The Brown University Child and Adolescent Behavior Letter

CABL

BROWN

Bradley Hospital
A Lifespan Partner

Published in cooperation with Bradley Hospital

February 2019

Vol. 35, No. 2 • ISSN 1058-1073
Online ISSN 1556-7575

Highlights…

Our page 1 stories this month look at importance of daydreaming as pathology, especially in the context of trauma, and at the evidence for play therapy.

✦ ✦ ✦

Guest Commentary

✦ ✦ ✦

Free Parent Handout…

When Mom is depressed, everyone suffers

Trauma

Maladaptive daydreaming: Is it a "real thing"?

By Mandy Witkin

Maladaptive daydreaming (MD) is a psychological concept first introduced in 2002 by Eli Somer, a professor of clinical psychology in the School of Social Work at the University of Haifa. MD is a preoccupation and compulsive fantasy process that causes distress because it interferes with social, academic, interpersonal, or professional functioning. The experience is described as an excessive form of immersive daydreaming that produces a rewarding experience based on a created fantasy of a parallel reality, and also impairment and distress associated with persistent and continual fantasizing. In recent years, interest in MD has produced a high degree of international attention, and yet it has not been acknowledged by the medical and psychological organizations, and is often encountered with doubt or confusion by mental health practitioners.

In the first publication on the concept of MD in 2002, Somer identified six patients in treatment for neglect- and trauma-related childhood experiences who showed a preference for living in elaborate fantasy worlds while engaging in repetitive physical movements to deal with their real-life situation. All six participants were socially isolated and had difficulty with occupational functioning. This was followed by three additional case descriptions. But during the past decade, and in response to the three published articles, MD has gone viral on the internet. Searching under this term currently yields well over 65,000 related hits linking to forums and chat

*See **Trauma**, page 5…*

Play

Why play? Thoughts on evidence-based treatments and why play therapy is still relevant

By Kiera Boyle-Toledo, Psy.D.

In the current age of managed care and evidence-based treatments, play therapy has declined in popularity and prestige. Other treatments offer more concrete techniques and means of achieving measurable outcomes. They have been studied using randomized clinical trials, providing solid evidence that they are effective at treating particular diagnoses and symptoms. Although some preliminary evidence exists to back play therapy as an effective treatment for certain presenting problems, it lacks the evidence base of other treatments. Why, then, do child therapists still use play therapy?

- *Play as children's natural language:* Play has long been considered to be the natural form of expression for children, allowing them to express and work through issues in a way that is appropriate to their developmental level. While most other forms of therapy require some level of emotional understanding and verbal expression, play does not rely on emotion vocabulary or abstract reasoning to achieve improvement. Imagine if you were learning a new language and trying to explain your deepest emotions in that language. It would likely be challenging, frustrating, and discouraging when you couldn't express how you felt and others around you

*See **Play**, page 7…*

View this newsletter online at wileyonlinelibrary.com • DOI: 10.1002/cbl

Trauma

From page 1

rooms, Facebook communities, YouTube testimonials, personal blogs, and articles devoted to the topic.

MD is a complex clinical entity that is difficult to categorize. Research results show a relationship between MD and dissociation, attention-deficit/hyperactivity disorder (ADHD), obsessive-compulsive disorder (OCD), depression, and anxiety. Findings also suggest MD could fit the description of a behavioral addiction. Studies show that a group of individuals with MD were subjected to adverse childhood experiences such as various forms of neglect or abuse, or social anxiety and isolation. Many MDers report it developed first in childhood with scenarios typically based on cartoon characters.

Research points to several characteristic features indicating MD:

- People with MD often report discovering their unique ability for vivid fantasy during childhood.
- Movement (e.g., pacing, rocking) and exposure to music are important catalysts to the behavior.
- Many individuals report consistent difficulties with the consequences of adverse childhood events or ongoing social and emotional problems.
- People report the experience is both satisfying and calming and developed into a harmful mental habit.

Plots of daydreams often include imagined emotional support, proficiency, and social recognition. Inner worlds often evolve infinitely, much like a daily TV soap opera. This results in a cyclical process where they use MD to ease their distress, only to experience further anguish about their wasted time and difficulty keeping up with daily activities, which they then relieve with more daydreaming.

At this time, there is evidence to suggest MD is a dependable clinical concept. MDers endorse significant distress and deep shame as a result of their difficulty in controlling their MD desires and behavior that interferes with social and daily functioning. There is evidence that sufferers experience distress and interference with life functioning. It differs significantly from normal daydreaming in terms of the quantity, content, and experience. In terms of content, MDers tend to daydream considerably more about fictional tales and characters, in comparison to more typical daydreams, which are usually anchored in real-life situations. MDers often report disrupted sleep due to daydreaming, and a strong desire to initiate daydreaming as soon as they wake. Another difference between normative daydreaming and MD is people with MD report a constant stream of fantasizing during their waking hours.

