups try to stake out some ground on the scientists' own terrain and wrangle with scientists on issues of truth and method, positioning themselves on the inside as experts in their own right. In this process of "expertification" they do not devalue scientific knowledge, but rather seek to re-value knowledge that professional science has excluded (Epstein, 1996).

For example, Scott (1990) showed how organized "lay" interests frequently play a significant role in the social construction of disease, as in the case of Vietnam veterans and the PTSD diagnosis. In the case of PTSD, those with control over classificatory processes needed to be brought to confront the legitimacy of this mental condition through concerted and repeated efforts. These efforts, which involved choosing how to speak about the disorder, with whom to discuss it, when to have those discussions and how to use collective action, eventually resulted in its inclusion in the DSM-III (Quosh & Gergen, 2008; Scott, 1990).

Brown (2008) argued that defining diseases is often like a turf war, with individuals and groups with different interests scrambling to establish the authenticity of their claims or of their expertise. These tensions can be present between laypeople and the representatives of medical/psychological science. According to Epstein (1996), who explored the unusual

politicization of AIDS in the United States since the early 1980s, knowledge emerges out of credibility struggles. Credibility describes the capacity of claims-makers to enroll supporters behind their arguments, legitimate those arguments as authoritative knowledge and present themselves as the sort of people who can voice the truth ... The credibility of any knowledge claim can depend on who advances it, who is an “expert” and who is a “layperson,” and what sort of evidence is invoked to support it (Epstein, 1996).

Latour (1983, 1987) assumed that the process of recognizing new scientific knowledge and accepting it as true or valid is basically a process of persuasion. He noted that just as scientists may enroll laypeople in support of scientific facts, so too may laypeople attempt to enlist scientists to their cause. Thus, the process of medicalization is not simply a result of the “medical imperialism” of professionals. Patients are not just passive objects of scientific inquiry but can be active participants in this process (Conrad, 1992).

Language is a crucial resource in the process of persuasion and legitimation of one’s distress. It is not merely descriptive but also performative, and it bestows power to influence and construct meaning. According to Van Leeuwen (2009), language is a kind of a tool kit for performing various social practices. It has a functional aspect and it is recruited for rhetorical intentions of speakers who wish to accomplish different social goals (e.g., positive self-positioning in interaction). Thus, Van Leeuwen’s approach - anchored theoretically in systemic functional linguistics developed by Halliday (Halliday & Matthiessen, 2014) - ascribes agency and capability to individuals and social actors.

What possibilities are there for laypeople to involve themselves meaningfully in the process of “doing medicine”? How do MDers use language to define the problem at hand and reinforce their claims? In this article we adopted an analytical model – usually employed to analyze public political speeches – to explore the linguistic ways in which MDers rhetorically construct their unrecognized mental health problem for the purpose of persuasion and reality change. Furthermore, unlike most above-mentioned authors who view the shifts in medical and institutional power from a macro perspective, emphasizing the role of social movements or laypeople’s collective actions, in this article we attempt to focus on a less examined dimension—the individuals and the micro-political processes in their struggle to turn their suffering into a medical issue. We hope this analysis will shed further light on the conceptual level of medicalization in the post-modern era.

Study Context

Orit Bershtling: As a scholar of discourse studies I attended a departmental colloquium presented by Eli Somer on emerging evidence for an unrecognized mental condition he termed “maladaptive daydreaming.” Beyond the scientific evidence presented, what caught my attention were his comments on the ongoing discourse he had been holding with countless individuals from across the world who volunteered information about their distress, sought his advice and offered their assistance in promoting his research in the field. In initiating this study, my aim was to explore ways in which individuals struggling with a seemingly obscure mental health problem interact with a scientist-practitioner who is interested in their condition, in an attempt to promote curative knowledge.

