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Strategies and Case Analysis of Interpersonal Issues in Group Therapy for Gaming Disorders

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ABSTRACT

With the formal inclusion of gaming disorders in the diagnosis of mental disorders, group therapy, as one of its core interventions, should focus on dealing with accompanying interpersonal issues while improving impulse control and cognitive bias in patients, which is also the core manifestation of impaired social function in patients with gaming disorders, and the key factor affecting the prognosis of treatment. Combined with the clinical characteristics of gaming disorders, this paper combs the common types of interpersonal issues in group therapy, constructs a three-stage processing strategy of "prevention intervention consolidation", combines three real cases of different ages and different types of interpersonal distress, and analyzes the practical process and adjustment points of the strategy in detail, so as to provide practical reference for clinical psychologists to carry out group therapy of gaming disorders, help patients rebuild healthy interpersonal connections and reduce the risk of reignition.

KEYWORDS

Gaming Disorders; Group Therapy; Interpersonal Issues; Handling Strategies; Case Analysis.

1. INTRODUCTION

In the 11th revision of the international classification of diseases (ICD-11), the World Health Organization (who) has clearly classified gaming disorders as mental disorders, whose core feature is sustained or repeated play behavior patterns, resulting in significant damage to important functional areas such as individuals, families and social interactions. Clinical practice shows that patients with gaming disorders are generally accompanied by serious interpersonal dysfunction. They often indulge in the virtual game world to escape realistic interpersonal pressure, lack real interpersonal interaction for a long time, and then lead to the degradation of social skills, the breakdown of trust relations, forming a vicious circle of "interpersonal alienation dependent game interpersonal alienation". According to the China national mental health development report (2021-2022), the incidence of gaming disorders among adolescents in China is about 10% - 15%, and the adult population is also on the rise. Interpersonal distress has become the core bottleneck hindering their recovery.[1]

With the unique advantages of "Interpersonal Interaction scenario simulation" and "peer support empathy", group therapy has become an important form of gaming disorder intervention, and its intervention effect is significantly better than that of simple drug therapy. However, group interaction itself may also lead to new conflicts such as peer exclusion and poor communication. If not handled properly, it will aggravate patients' interpersonal fear and even lead to treatment loss. At present, the research on group therapy of gaming disorders in academia mostly focuses on cognitive behavior intervention and impulse control training, and there is less discussion on the targeted treatment strategies of interpersonal issues, and there are problems such as homogenization of expression and single case. Based on this, combined with clinical cases, this paper systematically combs the types of

interpersonal issues, constructs a scientific and operable three-order processing strategy, and provides practical guidance for clinical intervention.

2. COMMON TYPES OF INTERPERSONAL ISSUES IN GROUP THERAPY FOR GAMING DISORDERS

Combined with clinical observation and related research, the interpersonal issues of patients with gaming disorders in group therapy have distinct commonalities, and there are individual differences due to age and course of disease, which are mainly divided into four categories. All kinds of issues are related to each other, which jointly aggravates the impairment of interpersonal function and game dependence.

(1) Interpersonal avoidance and social fear

This is the most common interpersonal issue. Patients who have been addicted to games for a long time are accustomed to the interactive mode of "anonymity" and "controllability" in the virtual world. They can shape their ideal self through virtual characters without worrying about being evaluated, which brings a sense of psychological security. The uncontrollability of real interpersonal interaction makes patients full of fear, afraid of exposing shortcomings, inappropriate words and deeds, causing resentment, mostly silent, avoiding interaction, and even deliberately alienating peers in groups, always in a "bystander" state. At its core is a lack of interpersonal self-confidence, viewing "non participation" as self-protection, which will further exacerbate the degradation of social skills in the long run.[2]

(2) Lack of communication skills and expression bias

Patients lack real interpersonal communication practice for a long time, and their daily interaction is mostly limited to game related communication in the virtual world, lacking emotional resonance, resulting in serious degradation of communication skills. On the one hand, the ability to express is insufficient, unable to clearly convey ideas and emotions, and words often fail to convey their meaning; On the other hand, the lack of listening and response ability, inattention and perfunctory response make it difficult to form an effective closed-loop communication. In addition, some patients transfer the "direct and rough" communication mode of the virtual world to groups, which is prone to verbal impulse and extreme attitude, triggering peer disgust and interpersonal contradictions.

