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CASE REPORT
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Dream on: Maladaptive Daydreaming as a Distinct Psychopathology in a Person with Obsessive-Compulsive Disorder

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Introduction

Daydreaming is a common coping mechanism used by individuals to deal with stress. However, when used excessively, this becomes maladaptive and may even impair social interactions.[1] Pathological immersion in imagination and fantasy is characteristic of maladaptive daydreaming. Involving incredibly detailed and vivid scenarios, it hampers crucial aspects of a person's functioning. The fantasy activity often takes up significant chunks of the person's waking hours and lasts for extended periods. It can even replace real-world social engagements.[2] Engaging in kinaesthetic activities and listening to evocative music also facilitates the imaginative experience. Studies have indicated that maladaptive daydreaming can coexist with other disorders, potentially resulting in incorrect diagnosis and insufficient therapy for patients.[3] Here, we elucidate the case of a young girl who presented to us with complaints of maladaptive daydreaming with a background of obsessive-compulsive disorder.

Case Presentation

A 16-year-old adolescent female presented to the Department of Psychiatry with 5-year history of engaging in a pattern of imagining a chain of images while watching television. She described these images as "stories" running continuously through her mind for the most part of the day. These stories mostly entailed her being the protagonist of her favorite TV shows. She reported enjoying being engrossed in her stories and only felt distressed later occasionally over the wasted time and not being productive. For the first three years, they consumed less time as she spent 1-2 hours of the day and were enjoyable, but the frequency and intensity gradually increased to 5-6 hours/day. This excessive engagement in daydreaming led to decline in her academic performance, as she found it difficult to concentrate in class. Her social interactions also suffered, with her increasingly preferring to retreat into her inner world rather than engage

with friends or family. Additionally, her sleep became irregular, contributing further to her overall distress and functional impairment.

On further exploration of childhood experiences, it was found that her parents frequently got in physical and verbal altercations with each other which significantly distressed her and she remained worried about the safety of her mother and consequently her own. She initially used daydreaming to distract herself. She reported that "fantasizing helped me escape the toxic environment in my house," and she felt "more in control" of the situation when she fantasized.

She reports that 4 years back, after watching a movie with explicit sexual content for the first time, she started getting sexual thoughts and images, initially for a few hours a day, which later progressed to 5-6 hours/day. This eventually started affecting her sleep. She recognised these thoughts to be useless, repetitive and distressing and she tried to control them but often failed at it. Most of the sexual thoughts and images were of male relatives, which was especially distressing to her. These sexual thoughts would occur involuntarily, were out of her control, and hence, unlike the stories that would play in her head and provide her comfort. The duration of voluntary daydreaming was reduced to 2-3 hours, while the repetitive sexual thoughts plagued her for 6-7 hours at the end. While studying, she would be unable to sustain attention due to the repetitive sexual thoughts, and she would end up feeling guilty regarding the same. She would also engage in masturbation intermittently, although she reports no distress associated with it, and it would be imagined scenarios with TV actors.

Over the next 2 years, the problem worsened, and interpersonal issues between the parents persisted. The repetitive distressing sexual thoughts that continued for 5-6 hours/day while the stories which patient would play in her mind to escape reality also started troubling her as they would now continue for 4-5 hours/day and her entire day would be spent between the two. As a result, her academic functioning deteriorated further, with difficulty in focusing on her studies and participating in classroom activities. She began to withdraw socially, avoiding interactions, especially with boys, due to the intrusive sexual thoughts, and experienced isolation and emotional exhaustion. Her ability to maintain daily responsibilities and a structured routine was significantly impaired. Due to worsening in her symptoms, the patient became irritable and had frequent crying spells as well at the time of presentation.

A complete general physical and systemic examination, routine blood investigations, and hormonal profile found no abnormalities.

Based on the history and clinical examination, a provisional diagnosis of Obsessive-compulsive disorder, predominantly obsessional thoughts or ruminations (F42.0) with Problems in relationship with parents (Z63.1) as per ICD-10 was made.[4]

Maladaptive daydreaming, despite having a separate course of illness and phenomenological distinction in the index case, is not a separate diagnosis in any of the classificatory systems; hence could not be labeled specifically.