Eli Somer: Since my first description of MD (Somer, 2002) I have been inundated with communications from many countries requesting information and guidance about ways of coping with MD. What had begun as a trickle of messages evolved into a barrage of emails that had signaled a genuine grassroots appeal to the scientific community to boost research in this embryonic field. This bottom-up consumer pressure had spurred a number of international research collaborations that has already resulted in several published papers. Currently, I have a waiting list of over 700 self-diagnosed MDers who volunteered to take part in future studies.

This paper is a tribute to countless of persistent sufferers who have added extra drive to my scientific motivation.

Method

This study aimed to explore one of the crucial uses of language: the process of legitimation, which stems (in this context) from MDers' personal experiences in everyday life. These personal testimonies and acts of persuasion are better captured by means of qualitative inquiry, grounded theoretically and methodologically in Critical Discourse Analysis. This method seeks to show how language can be used as an ideological instrument; as a part of the way that people promote particular ideas, values or views of the world (Denzin & Lincoln, 1994; Johnstone, 2000; Machin & Mayr, 2012).

Data and Participants

We examined the language used by MDers by means of two data sets. The first set included 35 email exchanges (2010-2016) of MDers (aged 18-63) who had contacted the second author in response to scientific and media publications on MD and online discussions. We sampled messages from individuals who included unsolicited statements of interest to provide personal information for current and future MD research. Some messages also contained requests for information and advice. These emails arrived from Austria, Argentina, Brazil, Britain, Egypt, Germany, India, Netherlands, Norway and the USA. Because this was a retrospective analysis of an existing database, available demographic details were limited. We also analyzed two submitted petitions. Both appeals demanded recognition of MD as a mental disorder and were submitted during 2015-2016 to the American Psychiatric Association (Reed, n.d.) and to the UK Parliament (Petitions, UK Government and Parliament, n.d.).

Ethics

The study was authorized by the institutional ethics committee, and the participants' full names were substituted by their initials. In line with research on existing datasets, the ethics committee waived the requirement for informed consent because it was convinced that: (1) The research involved no risk to the subjects, (2) Participants proactively consented to provide personal information for MD research, (3) Participant identifying detail was concealed or deleted, and (4) The waiver would not adversely affect the rights and welfare of the subjects.

Data Analysis

The various texts differed in length and in the chosen ways of representing personal and family history. Because the petitions addressed a more skeptical audience, they contained fewer personal descriptions and focused more on figures and quotes of others. Emails addressed to the MD researchers frequently opened with a personal introduction and proceeded to describe the course of their condition: when it started; how it developed; the circumstances associated with its exacerbation; the frequency of its major symptoms; the amount of time invested in MD; the impact of MD on daily functioning; and descriptions of unsuccessful attempts to get help. These email messages typically ended with a brief epilogue containing both a request for information and a plea for help, as well as offers to participate in future research and assist in promoting MD as a recognized mental condition. Some writers offered explanations regarding the etiology of their MD, typically utilizing clinical discourse to anchor it in their early childhoods.

Beyond the above content analysis, we aimed to explore modes of language use - such as lexical preferences, ways of justification (e.g., personal stories or statistics), use of pronouns, adjectives or inclusions - and its rhetorical function in MDers' effort to convince their target audiences in the two data sets that MD is a valid condition. In doing so, our premise was that the process of persuasion contains strategies that foster dialogic interaction with the interlocutor. In other words, rhetoric serves as a unifying process that unites speaker and listener and shapes the quality of their relationship. The degree of the elicited emotional identification generated in the target audience determines the influential power obtained by the interlocutor (Burke 1969; Perelman 1982). Hence, in our qualitative analysis of the utilized verbal strategies, we adopted the model suggested by Livnat and Lewin (2016). We sought to examine whether and how MDers foster interaction with the interlocutors as they try to bring them closer to their point of view. We also sought to explore whether and how MDers evoke sympathetic feelings by appealing to shared values and by identifying a common denominator. In their analysis of verbal strategies, Livnat & Lewin identified three main domains that we elaborate on below: forming social bonds, building a consensus, and revealing ideology (2016). Table 1 shows the linguistic strategies and their domains that were pertinent to our study. Further elaborations are introduced in the findings section.

