A Cognitive Approach to Maladaptive Daydreaming: A Case Report

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ABSTRACT

Background of the study: Maladaptive daydreaming (MDD) is a mental activity that develops from unconscious material but differs from normal daydreaming in terms of experience, content, quantity, control, distress, and interference with everyday living. Dreaming often involves fantasizing about an idealized self, which includes motifs of companionship, romance, and compensatory scripts like power, escape, and rescue. The MDD is understood as a form of unusual imagination that is vivid and addictive but impedes academic and occupational responsibilities. Individuals report narratives that feature their idealized selves or characters, which are conflicting but rewarding, thus resulting in repetitive episodes of MDD.

Materials and method: The present study explored the phenomenon of MDD and evaluated the clinical effectiveness of a single case intervention study of a 24-year-old male with MDD. The patient was assessed using the MDD Scale (MDS-16). The data were collected at baseline and treatment termination. The intervention for the patient was conducted in four phases: building coping skills, behavior modification, cognitive restructuring, and relapse prevention.

Results: The data analysis showed a decrease in scores between baseline (66) and treatment termination (32), below the cut-off of 40, indicating a significant reduction in the symptoms.

Conclusion: MDD is associated with emotional and functional distress. A tailor-made cognitive approach to the intervention effectively reduced the symptoms of MDD.

Keywords: Maladaptive daydreaming, unusual imagination, MDS-16, functional distress

Daydreaming is a mental activity that develops from unconscious or tacit material.[1] Maladaptive daydreaming (MDD) differs from normal daydreaming regarding experience, content, quantity, distress, control, and interference with everyday living.[2]

According to Freud, the underlying conflict is represented in conscious awareness through daydreaming. It acts as a middle ground amidst the moral and societal restraints and the underlying wishes of the individual.[1] Hilgard hypothesizes that imaginative involvement is connected with physical and sexual abuse and an aversive childhood environment.[3] Daydreaming can be a disengagement from pain, fantasizing into an idealized self, which involves motifs of companionship and romance and compensatory scripts like power, escape, and rescue.[4]

MDD is understood as a form of imaginative involvement that is dysfunctional.[4] It is characterized by vivid, addictive, and unusual imagination activity, causing distress as it impedes academic and occupational responsibilities.[4] Imagination lasts for hours, resulting in neglect of responsibilities and social relationships. This often results in distress caused by the inability or difficulty to control desires to engage in fantasizing and shame experienced and intense efforts to hide the behaviour.[2,5]

The MDD contains some aspects of dissociation.[6] These include adopting an alternative identity temporarily, detachment from external reality and favoring

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one's inner experience, and complete absorption.[6] It is considered a medium to avoid traumatic social environments. It acts as a means of escape for individuals suffering from social anxiety disorder.[4,7] Individuals also report narratives that feature their idealized selves or characters aging over the years.[7] The characters are often an attempt to satisfy their psychological needs. They may involve live-action figures or imaginary avatars who share similar preferences or express ideas that are conflicting in nature.[8-10] They are rewarding, thus resulting in repetitive episodes of MDD.[7]

Case Presentation

Mr V.S. is a 24-year-old single male adopted into a Hindu family of middle socioeconomic status. He is currently pursuing second years diploma in Radiology. The patient had a slow-to-warm-up and anxious temperament as a child, so he found it challenging to make friends. He could not understand what was taught in school, so his academic performance was poor. He experienced rejection from his classmates, which always made him sad and lonely. He would feel stupid about himself. When he was in Class VII, aged 12, he attempted to befriend a female, which resulted in the girl slapping him in front of the class. He felt embarrassed, left school early, and did not attend school for a few days. None of his classmates called him regarding the absence, so he felt ignored in school. His grades dropped further, and he would make excuses to avoid attending school. Though his parents changed his school, his academic performance showed no improvement.

As he entered college, his grades continued to be poor. He noticed a developing fear of initiating conversations with others, leading to avoidance of classmates and acquaintances. Gradually, he began to have palpitations, sweating, shivering, and dry mouth when introduced to females and when he met authority figures such as teachers. When entering a social situation, such as attending classes, he would have multiple thoughts, such as "what would happen in the situation?" In social situations, all these thoughts would take a backseat, and he would have only one thought about how others would perceive him. Eventually, he refrained from talking to his batchmates. He reported not being able to enjoy their company. He mentioned that his daily routine involves waking up, attending classes, and returning home. Once in his house, he stays in his room and does not interact with his parents. He mentioned that whenever classes are in online mode, he mutes them and continues with his work, as that helps in reducing his anxiety. He reported feeling angry as he cannot express his ideas to others. He also gets angry when forced to study or questioned about his poor academic performance. He breaks things around him, shouts at them, or walks off when angry.

