Journal of Behavioral Addictions 6(2), pp. 121–123 (2017)
DOI: 10.1556/2006.6.2017.014
First published online March 13, 2017

Stepping back to advance: Why IGD needs an intensified debate instead of a consensus

Commentary on: Chaos and confusion in DSM-5 diagnosis of Internet Gaming Disorder: Issues, concerns, and recommendations for clarity in the field (Kuss et al.)

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(Received: December 1, 2016; revised manuscript received: January 4, 2017; accepted: January 5, 2017)

Based on their analysis of Internet gaming disorder (IGD) criteria, Kuss, Griffiths, and Pontes (2017) come to the conclusion that the current situation can be described as "chaos and confusion." Their assessment is not an exaggeration. It can be argued that there are even more issues, on logical/definitional and political/social levels: (a) the IGD diagnosis is lacking a well-defined object, (b) the cause and effect cannot be differentiated outside lab conditions, (c) the social and political effects of declaring a social behavior as a disease are worrying, and (d) a rushed diagnosis may construct an addiction with potentially harmful effects on (formerly) healthy populations. Instead of closing the debate by declaring a consensus and codifying IGD in the DSM, an undogmatic, intensified, and broader discussion is needed.

Keywords: Internet Gaming Disorder (IGD), DSM-5, video games addiction, digital games, consensus

In their insightful and important paper, Kuss, Griffiths, and Pontes (2017) describe the current situation of the DSM-5 diagnosis of Internet gaming disorder (IGD) as "chaos and confusion." The authors identify several problems, focusing on the IGD criteria and their conceptual and empirical issues. Their criticism is also directed against a position that aims to end the current debate by simply declaring a consensus instead of actually working on one (Petry et al., 2014). This "consensus" has been disputed elsewhere (Griffiths et al., 2016), but the criticism may have remained unheard outside the ivory tower.

At present, several parties seem interested in shortcutting the scientific debate and in normatively establishing a disease without the clarity that Kuss et al. (2017) thoughtfully ask for. There are solid data that challenge the proposed diagnosis in its current form (as also mentioned by Griffiths et al., 2016), but this evidence seems to be ignored to push forward the goal of a normative codification. Obviously, this situation is not helpful for the advancement of research in that area. However, what is far worse is that premature steps in defining "something" as an addiction may affect many people's lives by stigmatizing them and exposing them to a potentially wrong treatment. In short, this is scientifically wrong, and even dangerous, both on the medical and societal levels.

The assessment of the situation may sound harsh. However, Kuss et al. (2017) make several valid and empirically well-founded points that cast severe doubt on the current situation and the political drive to codify IGD. In addition to their discussion operating on the level of criteria and their empirical proof, I would like to add some other doubts operating on the logical/definitional and political/social levels.

On the definitional level, some of the very basic elements of the diagnosis are unclear or, worse, may even be nonexistent. The current diagnosis and most attempts to measure IGD, for that matter, are lacking a well-defined object of the disorder. In short, *what* are people actually addicted to? A large variety of platforms, channels, and genres of games may or may not be relevant here. There are games on personal computers, consoles, and mobile devices, played solo on- and offline, with other co-present players, or with other players online, in small groups or large socially rich environments. There are elaborate Triple-A titles, casual games, browser games, and games with a clear end, an open end, or with limited or open game worlds, played with traditional controllers at home, on the go with touch devices, or, lately, using Virtual Reality goggles or Augmented Reality devices. There are free-to-play games with microtransactions, subscription models, and retail titles. There are sports games, massively multiplayer online role-playing games, first-person shooters, and Jump-and-Runs, to name but a few genres, and their users differ in their motivation to play these games (DeGrove et al., 2017; Scharkow, Festl, Vogelgesang, & Quandt, 2014). Anybody who has done just limited research in the field must know that some of these types of games are much more likely to cause problems than others, but certainly, the mechanism or the cause here is not the Internet as the technological "channel" of play (and indeed, the exclusive focus on "Internet" gaming is

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irritating). Some elements of the game mechanics, in particular the reward systems, may play a role in problematic behavior, as well as the narrative and graphics, accessibility, immersion, persistence of game worlds, or the social aspects of the games. In short, player experience is much more complex, and the interplay of narrative, mechanics, and context need to be considered (Elson, Breuer, Ivory, & Quandt, 2014). However, all of these differentiations seem to be absent from the diagnosis so far. As it is, IGD is as well defined as calling a specific substance addiction as a "stuff that emits smoke disease" or "powder disorder" (and this is not even an ironic overstatement).