Table 1. Linguistic strategies and their domains

(The provided illustrations were derived from MDers' communications)

Domain	Sub-domain	Strategy	Example
1. Forming social bonds between interlocutor and addressee	Positive speech actions towards the addressee	Expression of gratitude	Thanks to you, I now know... (M.H.)
		Expression of praise	Sir, you are the father of MD (S.S.) Thank you even more for your impressive work (C.A.)
		Informal addressing	Hi Mr. X
	Self-disclosure	Disclosure of sensitive autobiographical information	I had a very traumatic, abusive childhood which led to a lifetime of loneliness and sadness (B.G.)
		Disclosure of emotion	MD is ruining my life (J.Z.) You are my last hope for a decent life (L.E.) I have been always very ashamed (A.A.) Please help me! (D.D.)
2. Building a consensus		Building a consensus based on the recognition of shared values	I was so happy to find someone who understands my condition (S.N.)
		Building a common action-oriented denominator	All my hair stood up as you started to describe my struggle (J.W.)
		Building a consensus based on shared knowledge	I'm sure I don't have to explain to you how frustrating it is (A.L.) But, as you know, it can be rather difficult (C.A.)
		Building a consensus based on irony towards a third party	I play by their rules and take the pills (Y.B.)
3. Revealing ideological position		Revealing a position by using verbs of knowledge and will	I strongly believe... (M.T.)
		Expression of intent	I would like to contribute (L.E.)

The Livnat and Lewin model was originally constructed for analyzing political speeches. The texts we analyzed related to individuals' efforts to legitimize a yet unrecognized condition that, in their cases, had often been dismissed or misdiagnosed. We therefore regarded the written messages as typical rhetorical texts, not unlike political speeches. The following quotes

represent MDers' endeavors to convince their interlocutors that their symptoms were real and similar to those described in published studies or in online MD communities:

I am articulate and able to express myself with confidence (S.J., February 2016).

I'd be a perfect candidate (S.F., December 2015).

You probably receive a lot of emails and it's understandable that you can't reply to all, but I would really appreciate it, if you would be able to, because I feel that I have nowhere else to turn (B.C., January 2016).

The reason I believe my case could help you get the disorder recognized is because my entire history of arrests and hospital visits all centered around maladaptive daydreaming, and there is extensive documentation of a lot of things that happened (C.A., August 2016).

By describing their attributes ("able to express myself," "perfect candidate"), their desperation ("I have nowhere else to turn") or their well-documented medical history, MDers communicated their conviction that they meet the MD diagnostic criteria and are entitled to participate in MD research and receive counseling for their plight.

Trustworthiness

The analysis was performed through two complementary levels: content and form (modes of language use). This cross-level analysis (triangulation) enabled us to control the range of interpretations to MDers' texts and strengthened our findings (Denzin, 1989; Yardley, 2000). Furthermore, the co-operation between two researchers, reading the same texts and analyzing it together, helped to verify our results.

Results: The Rhetorical Maneuvers of MDers

We divided quotes extracted from MDers' statements and communications into the three domains suggested by Livnat and Lewin (2016): forming social bonds, consensus building, and revealing ideological position. The three domains encompass nine rhetorical strategies aimed at creating and fostering interlocutor-audience solidarity. Notably, some participants used a number of linguistic means in parallel. Below we present some prominent illustrations of these employed strategies.

1. Forming social bonds

Four main verbal strategies illustrate the formation of social bonds between interlocutor/writer and addressee/reader: expression of gratitude, disclosure of emotion, disclosure of personal information, and use of humor or irony. MDers applied each of these strategies to create a sense of closeness to the reader by demonstrating the level of their distress or by clarifying their willingness to contribute to a common goal: the advancement of future research in the field as a means of endowing MD with scientific validation.

