

Internet gaming disorder: Remarks of psychiatrists

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Abstract

Psychiatrists were interviewed to elicit their remarks on and clinical experiences with Internet Gaming Disorder (IGD). A case study design with four open-ended questions was chosen. Psychiatrists were asked to answer questions related to the clinical cases they encountered, what they have gone through and what they think about the diagnosis of IGD. Purposive sampling was employed and eight psychiatrists working in Istanbul made up the study sample. There have been numerous studies focusing on its prevalence and treatment but, to the best of author's knowledge, there are no studies on psychiatrists' experiences with and remarks on IGD. Therefore, the current study will contribute to the literature by shedding light on practical knowledge and experience, which is as much important as theory. The findings showed that psychiatrists diagnosed a few of the patients suspected of IGD with depression, anxiety disorder and attention-deficit/hyperactivity disorder as comorbidities. Medications were often used to treat comorbidities and cognitive behavioural therapy in some cases. They also stated that they had difficulties while applying the criteria for diagnosis and paid attention to various symptoms. Functionality was reported as the most important criterion and it was suggested to be coded separately in clinical trials.

Keywords: Psychiatrist, internet gaming disorder, video games, case study.

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1. Introduction

Play and games are a fundamental part of human life. With the recent developments in technology, millions of people have started to play online games (Banyai, Griffiths, Kiraly & Demetrovics, 2018). There are over 164 million adults playing video games with at least one gamer in every four households in the United States (ESA, 2019). Playing online games is quite enjoyable for most gamers. However, it may turn into an addiction for some individuals. Disorganization in daily life, such as failure at school and work and breakdowns in social relations, may be an indicator of addiction. The observations of problems similar to those of addiction have given rise to the studies on gaming disorder, which have regarded it as a criterion for psychiatric diagnosis. Two of the most comprehensive handbooks for the classification of psychological and mental disorders, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and International Classification of Diseases (ICD) have included Internet Gaming Disorder (IGD) in the diagnostic criteria. Now, it is included in DSM-5, which was updated in 2013 and has been widely used by American psychiatrists, as a criterion for diagnosis (American Psychiatric Association, 2013)

According to DSM-5, one must demonstrate at least five of nine symptoms for at least 12 months to be diagnosed with IGD, which are heavily focused on the games in everyday life: getting nervous, anxious or upset when not playing, spending more time gaming, losing interest in other daily activities, not being able to give up playing despite problems, gaming to avoid and relieve negative moods, and experiencing losses, such as a job or breakdowns in social life. On the other hand, ICD-11, which was released by the World Health Organisation included the diagnostic criteria for gaming disorder (Petry et al., 2014) despite the ongoing debates on its definition, prevalence and the different methods employed for the diagnosis (Lemmens, Valkenburg & Gentile, 2015; Pontes & Griffiths, 2015; Sigerson, Li, Cheung, Luk & Cheng, 2017). In addition, various studies revealed different results pertaining to the prevalence rate, such as 0.6% (Mentzoni et al., 2011), 2% (Laconi, Pires & Chabrol, 2017), 4% (Lemmens et al., 2015) and 50% (Hur, 2006).

As in the diagnosis stage, there are still uncertainties in the treatment because there are no specific treatments (King & Delfabbro, 2014; Rho et al., 2018; Zajac, Ginley, Chang & Petry, 2017). In addition, most of the studies have been conducted with either normal populations or limited samples (Zajac et al., 2017). Although there are no straightforward methodology and precise results regarding IGD symptoms, prevalence and treatment, the increasing number of the people seeking professional help has led psychiatrists to find ways for treatment (Zajac et al., 2017). However, the lack of a precise diagnosis is an important problem as it causes confusion with the symptoms and its treatment (Weinstein, 2010).

The number of studies focusing on psychiatrists' approaches to suspected IGD and what they do about it seems scarce. Thus, the current study may contribute to the existing literature. For this purpose, the current study aims to investigate psychiatrists' remarks on and experiences with IGD. This study will, therefore, address the following research questions:

What do psychiatrists think about the diagnosis of IGD?

What do they think about too much screen time in IGD?