He began watching wrestling videos to overcome his loneliness. Initially, he would watch for two to three hours. As the duration for watching videos increased, he created a character out of his imagination, which he named Brandon Jackson. He imagined himself as that character and pretended to be in the wrestling ring. He would imagine hearing his fans cheering and clapping for him and clicking pictures of him. He reported that the character makes him feel powerful and protected. He also started imagining a character named Disha, his imaginary younger sister in her first year of engineering. Most of the time, when he feels lonely, he imagines her comforting him. He likes to share his feelings with Disha as she respects and supports him, unlike his cousins, who make fun of him and ignore him. Eventually, he also started imagining having a group of friends (7 in number). He reported that he knows these friends are all imagined, but sometimes he feels unsure whether he imagines them or if they are his real friends as he hears their voices talking to him and talking to each other, making plans, etc. He mentioned that all these friends know each other. When he reached Class XII, he developed a superhero character named X man/Dev. He said that Dev is the other side of X man. He is caring and protects him by taking over him when he is angry, fighting, saving, or punishing people for their wrongdoings. Dev makes him feel secure, confident, and superior and allows for smooth interaction with people. Later, he reported that he does not have to control them as he got used to imagining these characters and often does not remember his thoughts and actions associated with his anxiety when he is in these characters, as it has become more natural for him to get completely immersed in these characters. He seldom gets to know from his friends that his behavior has changed. These characters give him a sense of identity and comfort, so he spends most of his time deliberately engaging in them.

There is no history of cognitive features of depression like hopelessness, helplessness, suicidal ideations, feeling detached from self or surroundings, or substance abuse.

Relationship With Family

He shares a close relationship with his mother. However, he mentions that she is anxious and over-involved in his life. He reports that his father has a strict parenting style and does not feel as comfortable talking to his father. He feels that his cousins are ignoring him, and they come to him only when they require some help from him.

Upon examination of his mental status, he was well-kempt, cooperative, and conscious during the interview. Attention and concentration were aroused and sustained, and rapport was well established. His affect was anxious. His mental functions were intact. In thought content, he reported feeling that he was the unluckiest person in the world, indicating worthlessness.

Diagnostic Consideration

Million Clinical Multiaxial Inventory (MCMI) was administered to gain insight into the patient's personality. Results in severe personality pathology domains indicated the presence of Schizoid personality traits. The results in clinical personality pattern domains indicated prominent Schizoid, Avoidant, Negativistic, and Masochistic traits. Results in clinical syndrome indicated prominence of anxiety, and severe clinical syndrome indicated major depression. Though he did not meet the criteria for depression,[11] history suggests that he frequently has thoughts of life's emptiness and meaninglessness. History also indicated anticipatory anxiety and associated avoidance of life experiences. He can be indifferent and

remote, rarely responding to the actions or feelings of others. He sees himself as socially inept and inadequate, justifying his self-imposed isolation. He also appears to have self-defeating tendencies, aided by failed past relationships and disparaged personal achievements. This also lends to his tendency to focus on his very worst features and a feeling that he has been unable to live up to other people's expectations and, hence, deserves to suffer painful consequences. An objective evaluation was done using the Maladaptive Day Dreaming Scale-16 (MDS-16). He scored 66 (cut-off score 40). State-Trait Anxiety Inventory (STAI) and Liebowitz Social Anxiety Scale (LSAS) were administered to assess the severity of anxiety. The scores on STAI were above 40 for both traits (61) and state (52) anxiety, which indicated severe anxiety. The score obtained on LSAS was 93, indicative of severe social phobia.

He presented with autonomic and behavioral symptoms in the presence of females and authority figures, which he tried to avoid. As he met the criteria for social phobia as per ICD-10, a working diagnosis of social phobia with significant dissociative symptoms was considered.[12]