Expression of gratitude. In their email messages participants tend to start the dialogue by thanking their interlocutors and creating a bond around a joint effort. I.H. writes: "First off, I would like to thank you, for giving a name and recognition to something I have been suffering from for so long without having any proof that it was a thing" (I.H., July 2015).

Like many other writers, I.H. (who did not disclose her age or place of residence) opens her text with an expression of gratitude. She thanks the reader for identifying the nameless symptoms she had been suffering from for so long and for concretizing something that medically had been so amorphous. That “thing” or that “something,” as she phrases it, evolves now into a potentially valid diagnosis that can explain her personal distress.

B.G., a 63-year-old American woman, opens her message with a simile and complements the message of the previous interlocutor:

It was as if I was struck by lightning. For the first time I became aware of the fact that there were other people who did what I did and I felt somewhat heartened that I now have a name for this horrible obsession (B.G., June 2016).

The writer thanks the reader for labeling the “obsession” she has been suffering from. She helps the reader understand the nature of her suffering by describing it as an obsession—a more familiar disorder. Her choice of words, her use of the adjective “horrible” to describe her suffering and her comparison of the realization that there were other people with a similar problem to a lightning strike all add, in line with Gee’s writing (2011), a dramatic effect to her gratitude and convey the powerful impact of the discovery of MD on her quality of life. The employment of this communication tactic seems not to diminish the sincerity of her expressed gratitude; rather, it suggests that the interlocutor employs a parallel rhetorical action. She points out to the reader that the subject of her gratitude is as important to her as it is to him, thereby emphasizing their common denominator and enhancing their sense of shared goals (Chilton, 1990).

Disclosure of emotion. The disclosure of emotions can accentuate the message and help forge the bond between interlocutor and addressee. Expressing emotion enhances intimacy in the dialogue and narrows the gap between writer and addressee. It is a key in the legitimization process, because it prepares the audience to accept and support the social actor’s stance or certain perceptions of reality (Reyes, 2011b).

J.Z., a 20-year-old German student, writes:

MD is ruining my life. It’s always there, every second of the day. It’s like a parasite in my brain and I just can’t get rid of it. However, when I experience what I call, moments of silence (when suddenly my, inner TV shuts off) I am overcome by a drastic fear and always start crying uncontrollably. It is taking me apart slowly (J.Z., January 2016).

The writer’s choice of words and images reflects the sense of urgency that accompanies her distress (“ruining,” “parasite,” “rid of it”). The evocative effect is intensified by the repetitive emphasis on the frequency with which she experienced the symptoms (“always,” “every second”), thereby eliciting empathy for her plight (Machin and Mayr, 2012).

Another young woman writes the words “Need help” in her message’s subject line. This is how she describes her experience:

...Please... please... please... sir give me some clue... how can I overcome this disorderplzz sir I need help.....I am only 18 years old.....and a helpless..... I know this is my last hope.....I need some help.....I will be waiting for your kind response (S.S., October 2010).

This excerpt clearly demonstrates how text form underscores text content. The fragmentary nature of the script, the multiple use of ellipses, the repetitive pleas for help (please=4, help=3),

the desperate search for a clue to her recovery and the mention of her young age (18) all enhance the writer's conveyed sense of vulnerability aimed at evoking the reader's feelings and serve as catalysts for swift action (Gee, 2011; Livnat & Lewin, 2016).

To convey their intense distress, writers often employed metaphors to describe their disengagement from their external worlds and the conflicts associated with their mental habits (e.g., "the war in my own mind" S.J., February 2016; "I get lost in my head" A.R., May 2016; "minute to minute struggle" J.W., October 2014). The "war," "loss" and "struggle" metaphors evoke emotions that may elicit a mental or behavioral response from the interlocutor (Reyes, 2011b).

Disclosure of personal information.

Imagine this: you are a student, failing your classes because instead of doing your homework you need to go to the park ... simply to daydream on the swing ... and you can't get help. Why not? Because it's not an official disorder (petition submitted to the American Psychiatric Association, Change.org, n. d.).