What do they think about the prevalence of IGD?

What are the experiences of psychiatrists' experiences with the treatment of IGD?

The current study presents an authentic in-depth analysis of psychiatrists' problems and experiences with IGD. Therefore, the results may provide researchers and clinicians with a practical perspective. The study aims to uncover and reveal psychiatrists' remarks on and experiences with IGD.

2. Method

To suit the purpose of the study, a case study method was employed to investigate psychiatrists' remarks on and experiences with IGD. Qualitative research focuses on how people interpret events and attribute meaning to their experiences (Merriam, 2013). In the case when the literature on a subject is scarce, a qualitative method is recommended instead of a quantitative one as it offers an in-depth exploratory analysis (Patton, 2002). For this reason, a phenomenological approach, which focuses on an individual's experiences with and interpretations of an event, was adopted (Creswell, 2014). The phenomenon explored in the current study is psychiatrists' experiences with the treatment of IGD.

2.1. Participants

A total of eight participants (four adult psychiatrists and four child and adolescent psychiatrists) made up the sample of the study. Half of the participants (two adult psychiatrists and two child and adolescent psychiatrists) were chosen from the public hospitals while the other half (two adult psychiatrists and two child and adolescent psychiatrists) were from private hospitals. Purposeful and snowball sampling was employed to recruit the participants. Criterion sampling was also used to further refine the participants. The first criterion was that a participant must be a psychiatrist while the second one was that a participant must have experience with the treatment of gaming disorder. With the snowball sampling, the psychiatrists who met the criteria were recruited on a volunteer basis. To suit the exploratory nature of the study, two psychiatrists represented each of the specialities and each type of hospital. The demographics of the participants are summarised in Table 1.

Table 1. Demographics of the participants

Participants	Age	Seniority	Private/public	Speciality
P1	50	20	Private	Adult psychiatrist
P2	45	18	Private	Adult psychiatrist
P3	40	13	Public	Child and adolescent psychiatrist
P4	40	12	Public	Adult psychiatrist
P5	42	15	Public	Child and adolescent psychiatrist
P6	39	14	Public	Adult psychiatrist
P7	51	22	Private	Child and adolescent psychiatrist
P8	33	5	Private	Child and adolescent psychiatrist

Five males and three females with a mean age of 31.1 years made up the sample of the study.

2.2. Data collection tool

Interview technique was employed to collect in-depth information on participants' opinions on and experiences with the research phenomenon. An interview is a useful technique to understand respondents' perspectives of and attributes towards a subject (Berg & Lune, 2001). The interview was chosen as a qualitative research, which is aimed at understanding a phenomenon in detail. Semistructured interview was preferred as this method enabled the researcher to interact with the participants in a flexible way, which helped to obtain more comprehensive and in-depth information. A semistructured interview form was designed based on the literature review and the personal observations of the researcher in order to present the perspectives of the psychiatrists. Three faculty members from the Department of Guidance and Counselling reviewed the interview questions providing an expert opinion. Following this, two psychiatrists were interviewed for the pilot study before giving the tool its final form.

The interview included four open-ended questions to reveal the psychiatrists' experiences with IGD treatment. The interviews, which were tape-recorded in a quiet setting with the consent of the participants, lasted about 25 minutes. All the interviews were face-to-face. The order of the questions was changed to provide flexibility and allow the researcher to interact with the participants in a natural way. When the researcher felt that he collected sufficient information, he ended the interview by asking the participants whether they had anything to add.

2.3. Data analysis

Following the data transcription, content analysis was conducted. The statements of the participants were analysed word-by-word for the coding. The codes that were thought to be related were grouped under general headings to identify the themes. QDA Miner Lite v.2.0.6 (Provalis Research, Montreal, Canada) software was used for data analysis.

To improve reliability and obtain verbal consent, all participants were informed verbally about the purpose, duration and scope of the study. In addition, the findings were supplied to the participants and the participants were asked to re-consent in order to eliminate possible bias. Interviewees were given pseudonyms to ensure anonymity.

3. Findings

First, the psychiatrists were asked to express what they think about the diagnosis of IGD and the results revealed that there are disagreements among them although they all stated that there should be some standards for the diagnosis.