(3) Interpersonal ambiguity and role conflict

In the virtual game world, the interpersonal boundary is vague, and patients can disclose personal information and express extreme emotions at will. This model migrates to groups, resulting in boundary ambiguity problems for patients, such as excessive exploration of peer privacy and forced imposition of their own wishes on others. In group tasks, some patients have vague role positioning, either overly dependent on others and unwilling to assume responsibility, or overly strong and arbitrary, triggering role conflicts and undermining group cohesion. In addition, some patients bring the competitive relationship of the virtual world into the group, showing jealousy and comparison psychology, which further aggravates interpersonal contradictions.[3]

(4) Lack of trust and peer tension

Lack of trust is the core sticking point and the main reason for peer tension. Most patients have interpersonal setbacks such as peer betrayal and family neglect, forming a negative perception of "no one really helps themselves". In the group, it shows that it is full of doubts about the kindness and help of its peers, unwilling to open up, accept help, and deliberately maintain a distance, which makes its peers feel indifferent, thus reducing interaction and forming a vicious circle of "distrust estrangement more distrust". When interpersonal conflicts occur, patients often choose to escape or confrontation, further exacerbating tensions.

3. THEORETICAL BASIS OF INTERPERSONAL ISSUES IN GROUP THERAPY FOR GAMING DISORDERS

The treatment of interpersonal issues in group therapy of gaming disorders is based on mature psychological theory to achieve "cognitive emotional behavior" all-round intervention and enhance the scientificity and professionalism of strategies. The specific core theories are as follows.

(1) Group dynamics

This theory is the core basis of group therapy, believing that groups are micro social systems, and the norms and cohesion formed by member interaction directly affect the effect of intervention. People with gaming disorders fall into a cycle of interpersonal alienation, the core of which is the lack of healthy interpersonal environment and positive group motivation. By building a safe and inclusive group atmosphere, patients can experience "understanding and acceptance" and break the loneliness; Group "mirror effect" can reduce patients' sense of shame, and group consensus and cohesion can become psychological resources for patients to improve interpersonal and resist the temptation of play.[4]

(2) Social support theory

The theory points out that material and emotional support in stressful situations is the key to buffer psychological crises. One of the core difficulties of patients with gaming disorders is the disintegration of social support system, the lack of family and peer support, and the formation of a "reality support vacuum", which is an important incentive for them to rely on play. This theory guides that intervention should take into account the improvement of interpersonal skills and the reconstruction of social support network, establish peer support through groups, link families and communities to activate the original support system, and make patients feel "needed and understood".

(3) Cognitive behavioral theory (CBT)

This theory is at the heart of gaming disorder interventions, arguing that emotional and behavioral problems stem from nonadaptive cognition. Patients have interpersonal cognitive biases such as "virtual relationship is more sincere" and "I am not good enough", which is the root cause of interpersonal issues. The guiding intervention ideas are as follows: identify and challenge nonadaptive cognition, and establish a new cognition of "real interpersonal security is valuable"; Through behavioral training such as role play and social micro task, we can accumulate positive interpersonal experience and improve interpersonal behavior.[5]

(4) Attachment theory

This theory reveals that early attachment patterns profoundly affect the quality of relationships in adulthood. Most people with gaming disorders have insecure attachments: avoidant attachments use the Internet to isolate emotions, anxious attachments excessively seek identity, and chaotic attachments have difficulty establishing stable connections. Through group interaction, its guiding intervention helps patients explore attachment experience, understand the root causes of interpersonal distress, repair unsafe attachment through safe interaction, and establish a healthy interpersonal model.[6]

4. PREVENTION INTERVENTION CONSOLIDATION STRATEGY FOR INTERPERSONAL ISSUES IN GROUP THERAPY FOR GAMING DISORDERS

Combined with the types of interpersonal issues, core sticking points and theoretical basis, this paper constructs a three-level processing strategy of "prevention intervention consolidation", focusing on the core of "safety atmosphere construction, cognitive bias correction, social skills training and

interpersonal confidence reconstruction", and pays attention to personalized adjustment to ensure the sustainability of intervention effect.

(1) Prevention stage: pre intervention to avoid interpersonal issues

The core of the prevention stage is "prevention in the first place". In view of the initial stage of group formation, we focus on three tasks: first, scientifically screen members, screen suitable patients through interviews and psychological evaluation, control the number of 8-12 people in the group, optimize the matching of age, course of disease and interpersonal distress types, clarify treatment rules, and reduce unknown fears; The second is to build a safe and inclusive atmosphere, narrow the distance through ice breaking activities, guide members to jointly formulate group contracts such as confidentiality, non judgment and respect for boundaries, and therapists to set a good example of interaction and build group trust; Third, pre interpersonal cognitive guidance, explain the relationship between gaming disorders and interpersonal issues, popularize interpersonal boundaries, communication etiquette and other basic contents, and stimulate patients' willingness to improve.

(2) Intervention stage: precise implementation of policies to solve existing interpersonal issues

The intervention stage is the core, aiming at the four major interpersonal issues, guiding group motivation and avoiding the escalation of contradictions.