This excerpt from the petition utilizes another persuasion strategy seemingly aimed at fostering intimacy with the addressee and at narrowing any gaps between interlocutors and their audience by means of disclosure of personal accounts designed to reify this elusive, unfamiliar psychological phenomenon. According to Wodak and Van Leeuwen (1999), the personal account serves as evidence. It frames the phenomenon in question, providing it with a more well-defined dimension of time and place. Thus, it helps validate the writers' state of mind and justifies the call for recognizing MD as a condition that affects the course and quality of their lives.

A.A., a 34-year-old Argentinian woman, demonstrates how a personal disclosure contributes to fostering a bond between the interlocutor and her addressee: "I have been always very ashamed to even mention them (MD symptoms) to anyone, I felt it was embarrassing and kept them completely private" (A.A., Aug 2015).

A.A. keeps her MD story secret from her relatives and acquaintances. She feels embarrassed divulging it to them. In this email she discloses her secret for the first time, thus transforming the reader into an exclusive confidant and ally and fostering the necessary bilateral bond (Reyes, 2011a).

Use of humor or irony. 56-year-old A.P.C from Britain and 28-year-old A.R. from the USA present a fourth verbal strategy for establishing an unmediated connection between writer and addressee—the use of humor. A.P.C writes: "I sometimes wish I'd done my doctorate in psychology rather than chemistry! L.O.L" (A.P.C., September 2015). He expresses laughter and ends his message by wondering about the course of studies he has chosen. A.R. describes how after writing the letter she is going to waste her time by staring aimlessly at a bottle ("I'm now off to examine a plastic bottle in awe for several hours!" A.R., May 2016).

According to Ungar (1984), the use of humor serves as an ice breaker. It can blunt embarrassment associated with the uncovering of personal flaws without tarnishing self-respect. This strategy neutralizes the reader's critical nature and intensifies empathic feelings towards the writer.

2. Building a consensus

A second domain of verbal strategies aimed at persuading an audience and at promoting solidarity is consensus building. This domain includes three rhetorical strategies that bind interlocutor and addressee in one common denominator: referring to shared beliefs or values,

referring to shared knowledge, and partnership and coalition building. These strategies evoke agreement and subsequently motivate the addressee to take the desired action.

Referring to shared beliefs or values. The attitude towards time in Western capitalist cultures, which most respondents were part of, is a shared value. The construct of time has evolved under capitalism into a resource designated to serve a worthy objective. Individuals are expected to utilize their time resources effectively, make pragmatic decisions concerning their course of study or career and demonstrate organizational skills, persistence and responsibility (Marcuse, 1972). Such expectations are reflected in the repeated mention of time wasted on daydreaming and in the use of time-related metaphors (e.g., “I am running out of time!!!!” D.M., Nov. 2010). Not only do these metaphors represent cultural values that associate time and performance, they also transform the abstract idea of time into a more concrete concept (Lakoff & Johnson, 1980). For example, I.H. writes: “Due to maladaptive daydreaming all the time, days go by where I don’t get any work done” (I.H., June 2016). A. A. adds: “I could not even calculate the amount of time that I have spent daydreaming” (A.A., Aug. 2015).

The performance principle reigns in capitalist societies, and associated rationality, self-discipline and the propensity to acquire intellectual, material and experience resources are also treasured (Marcuse, 1972). Most MDers contrast the real material world with their fantasy world and link their MD to treading water and underachieving relative to their peers:

... It has affected me a lot; affected my education, my motivation, my personal relationships. I don’t see any appeal to the real life. I lost all motivation and ambition ...It feels like my life is on hold, and life doesn’t wait for anyone. People my age are evolving and improving, and I’m here, unable to let go of my fantasy world to focus on the actual person that I am (I.H., July 2015).