It is hard to talk about a standard diagnosis (P4).

It is difficult to diagnose someone based on the DSM-5 criteria (P6).

Some psychiatrists feel that the diagnosis of IGD should be included in another diagnosis in the updated version of DSM.

It can be addressed in a new diagnosis as a type of affective spectrum disorders (P1).

It can be included in Attention Deficit and Hyperactivity (P8).

I think it should be related to pathological gambling as huge amounts of money are spent (P2).

Some psychiatrists think that it is better to focus on the comorbidities instead of just focusing on the diagnosis of IGD.

We often see comorbid depression and anxiety disorders. I have been observing this problem among children and adolescents with ADHD (P5).

No agreement on the diagnosis of IGD was observed among the participants.

Participants were asked to report on whether there is a certain amount of screen time which is an indicator of the addiction and they all agreed that there is no standard duration for the diagnosis.

I don't think it is right to talk about problematic screen time as there may be times when someone gets depressed and the screen time may fill that emptiness. For example, one of my clients broke his leg and started to play video games at home as he felt bored. Sometimes 12 or 14 hours a day. However, when he got well, he was back on his work again. So, we can't label him as a gaming addict. (P7).

Some of the psychiatrists emphasised that the other activities in daily life should be investigated rather than the screen time.

I don't care about how much time they spend playing. What is more important to me is whether a person desires to play games while he/she is eating, when he/she is in the restroom or even on holiday (P2).

One of the psychiatrists suggested that the amount of money spent on games might be a strong indicator of addiction.

I want to know whether a client spends money on it or whether that amount is increasing over time (P3).

Most of the participants disagreed with the results of the prevalence studies in the literature. They suggested that the diagnostic criteria and assessment/evaluation scales should be standardised. They also stated that they rarely observe IGD among their clients.

It is less than 1 per 1,000 clients. I have roughly 50 clients a day and I come across with IGD once in every three months (P5).

I rarely observe it. I can remember only few cases (P8).

I don't think prevalence rates reflect the truth. Although research results indicate quite high prevalence of IGD, the number of the clients making appointments and suspecting IGD is quite low. Also, most of them are problematic users rather than addicts (P4).

One of the participants thought that the number of incidents being lower than expected is a result of the diagnostic criteria.

The diagnostic criteria should be standardised. If the prevalence rates reflected the truth, we would be having clients with IGD from morning till night. However, it's not the case as we rarely observe IGD (P3).

The participants did not converge on the treatment of IGD as well as its diagnosis. Some participants stated that the treatment should be designed according to the comorbidities rather than focusing on the diagnosis of IGD alone.

I mainly pay attention to the comorbidities. I design a different treatment for comorbid depression or hyperactivity each (P7).

If a patient has attention deficit, I design the treatment accordingly (P5).

I do not have a special treatment for those. I often advise families for controlling the behaviour and I try to treat the other psychopathologies of the child (P1).

There is no agreement on the medications that are often used for the treatment of IGD as well.

For impulse control disorders I prescribe low-dose antipsychotic and sometimes, perhaps, antidepressants (P2).

I prescribe red-prescription drugs for ADHD (P7).

One of the participants told that she tried to solve the problem by taking legal precaution to delegate the spending authority to the patient's spouse.

In the case of a patient who has been causing increasing economic loss, I prefer taking legal precautions. One of my patients has been spending high amounts of money on online games. I talked to his wife and took legal action. When he was not able to use his credit card, the problem was solved (P2).

One of the difficulties with the treatment of IGD is that most clients either make the appointment reluctantly or do not believe in the success of the treatment even if they come voluntarily. Therefore, the tracking of the incidents and the observation of the treatment result can be quite difficult.

I had a patient suffering from game addiction. However, he did not show up for the periodic control visit (P4).

In the beginning, they come to the appointment because their families make them do so but then they do not come for the control visit (P6).

The participants do not feel competent with the diagnosis and treatment of IGD and report that they organise the treatments referring to their basic knowledge.

It is a subject where I feel incompetent. There are cases of game addiction that require critical interventions. I don't feel well equipped (P2).