1) Interpersonal avoidance and social fear: adopt the strategy of "gradient exposure+positive reinforcement". Gradient tasks are formulated according to the degree of fear, from passive listening and simple response to active sharing and active interaction, and gradually promoted; Give timely affirmation to every progress of patients, guide and record progress, obtain resonance through peer sharing, and break the cognitive bias of "non participation=safety".

2) Lack of communication ability and expression deviation: adopt the strategy of "skill training+practical exercise". Carry out training in expression, listening and response ability, guide patients to express their needs and emotions in standardized sentences, and ensure the effectiveness of listening through "listening+retelling"; Through role-playing to simulate real interpersonal scenarios, practice communication skills, carry out emotional management training, master Nonviolent Communication methods, and avoid impulse induced contradictions.

3) Interpersonal boundary ambiguity and role conflict: adopt the strategy of "boundary guidance+Role Positioning". Through special explanation and case analysis, help patients clarify interpersonal boundaries, learn to respect others' privacy and wishes, clarify their own boundaries and refuse unreasonable requirements; Rationally allocate roles in group tasks, arrange tasks according to patients' abilities, intervene in time when conflicts arise, guide communication and consultation, and resolve contradictions.

4) Lack of trust and peer tension: adopt the strategy of "emotional connection+trust construction". Promote peer emotional connection through emotional sharing and mutual assistance tasks, and establish a "commitment fulfillment" mechanism to let patients feel trust and sincerity in fulfilling small commitments; When peer conflicts arise, guide both sides to communicate frankly, resolve misunderstandings, learn to be inclusive and understanding, and improve peer relations.

(3) Consolidation stage: long-term maintenance to prevent the recurrence of interpersonal issues

The core of the consolidation stage is "long-term maintenance", focusing on three tasks in the later stage and after the end of group treatment: first, summarize the review, guide patients to sort out their skills and shortcomings, strengthen skills through peer feedback, and formulate personalized consolidation plans; The second is reality transfer, guiding patients to formulate gradient reality interpersonal practice tasks, recording practical feelings and problems, sharing and communicating in groups or online support groups, and obtaining guidance; Third, long-term follow-up, through regular interviews, telephone follow-up to track the status of patients, timely find signs of recurrence, intervention adjustment, to ensure the long-term effect of intervention.

5. CASE ANALYSIS OF INTERPERSONAL ISSUES IN GROUP THERAPY FOR GAMING DISORDERS

Combined with three anonymous cases of different ages and different types of interpersonal distress, this paper analyzes the practicality and effectiveness of the third order strategy, ensures the authenticity and originality of the cases, and avoids homogenization.

(1) Case 1: adolescent patients (interpersonal avoidance and social fear)

Case 1 is Li Mou, male, 16 years old, a senior high school student, who has been diagnosed with game disorders for 6 months, spends more than 8 hours a day playing games, and is addicted to role-playing games. His parents are away all year round and raised by his grandparents. After being ridiculed in primary school because of his small body, he began to avoid interpersonal and unwilling to communicate with others, and then indulged in games to escape pressure. When participating in groups, he was always silent, deliberately alienated his peers and worried about being ridiculed; The core interpersonal issues of the patient were interpersonal avoidance and social fear, which were rooted in self denial and lack of self-confidence caused by childhood interpersonal trauma. Game addiction further aggravated the degradation of social skills and formed a vicious circle; In terms of strategy application, in the prevention stage, they should be matched with mild companions, eliminate their unfamiliar fears through moderate communication, let them listen first, do not speak, and popularize knowledge related to social fear. In the intervention stage, four gradient exposure tasks should be formulated, combined with cognitive behavior theory to break their cognitive bias of "being laughed at". At the same time, simple group tasks should be arranged to help them integrate. In the consolidation stage, they should be guided to summarize their progress, formulate practical tasks to communicate with grandparents and classmates and participate in associations, and carry out regular follow-up guidance; After 12 times of group therapy and 6 months of follow-up, Li Mou has been able to actively participate in group interaction, actively communicate with people and participate in community activities in reality, social fear has been significantly alleviated, and the length of the game has been controlled within 2 hours a day, successfully getting rid of the vicious cycle of "interpersonal avoidance dependent game".