The writers appear to use these shared societal values - the performance principle and the reverence for time – to legitimize their standpoint. When they comment on their time wasting or compromised performance as outcomes of MD, they narrow the psychological distance between them and their addressees, thereby justifying the need for joint action to eradicate the problem.

Referring to shared knowledge. Another approach to promoting rapprochement and reducing the hierarchy between writers and readers is associated with the attempt to demonstrate shared knowledge:

I have a master’s degree in social work, so I am fairly knowledgeable about mental illness and human behavior. I would be very interested in talking to you or other professionals about my experience. I believe that there needs to be more awareness of this problem in order to help people who suffer (J.T., October 2014).

In the excerpt above, J.T., a 48-year-old woman, self-diagnosed with MD, describes her relevant education and emphasizes her thorough familiarity with the nuances of clinical discourse. She makes no mention of her own difficulties but rather stresses her willingness to help others and to contribute from her own knowledge and personal experience. Thus, legitimization is constructed in her discourse by persuading the audience that her actions will benefit others (Reyes, 2011b).

36-year-old D.M. also finds a way to show the common knowledge she shares with her readers: “Unlike your subjects, I have never suffered at the hands of an abuser ... Just like your subjects, I am not married” (D.M., November 2010). It seems as if D.M. negotiates with her

reader's accumulated knowledge. She hints that she read one of Somer's papers, compares her experiences to those of participants in his past research and advises the reader that the MD community is probably more heterogeneous than that described in his seminal paper on MD (Somer, 2002), to include individuals like her who had never experienced childhood trauma. Most MDers describe a process of self-exploration and a keen wish to learn more about their troubling condition. They do this by employing clinical discourse, thus exposing their familiarity with medical and psychological language and vocabulary, a familiarity they tend to point out. This heeded, thoughtful process presents them as rational and knowledgeable, thus validating their stance.

The petition submitted to the APA even quoted the medical definition of mental illness verbatim: "The very definition of mental illness is, and I quote: 'any of a broad range of medical conditions'" (Petition written by M.R. to APA). The mentioned medical text is integrated in a persuasive rhetorical maneuver geared to validate the mental condition of the signatories and to provide supportive evidence for their potentially contested standpoint. It also produces a dialogue between equals and moderates likely differences in status (Abell & Myers, 2008). This is accomplished by presenting the rationale for reparative action and by evoking readers' empathy and moving them closer to understanding the MDer perspective.

Partnership and coalition building. We identified a third verbal strategy characterized by the effort to establish an action-oriented coalition.

I am not emailing you to complain. I want to help you in any way I can. I can research legal implications of the classification of MD as a disorder, or anything else you would like. I would also be interested in participating in a study (K.B., June 2016).

K.B. informally addresses the reader ("Hi Mr. X") in a message that bears the words "I want to help" in the subject line. She positions herself in the role of "helper" rather than "helped" and as an active rather than a passive partner in a campaign to promote public awareness of MD. K.B. creates a sense of reciprocity in her message. She is not a mere research subject, but rather possesses unique knowledge of the law, an intellectual resource that complements the reader's clinical knowledge. She suggests that she can help the reader expand the knowledge on MD and implies a benefit for her.

The desired partnership is also advocated as a coalition against a third party. S.F. writes in an email: "But, armed with your recent article, at least I have something to hand over to a therapist and say: "ditto for me---sums it up perfectly" (S.F., Dec 2015). Y.B. also assembles a coalition against his psychiatrists: "Therefore, I am writing to ask for help. Psychiatrists just throw me in a classical bin (Bipolar I is the diagnostic du jour). I play by their rules and take the pills" (Y.B., January 2016).

In their messages, S.F., an American attorney, and Y.B., also from the USA, seems to form a coalition with their readers as they ironically refer to their current therapists. While Y.B. accepts his psychiatric diagnosis and chooses to cooperate with his doctors, S.F. seems to be more active and plans to confront his incredulous clinician with a paper written by his addressee. The metaphor in the verb "armed" is infused with a double meaning: by submitting the paper to his doctor he hopes to secure an accurate diagnosis and better treatment. At the same time, he seems to want to "fight" his erring therapists with more effective new "weapons" he acquired from his audience.