Furthermore, how can we *differentiate cause and effect* in IGD? The few longitudinal studies in the field do not give a good and consistent answer. Indeed, support exists for both causation and selection effects, virtually no effect at all, or anything in between (Gentile et al., 2011; Haagsma, King, Pieterse, & Peters, 2013; King, Delfabbro, & Griffiths, 2013; Scharkow, Festl, & Quandt, 2014; Van Rooij, Schoenmakers, Vermulst, Van Den Eijnden, & Van De Mheen, 2011). Logically, arguing for a clear starting point is difficult. In social reality, outside conveniently controlled lab studies, gaming can be many things at once – a compensatory behavior used for escapism, a tool for mood management, a reinforcing agent for existing problems, a stress relief, just fun, and much more. As scientists, we try to trim down social reality and its complexity to a manageable level and to causal chains, but under field conditions, fully untangling the underlying processes as being directional may be impossible, even if some partial causality is involved. Furthermore, the reasons for life problems may not be in the problematic behavior itself but somewhere else. Indeed, one may not ask what excessive users of games do too much, but it should actually be what is *missing* in their life in terms of meaningful and fulfilling *other orientations*. In short, just blaming the game is most likely too simple, but the identification of a clear "villain" seems to be not only important for etiological reasons but also for the justification of a clear-cut diagnosis.

On a more general level, one may question the very idea of *defining a social behavior as a disease*. Stigmatizing forms of media use and social behavior has serious political and social implications. Does this, in the end, not open the door for behavioral control along the lines of norms decided in academic (or other) circles? Furthermore, should we not critically ask who has the right to decide on what form of behavior is healthy, reasonable, and even desirable, and where does it stop? Arguably, including gambling and IGD as behavioral disorders in the DSM has set a precedent for behavioral "addictions." Now that Pandora's box has been opened, others may follow, and it is not unlikely that social media/network addiction (Andreassen et al., 2016; Andreassen, Torsheim, Brunborg, & Pallesen, 2012; Griffiths, Kuss, & Demetrovics, 2014) may be the next on the list. With the principle being established, arguing against the inclusion of other forms of problematic behaviors may be difficult, at least if gaming should not be treated differently than other forms of behavior.

Finally, *rushing a diagnosis* on the basis of chaos and confusion, as Kuss et al. (2017) describe it, is certainly not a good idea. The moral panic surrounding games – a situation that urges researchers to come to quick conclusions – has been discussed elsewhere (Bowman, 2015; Ferguson & Beaver, 2016). However, taking the time to improve the theoretical and empirical weaknesses of the current debate is not a hindrance to scientific progress. On the contrary, advancing science instead of closing the door for critical research by proclaiming a normative "consensus" is necessary. Such a premature closure of crucial definitional processes and accompanying empirical research may lead to the "invention" of a disorder. As psychology has a certain inglorious past of defining behaviors as being outside the acceptable or even mental illnesses, one needs to be careful here not only for historical reasons. The effect of the codification of IGD may be similar to flip-flop pictures: if IGD is being codified in the DSM and discussed widely in public, then parents, peers, and therapists may see patterns of "medically relevant" behavior in forms of use that were previously considered normal. Once the perceptional pattern is established, reverting to the previous viewpoint may be difficult. Indeed, there is anecdotal evidence of parents committing their children to hospitals for the treatment of "online games addiction" in panic, based on press coverage of the topic and the very existence of specialized help services. In some cases, these children have relatively low exposure times and show few clinical characteristics. It has been warned elsewhere that there is a tendency in addiction research toward "overpathologizing everyday life" (Billieux, Schimmenti, Khazaal, Maurage, & Heeren, 2015) – which in turn will have an impact on social reality.

In short, the current situation seems to be an attempt to nail jelly against the wall. Such attempts have not been very successful in the past, and they typically result in a mess. Instead of pushing toward an imminent codification of IGD, it may be helpful to take a step back and start an intensified debate for a real consensus, including all researchers in the field, with an open end, which may include the rejection of IGD being a clinically relevant condition as *one* likely option, besides its inclusion in the DSM. This goal may require targeted workshops and conferences, intensified scale development, and cross-national comparative and longitudinal studies, among other steps (some of which are also mentioned by Kuss et al., 2017). It would also require moving past thinking in stereotypes and camps. Furthermore, it may entail dedication and time. However, as the paper by Kuss et al. (2017) has clearly shown, we need to take that time to move beyond the current state of chaos and confusion.

Funding sources: No financial support was received for this study.

Conflict of interest: The author declares no conflict of interest.

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