I haven't worked on game/Internet addiction or with people who have problems with it. I don't think I am fully competent in IGD (P3).

4. Results, discussion and recommendations

In line with the purpose of the current study, the psychiatrists were first asked to report on what they think about IGD and share their experiences with it. It became apparent that there are disagreements between the psychiatrists on the diagnosis of IGD, which is in line with the previous research pointing out the confusions with the diagnosis of IGD (Kuss, Griffiths & Pontes, 2017). The studies which found associations between IGD and depression (Desai, Krishnan-Sarin, Cavallo & Potenza, 2010; Wang, Cho & Kim, 2018) are also consistent with the studies that relate IGD to ADHD (Swing, Gentile, Anderson & Walsh, 2010) and drug abuse (Van Rooij & Kauppinen, 2014).

Another thing that the current study aimed to reveal was the amount of problematic screen time. It was clear that the participants did not concur on that, too, which is in parallel with the contrasting approaches to problematic screen time in literature. The studies in literature have defined IGD differently with respect to weekly gaming time ranging from 20 or more hours (Kim, Kim, Shim, Im & Shon, 2013) to 30 or more hours (Han, Kim, Lee & Renshaw, 2012; Park et al., 2016; Zang et al 2016). However, the current study focuses on the functioning loss of the patients rather than referring to the weekly gaming time as the diagnostic criterion. In addition, the increasing amounts of money spent on games may suggest that a gamer is getting more fascinated by playing games day by day. This finding is consistent with previous research indicating a positive association between the amount of money spent on games and the time spent playing games (Yesilyurt, 2014)

We also aimed at determining the prevalence rate reported by the participants. The participants stated that they rarely encounter clients with IGD. This finding is consistent with the previous research result which found that only a small part of the population is affected by IGD (ranging from % 0,3 to % 1,0) (Przybylski, Weinstein & Murayama, 2017) while it contradicts with a study which estimated the prevalence rate to be %50 (Hur, 2006).

Today, there is no evidence-based treatment for IGD yet (Zajac et al., 2017; King & Delfabbro, 2014; Nazligul et al., 2017; Rho et al., 2018). The psychiatrist who participated in the study reported that they rarely used cognitive behavioural therapy and often resort to medications although they all have different choices for that. This shows that they have disagreements on medications as well as the treatment. Similarly, there have been antidepressant treatments (Deldoost, Mohammadzadeh, Akbari, & Saeedi, 2019; Song et al., 2016; Han & Renshaw, 2012) and ADHD treatments (Han & Renshaw, 2010; Han et al., 2009) for IGD as stated in the previous research.

However, recent studies have found that although medications are used for the treatment of IGD, it has not been proved effective. On the other hand, they seem to have methodological problems, such as relatively small samples and the absence of control groups (Rho et al., 2018).

Although various methods have also been used for the treatment of IGD in addition to the medications (Han et al., 2009; Han, 2010; Han, 2012; Han, 2016a) such as Family Therapy (Han, 2012),

Eclectic Therapy (Pallesen, Lørvik, Bu & Molde, 2015) and Self-Discovery Camp (Sakuma et al., 2017), none of them have been scientifically proved yet.

The current study aimed to reveal the experiences of psychiatrists with IGD highlighting their remarks. The participating psychiatrists reported that there have been only a few clients with IGD among the suspected cases and that depression, anxiety disorder and ADHD were the most frequent comorbidities they have observed. The participants also stated that they often resort to medications to treat the comorbidities. In addition, they admitted that they have difficulties with the implementation of the diagnostic criteria and they had to look for other symptoms. They emphasised that the most important criterion should be functioning for the diagnosis and recommended that it should be coded separately in clinical studies. They remarked that there is an apparent need for in-service training.

There is a need for future research on the prevalence, diagnostic criteria and treatment of IGD. Psychiatrists should be provided with training on new treatment approaches in the light of up-to-date research. The functioning field should be rated and evaluated in a different way for the diagnosis of IGD. Only eight psychiatrists participated in the study; therefore, findings of the current study cannot be generalised to the general population. Future research may be conducted with larger samples and qualitative designs.

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