In the analyzed discourse we identified an additional approach to coalition building—the use of the pronoun "we": "Since we can't call it disorder, I do believe it's a coping mechanism though" (I.H., Jul 2015). By utilizing first person plural, I.H. positions herself close

to her reader's viewpoint and establishes a joint reference group with him that is committed to a common cause (Malone 1997).

3. Revealing ideological position

Finally, the third domain suggested by Livnat and Lewin (2016) concerns the expression of an ideological or personal stance. We identified two prominent verbal strategies that reflect this third domain and are employed to persuade the reader to accept the writer's arguments: personal evaluation and provided analogies to well-known medical diagnoses.

Evaluation. Evaluation is an act of meaning given to a particular subject. It reveals the writer's position on what is regarded as "good" or "bad," "normal" or "deviant." Evaluations encapsulate social presuppositions and involve elements of critique and rationale for action (Van Leeuwen, 2009). One example of an evaluation that discloses a personal stance is manifested in the words of S.N., an 18-year old girl from India: "I am completely aware of my surroundings and can differentiate between reality and a daydream ... I am perfectly normal (S.N., November 2015). S.N. seems to self-diagnose, while her verbal choices signal high modality - a high degree of certainty about the evaluation of her mental condition ("completely"; perfectly):

S.F. also engages in evaluation of his condition and the onset of his symptoms: "I have been a fantasizer, dreamer, day dreamer since around age five. My father would always say jovially: ahh, S.F., you're a dreamer" (S.F., December 2015). He quotes his father to strengthen a stance aimed at persuading the reader (Van Leeuwen, 2009). Furthermore, in line with Wodak and Van Leeuwen's ideas (1999), by evaluating the course of his condition as long-standing in duration, S.F. appears to depict it with an "air of objectivity." His MD began when he was very young, and it prevails through the present time. In other words, MD has always been a part of him.

Another example of an evaluation and of revealing an ideological position is embodied in the message of 18-year-old A.S. from Britain: "I would love to see this phenomenon given scientific acknowledgement and I would also love to get to the bottom of what has affected me and evidently thousands of others our whole lives" (A.S., June 2016). A.S. presents her positive stance towards the study of MD and its hypothesized contribution to the advancement of knowledge about the phenomenon. Her position is based on prior social assumptions and on the perception that generating scientific knowledge is essential for understanding any particular medical problem. Her use of the verb "love" indicates a positive appraisal and connotes her intention and will to act towards advancing the cause she cherishes. Her justification for action is also based on the presented prevalence of MD. Her persuasive message and call for action is empowered by the thousands of MDers she is allegedly speaking for (Van Leeuwen, 2009).

M.T. from the USA also estimates that the number of MD sufferers is large. She uses the verb "believe" as a seemingly objective rhetorical act aimed at recruiting the reader for joint action: "And I strongly believe there are a lot of people who suffer from it" (M.T., March 2016).

Analogy to a known medical diagnosis. I.H. draws an analogy between MD and substance abuse. She uses prior common knowledge about the effects of drug use and relates to a more familiar social phenomenon. She uses this comparison to render her unfamiliar symptoms more accessible to her audience:

Another thing I would like to say about MD is that, even though I have never tried drugs, I think the pleasure it gives is similar to it. I hate how MD messes up my life, but there is nothing else that gives me as much pleasure as MD. I

feel a rush of happiness and satisfaction with it. And it's so addictive ... I can get instant gratification just by daydreaming (I.H., June 2016).

I.H. explains that the immensely rewarding experience of MD is akin to drug use, as are MD's negative consequences. To accentuate her analogy, the writer employs verbs of knowing and evaluation (think, hate) that may underscore her stance and illuminate her daily experience. These findings are in line with Armentor's findings (2017) about the ways in which women with Fibromyalgia – a contested, stigmatized illness – communicate their illness with others. The women compared Fibromyalgia with a well-known illness, drawing upon existing knowledge to convince others and help them to understand their personal experiences.