(2) Case 2: Young patients (lack of communication skills and expression bias)

Case 2: Zhang, a 22-year-old male college graduate diagnosed with gaming disorder for one year, with a lack of communication skills and expression deviation among young people. He spends more than 10 hours playing games every day and is addicted to competitive games. He has lacked communication practice since childhood and has a lack of family communication atmosphere, resulting in unclear communication and logical confusion. He does not know how to listen to others, and is prone to interrupting others' speeches and emotional impulses, leading to tense peer relationships; The core interpersonal issue of the patient is a lack of communication skills and expression deviation, which is rooted in a long-term lack of communication practice, a lack of family communication atmosphere, and the transfer of the "direct and rough" communication mode in virtual games to reality, resulting in frequent interpersonal conflicts, and can only rely on games to alleviate frustration; In terms of strategic application, during the prevention phase, it is recommended to pair individuals with good communication skills and tolerant personalities, clarify communication rules, popularize communication etiquette, and focus on expression, listening, and emotional management training during the intervention phase. Through role-playing exercises, rational responses are encouraged to break the cognitive bias of "only one's own opinions are important". During the consolidation phase, individuals are guided to summarize their own shortcomings, develop practical tasks for communicating with friends, job interviews, and participating in volunteer activities, and receive regular follow-up support; After 16 group treatments and 6 months of follow-up, Zhang's communication skills have significantly improved. He is able to patiently listen to others and respond rationally to different opinions. His peer relationships have significantly improved, and he has

successfully achieved employment. He controls his game time within 1.5 hours per day and no longer relies on games to alleviate communication frustration.

(3) Case 3: Middle aged patient (blurred interpersonal boundaries and lack of trust)

Case three is a middle-aged patient named Wang, male, 38 years old, an employee of a company, diagnosed with gaming disorder for 8 months. He spends more than 7 hours playing games daily and is addicted to strategy games. After marriage, his relationship with his wife was tense, and he was isolated due to excessive interference with colleagues at work. When participating in groups, he also excessively inquired about the privacy of his peers, forcibly imposed his own wishes on others, and had doubts about their help, making it difficult for him to integrate into the group; The core interpersonal issues of the patient are blurred interpersonal boundaries and lack of trust, rooted in psychological trauma caused by marital conflicts and work setbacks. At the same time, the fuzzy interpersonal boundary patterns in virtual games are transferred to real life, further exacerbating interpersonal pressure and game dependence; In terms of strategic application, in the prevention stage, it is necessary to pair them with peers with strong boundary awareness, clarify interpersonal boundary rules, and promote the importance of trust. In the intervention stage, case studies are used to help them clarify interpersonal boundaries, and auxiliary group tasks are arranged to guide them in correctly positioning their roles. Emotional sharing and commitment fulfillment mechanisms are used to help them build trust. In the consolidation stage, they are guided to summarize progress, develop practical tasks to improve marital relationships, colleague relationships, and actively seek help from others, and receive regular follow-up guidance; After 14 group treatments and 6 months of follow-up, Wang's awareness of interpersonal boundaries and trust in others have significantly improved. His marital and colleague relationships have also improved, and he has regained job recognition. His gaming time has been controlled within 2 hours per day, and his interpersonal function has basically returned to normal.

6. DISCUSSION AND REFLECTION

The third-order processing strategy can effectively address various interpersonal issues, and the intervention effects on patients of different age groups and types of distress are significant, indicating that the strategy has strong pertinence and operability, and can be personalized and adjusted according to individual differences. At the same time, four key issues need to be addressed in the intervention: firstly, the therapist's neutral, sincere attitude, and professional ability, which directly affect the effectiveness of the intervention; Secondly, the patient's willingness to actively participate is the key to successful intervention, which needs to be stimulated through positive reinforcement; Thirdly, it is necessary to collaborate with families and communities, build a diverse support network, and enhance the long-term effectiveness; Fourthly, personalized intervention should be emphasized to avoid a one size fits all approach.

This study has limitations: the number of cases is small, the follow-up period is only 6 months, and the effectiveness evaluation relies on clinical observation and subjective feedback. In the future, it is necessary to expand the number of cases, extend the follow-up period, introduce scientific evaluation tools, optimize the third-order strategy, strengthen the combination of group therapy with individual and family therapy, and promote the standardized development of group therapy for gaming disorders.

7. CONCLUSION

There are four common types of interpersonal issues among patients with gaming disorders in group therapy, which are interrelated and important reasons for the impairment of social function and the resurgence of gaming. The "prevention intervention consolidation" three-stage treatment strategy

based on the four core theories can effectively improve patients' interpersonal function, help rebuild interpersonal connections, and reduce the risk of relapse.

Case analysis shows that the third-order strategy has strong pertinence and operability, adapts to different patient needs, and has significant intervention effects. At the same time, attention should be paid to the role of therapists, patient participation willingness, multidimensional linkage, and personalized intervention in order to further improve the effectiveness. This study provides practical reference for clinical intervention, and in the future, strategies need to be continuously improved to promote the scientific development of group therapy for gaming disorders, helping more patients overcome interpersonal difficulties and return to normal life.

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