Case study

Lee is a 14-year-old natal white female with past diagnoses of unspecified anxiety disorder, major depressive disorder with psychotic features, unspecified schizophrenia spectrum and other psychotic disorder, ADHD-inattentive type, OCD, and autism spectrum disorder, Lee has an extensive psychiatric history that includes nine inpatient and four partial hospital admissions, between December 2016 and March 2018, secondary to auditory and visual hallucinations, suicidal and homicidal ideation, delusions, depression, and a decline in functioning across settings. This was followed by an out-of-district placement in a therapeutic school for 14 months.

Lee was a healthy baby who met developmental milestones on time. Lee was described as affectionate and friendly. Some OCD traits were described, such as being very precise with arrangement of things, and having to restart sentences if interrupted (precision and slowness in completing things had gotten in the way of completing school work). Lee was also reported to have sensory sensitivities. Additionally, Lee endorsed having a rich fantasy life since being a small child. She could not recall when this began but remembered having an obsession with *My Little Pony* and subsequent plots of stories continuously playing in her mind.

Intelligence testing in 2017 with the WASI-II revealed broad abilities in the superior range.

Lee initially presented after a dramatic change in presentation and functioning over the course of 2 months. Her parents reported that she was withdrawn and isolative, exhibiting increased somatic complaints and decreased concentration. Lee was reporting intrusive thoughts and visual and auditory hallucinations. Lee had a history of obsession with a cartoon and, more specifically, the main male characters, and was obsessively writing stories about the show that were graphic and gory in nature. This evolved into intrusive thoughts regarding the developed character, and she started to report both visual and auditory hallucinations related to the story. Additionally, Lee reported initial, middle, and early sleep disruption due to preoccupation of the story plot. Of note, Lee's reports of delusions were often referred to as "I had a dream," continued to build upon one another, and were organized and linear. Lee became very upset whenever providers used the words *psychosis* or *delusions*, and spoke about her strong desire to live in the alternate world she created, preferring that reality. She often set her treatment goal to work on anxiety, and when asked if she needed help learning how to distinguish things that were real, she reported it was "pointless" to work on that because she had a "pretty good idea" of what was real.

Lee presented in the initial phases of treatment while at the hospital with constricted movement, resulting in providers questioning catatonia, which was ruled out. Additionally, a medical workup (MRI, EEG, blood work) did not provide any evidence for an organic cause of psychosis. Medication trials have included Intuniv, Abilify, Latuda, Lexapro, Cymbalta, Ativan, and Klonopin. Her current medications include Zoloft 150 mg, Risperdal 2 mg, and Intuniv 3 mg.

A comprehensive search on Lee's unique symptoms led to the ICMDR (International Consortium for Malaptive Daydreaming Research) website, as well as several YouTubers talking about their experiences. After contacting Somer, I gave Lee the Child Maladaptive Daydreaming Checklist, and parents completed the 16-item Maladaptive Daydreaming Scale. Somer felt that Lee would likely meet criteria for MD in the severe range, if it were a formal diagnosis.

Phases of treatment

In working with Lee, several phases of treatment have been helpful. In the first phase, treatment was focused on safety and stabilization with the combination of medication management, communication, and safety planning. In the second phase, treatment was focused on building trust and rapport through a combination of supportive therapy and allowing Lee to teach about her unique symptoms while showing a genuine interest and desire to learn. By this point, Lee was acknowledging prior difficulty with reality testing and vocalizing

an awareness of the difference between their daydreams and reality, while expressing pronounced sadness of this truth. Lee was informed about MD and shown a YouTube video of an adolescent speaking about symptoms and struggles. This seemed to be a turning point for Lee, as she experienced less shame, increasing her ability to engage in therapy and empowering her to explore aspects of the daydreams. During one session, Lee opened with "My daydreams are what keep me sane, but they are driving me insane."

In the third phase, Lee grieved the loss of her alternate reality, with the goal of accepting that her daydreams are fantasy, and ultimately can be used in a positive way if she can learn to control them. She continues to intermittently experience sadness that the alternate reality is not her primary reality. Motivational Interviewing (MI) was employed to help Lee see how her daydreaming was getting in the way of her long-term goals and welfare. Developing motivation to change the daydreaming was a significant roadblock to treatment due to the rewarding aspects of the behavior.