Discussion

The persuasive strategies employed by MDers derive from an interpersonal discourse aimed at advancing awareness and recognition of MD as a mental health problem. The illustrations we provided represent the main verbal strategies used by MDers to influence their interlocutors along three dimensions: (1) the professional dimension—an appeal to the reader's professional identity as a scientist-practitioner and the presentation of shared knowledge; (2) the social dimension—formation of a joint consensus group, coalition or partnership; and (3) the psychological dimension—an appeal to the reader's emotions through gratitude, self-disclosure or humor.

This three-dimensional analysis can organize and enrich our view on the participants' discursive practices and its functional capacities and highlight the multiple ways in which individuals can contest medical claims and demand legitimization to their health condition. Furthermore, our focus on micro-politics—the less explored dimension of the social construction of disease—complements observations on social movements, widespread political struggles, collective acts and organizational factors of disease discovery processes. After all, the talk of people as they attempt to make sense of themselves and their distress may draw together the macro processes of medicalization and can eventually evolve into a venue for social change and resistance to medical authority. That is, resistance should not be reserved for visible, collective acts, but rather can be accomplished in smaller-scale dynamics of power and embodied in everyday-life acts.

The documented rhetorical effort to mobilize the reader reveals the MDers' active stances as both a source and an object of medical gaze. Our respondents were neither simply passive consumers of the medical discourse nor submissive victims of the biomedical machine. In their quest for a remedy for their unidentified trouble, MDers sought and obtained pertinent information, disseminated it, showed proficiency in professional terminology and knowledge in evidence-based medical discourse.

Notably, the interpersonal undercurrents between MDers and members of the scientific-professional community are atypical. It is usually mental health professionals and academics who disapprove of the medicalization of daydreaming and the imposition of constructs borrowed from the medical discourse on the description of excessive daydreaming. In the case of MD, the tables are turned. As cited in *Wall Street Journal* (Reddy, 2016), the doctors are conspicuously those who are reluctant to label a “normal” and prevalent phenomenon (daydreaming) as psychopathological, dreading the consequences of stigmatic labeling on the individual. Similarly, as opposed to the research attention that recently has turned to stigma resistance of people who have been labeled “mentally ill” (Link et al., 2002; Thoits & Link, 2016), MDers strive for a “label,” which will confirm their mental condition.

In other words, a significant part of the difficulties MDers are facing stems from the fact that they alone cannot produce credible clinical knowledge about effective treatments for

their condition. To generate clinical recognition and evidence-based treatment for MD medical knowledge must be jointly created from the mutual nourishing or diffusion of both parties. MDers and scientist-practitioners need to engage in discourse and jointly produce the texts that strongly mediate professional activity. Thus, we should examine different social actors and additional gazes pertinent to the exercise of power (Halpin 2016; Langdrige, 2016). By acknowledging that medical knowledge is constructed by socially situated claim-makers and other interested parties, we can bring greater critical awareness to the policy making process. After all, any policy response to a problem is determined by how the problem is defined or framed in the first place (Conrad & Barker, 2010).

Self-representations of health and illness offer a strong counterbalance to the dominant biomedical focus. All knowledge about emotional and physical suffering stems from reports by individuals seeking remedy and healing (Epstein, 1996). Thus, the origins of all current diagnoses are rooted in laypersons' complaints. Therefore, instead of sanctifying individual or expert ownership of knowledge, we should use the wisdom of crowds and the unique knowledge retained by community members as well as leverage expert collaboration. This is the key to developing a new understanding emanating from the intellectual encounter and bilateral fertilization. As Kroll-Smith (2003) mentioned, those who self-diagnose do not themselves threaten modern medical authority. Rather, they are exercising, if only momentarily, an alternative authority, one worth investigating.

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