Psychometric evaluation with the Rorschach inkblot test and Human figure drawing test revealed a high tendency to break, no active coping, and the presence of family discord. She scored 57 on the 16-point Maladaptive Daydreaming Scale [5] (≥ 40 indicates the probability of maladaptive daydreaming) and a total of 20 on the YBOCS scale [6] (16-obsession, 6-compulsion). The patient was treated pharmacologically with Cap. Fluoxetine up titrated to 40mg/day, Tab. Amitriptyline 25mg/day, Tab. Quetiapine up to 100mg HS in view of persisting sleep disturbances, anger outbursts, and irritability, and Tab Propranolol 40 mg OD.

Parents were psycho-educated regarding the illness and explained that the interpersonal issues between the parents were a perpetuating factor in her illness. A psychosocial assessment was conducted with the parents, and family dynamics and parenting styles were also explored. Sex education was also done for the patient, along with supportive sessions after assessing her psychological sophistication.

With treatment, the patient's maladaptive daydreaming completely subsided, and there was a significant reduction in the obsessive thoughts. The score on the Maladaptive daydreaming scale was reduced to 5, and Y-BOCS was reduced to 6 over the course of six weeks.

DISCUSSION

Normally, fantasy serves as a healthy coping mechanism to control emotions. However, it seems that in maladaptive daydreaming (MD), it leads to escapism, which impairs functioning in social, professional and academic contexts.[1] The most frequent comorbid disorder with MD, as per a 2017 study, was attention deficit hyperactivity disorder (76.9%), anxiety disorder (71.8%), depressive disorder (66.7%), and obsessive-compulsive related disorders (53.9)%.[7] Unlike OCD, which often links daydreaming to the urge to repeat images in an attempt to reach perfection or prevent a feared consequence, MD does not typically involve the compulsive and time-consuming desire to fantasize. Moreover, fancy narratives of fantasy or kinesthesia are not a part of the mental compulsions associated with OCD.[3] In our case, the patient was clearly able to express her maladaptive daydreaming and obsessive symptoms separately and did not view it as a singular entity. However, it is possible that MD served as a predisposing factor for the development of OCD in this case. It has been widely documented that patients with low distress tolerance are more prone to develop neurotic disorders such as OCD. [8] In certain cases, MD in itself can progress to OCD as phenomenology. Current diagnostic systems do not stress upon content and form of obsessions and compulsions. However they remain relevant in management by psychotherapeutic routes. It is widely accepted that behavioral addiction has several distinctive elements, including salience, mood alteration, tolerance, withdrawal, conflict, and relapse. Likewise, our patient looked for opportunities to indulge in her fantasies. While fantasizing, she was excited, showed signs of excessive and increasing use (tolerance), became agitated when someone interrupted her in her state of reverie (withdrawal), and felt inner frustration from avoiding conflict. It is imperative to further study the relationship between maladaptive daydreaming and behavioral addictions.[1] A study on 510 self-identified Maladaptive Daydreamers (MD) found a moderate link between MD and Obsessive-Compulsive Spectrum Symptoms (OCSS), with a stronger association to obsessions. Dissociation and reduced control were key mediators, highlighting dissociative absorption as a crucial factor in their overlap.[9] In clinical settings, MD still runs the danger of being misdiagnosed or oversimplified as a single symptom of another diagnostic category. MD is a distinct state of consciousness, as well as possibly a mental disorder with its own definitive features. We recommend that clients should be questioned about MD during routine clinical assessment. Professionals should devote the necessary clinical attention to this condition in light of the empirical evidence and the requests for consultations from MD clients.[3]

CONCLUSION

This case highlights the complex interplay between maladaptive daydreaming and obsessive-compulsive disorder. Maladaptive daydreaming, though not yet recognized as an independent psychiatric diagnosis, significantly impaired the patient's daily functioning and was exacerbated by underlying psychological distress and family dynamics. The patient's condition responded well to a comprehensive treatment approach, including pharmacotherapy, psychoeducation and supportive interventions which underscores the importance of early recognition and targeted management. Given the increasing recognition of maladaptive daydreaming as a distinct clinical phenomenon, further research is needed to refine diagnostic criteria and establish standardized treatment guidelines.

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