With daydreaming, unlike in other addictive behaviors, removal of the rewarding substance (alcohol, drugs, food) or external items (gambling, computer, gaming, etc.) is not possible. The brain is always available to the daydreamer, requiring a higher level of motivation and control. MI allowed Lee to become more aware of likely difficulties and long-term consequences resulting from her excessive daydreaming, inconsistent with her personal values, such as happiness, education, and success.

In the fourth phase, the goal was to increase social engagement. Lee attempted to straddle both "worlds," needing encouragement and external incentives to engage in the present world. Her social anxiety and difficulties socializing due to autism played a significant role in her strong urge to daydream. Cognitive behavioral therapy was utilized to help Lee recognize her cognitive distortions about her social situation and begin to challenge them. Lee began going to a teen social skills hangout group, classes, and summer camps of interest. During this phase, we also worked on communication skills and assertiveness. Lee started going to LGBTQ+ groups once weekly and reported some positive social experiences.

In the current phase, the goal is to explore options to control daydreams, which has been quite challenging. Multiple strategies have been attempted, such as grounding techniques, which reportedly work while in use but then the daydreams become "more intense." Attempts to tolerate the increased anxiety and intensity of "pushing away" the daydreams for increasing amounts of time (3 seconds to start) have been challenging. Exposure to music/repetitive movements while engaging in an incompatible behavior has also not been successful. Exploring the themes of anger and aggression, prominent in her daydreams, has increased insight into the content of the daydreams and allowed for improved communication with family members about negative feeling states, but has not changed the frequency or intensity. Additionally, Lee has tried designating specific times throughout the day to daydream, and implementing external rewards for being able to control the daydreams for short periods of time.

In summary, Lee has worked hard over the past two years to understand her unique symptoms and learn how to integrate into the "real world," while wishing to remain in her daydreams. She has met their goal of transitioning out of the therapeutic school, made new friends, developed additional interests, and is able to recognize when her symptoms are impairing her functioning. She has accepted her daydreaming and is working on ways to make it more adaptive, as well as teaching others about MD. The recognition of MD as a clinical concept has been a valuable aspect of treatment, and something that should be watched for in the future.

Note: Lee (not her real name) prefers "they/their," but we have used "she/her" for grammatical clarity.

References

Bigelsen J, Lehrfeld JM, Jopp DS, Somer E. Maladaptive daydreaming: Evidence for an under-researched mental health disorder. *Conscious Cogn* 2016 May; 42:254–266. doi: 10.1016/j.concog.2016.03.017. Epub 2016 Apr 12.

Bigelsen J, Schupak C. Compulsive fantasy: Proposed evidence of an under-reported syndrome through a systematic study of 90 self-identified non-normative fantasizers. *Conscious Cogn* 2011 Dec; 20(4):1634–1648. doi: 10.1016/j.concog.2011.08.013. Epub 2011 Sep 29.

Somer E, Lehrfeld J, Bigelsen J, Jopp DS. Development and validation of the maladaptive daydreaming scale (MDS). *Conscious Cogn* 2016 Jan; 39:77–91. doi: 10.1016/j.concog.2015.12.001. Epub 2015 Dec 17.

Somer E, Somer L, Jopp DS. Parallel lives: A phenomenological study of the lived experience of maladaptive daydreaming. *J Trauma Dissociation* 2016 Oct–Dec; 17(5):561–576. Epub 2016 Mar 4.

✦ ✦ ✦

Mandy Witkin is a clinical social work supervisor at Bradley Hospital. She works in the Children's Partial Hospital Program and is a teaching associate in the Department of Psychiatry and Human Behavior at the Warren Alpert Medical School of Brown University.

Play

From page 1

didn't understand. Wouldn't it be a relief to have someone understand your native tongue and respond back to you in the same language? Play therapists believe this is what talk therapy is like for children who have not yet learned the language of emotions. Adults ask them to think about how they feel and why they behave the way they do, when their brains simply haven't gotten to the stage yet where they understand these concepts. Through play, children can "tell" therapists how they feel and why they're behaving the way they are.

- *Play as fun:* Furthermore, play is naturally reinforcing, making it an easy way to engage children in working on their difficulties. Children who would never agree to discussing their problems or completing homework assignments can be treated using play therapy. Somewhat similarly to adult patients who find the experience of therapy to be a respite from daily stress, children can find coming to the playroom to be an open and freeing experience they look forward to; often in play therapy, the child is in charge! Therapy can then be perceived as a special, positive experience rather than as another requirement that children have little control over.
- *Play as relational:* Beyond this, play offers the ability for children to experience their therapist as another person who is playing with them. The