Intervention

The intervention was planned in four phases: to build coping skills, behavior modification, cognitive restructuring, and relapse prevention. The core principles and processes of cognitive behavior therapy (CBT) and trauma therapy were delivered in a 15-session format of weekly sessions over 15 weeks. The duration was 60 minutes. Every session involved reviewing the homework exercise and the skills learned in the previous session. The first session focused on clarifying the client's history and chalking out an outline of the further sessions. The next week, Socratic questioning was used to identify the patient's negative automatic thoughts. The thoughts elicited were "I have much anger," "I am the unluckiest person in the world," and "I fear that bad things will happen to my life." Verbal reattribution using evidence and counterevidence was used to work on his negative automatic thoughts. The patient was seen to be resistive in therapy in the third session. He said, "I am afraid that I will get to know things I am unaware of." The patient was socialized to the conceptualized formulation of his problem. The patient felt understood, as the formulation gave him an insight into the cause of his anger and loneliness. The patient was asked to record his thoughts and maintain a thought record diary. Sessions four and five focus on exploring verbal and nonverbal behavior when angry. An altered response method was practiced by cultivating and enhancing positive behaviors using appreciative inquiry. He described a few situations in which he succeeded and what made them successful. He responded that since he has a good command of the English language, he was a good host at functions organized in the college as he would make agendas, write creative flyers, and plan the goals for which he also got appreciation from others. However, he vividly recalled needing a cohost when inviting or interacting with the guests and speakers. As self-efficacy was established, assertiveness skill training was initiated. In the sixth session, the patient reported feeling distressed as he could not control his anger in all situations. The session highlighted his ability to control anger in certain situations, like being questioned on his academic performance or being told what to do. A cost-benefit analysis was used, which helped the client determine the usefulness of using his good qualities in all situations while using assertiveness skills. In the seventh session, the patient was reviewed, and he reported feeling happy as he could manage his anger in many situations. By this time, the patient had developed trust and rapport with the therapist. The seventh and eighth sessions emphasized exploring the characters used by the patient. He revealed that he made up the characters as he does not feel lonely when he imagines them. He was not ready to discuss these characters initially, but he feared that his imagination was probably becoming a reality. He described Brandon as someone who can be controlled and comes only when he is watching or thinking about wrestling. He can come out of the character when he gets distracted by the phone ringing or being called by a family member. He goes to sleep while being in character and returns to his real self when he wakes up the next morning. However, X man/Dev come anytime, are punishing or protective, and take over automatically. He feels powerful when in the character and comes out of the character when he feels relaxed. Although he has control and starts with deliberate imagination of these characters to express and deal with his emotions, he notices that he gets completely immersed in the character and occasionally learns of his behavior change from his friends. Though he likes being in these characters, he has realized that the characters are affecting his studies, pulling him out of reality. He reported feeling fearful of becoming weak and alone if the characters are taken away through therapy. Sessions 9–12 used trauma-focused intervention to deal with his dissociative symptoms. The sessions aimed at building awareness of the adaptive nature of the characters and the acquisition of skills to help the patient deal with reality and social situations. The patient believed his life would worsen if the characters were taken away. The therapist used the disputation technique through the "frog in the well" metaphor. He could identify how his life was affected by the characters. To build the patient's confidence to face life without depending on the characters, the sessions focused on coping skills training. As discussed in earlier sessions, anger management and assertiveness skills were re-discussed with the patient. In session 13, the patient reported feeling better. To avoid Brandon and X man/Dev, he changed his sleep time from 12 A.M. to 10 P.M. He mentioned that he would start by imagining these characters immediately after he reached home from college, and the daydreaming would continue till midnight. As he avoided engaging in deliberate imagination, he reported having free time in the evening and being able to wake up early in the morning. The session focused on using the free time to engage in pleasurable activities or study for upcoming exams. In session 14, the patient expressed his insights from a deeper self-reflection on how he made the characters stronger, which eventually made him

weaker and how he is building himself now. The session highlighted the identification of values associated with his roles as a son, student, and brother. It was suggested that he play these roles and strengthen himself. He reported feeling guilty about not doing anything for his parents, who love him so much that throughout his life, he kept himself busy with characters and kept his parents away from his life. He wrote down the following positive statements that he wanted to follow and improve his relations with his parents • "I will speak to them," • "I will spend time with them."

His core beliefs on unworthiness were successfully restructured, and alternate thoughts were established. Relapse prevention included maintaining a diary to identify triggers, practicing strategies to cope with anger and maintain stability, and making friends to overcome loneliness. There was a significant improvement in therapy after 15 weekly sessions. The score on MDS post-intervention was 32, well below the cut-off score of 40.

Discussion

The current case presents the phenomenology of MDD in a male college student. Literature on MDD states that the MDD diagnosis is co-morbid with other disorders like anxiety disorder, dissociative disorder, and obsessive-compulsive disorder.[5] The present study found co-morbid social anxiety with MDD, which is stimulating and is a potential developmental pathway for MDD.[13] The patient visited the OPD with complaints of anger, loneliness, and difficulty facing and initiating conversations with people. The current case also presented clinical manifestations of being in a "dream-like state" and feeling powerful during daydreaming. However, the phenomenology of daydreaming duration lasted longer and led to functional impairment. Though the daydreaming process was pleasurable, he experienced distress as it led to a decline in academic performance and loneliness. The case provided insight into the causal and maintaining factors of MDD.[7] The case also shows how MDD leading to experiential disintegration can evolve into multiple personality disorder[6] and an outline of how such cases can be approached in intervention. It is to be noted that it is essential to establish coping skills for the client to deal with reality before weaning off from the imaginary characters. There is no recognition of the diagnosis of MDD in DSM 5 (The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) or ICD 10 (International Statistical Classification of Diseases and Related Health Problems).[14]

Conclusion

Research on MDD lacks definitive evidence and requires further investigation. The disorder is associated with significant emotional and functional distress. Psychoeducation of the family members is pivotal and needs to be incorporated into the therapeutic process. Future studies can aid in developing therapy guidelines for overcoming the act of excessive daydreaming.

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The authors certify that they have obtained all appropriate patient consent forms.

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