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# The Screen as a Shield: Internet Addiction as a Maladaptive Defense Against Childhood Emotional Neglect in a Left-Behind Adult

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**A B S T R A C T**

**Introduction:** Internet addiction (IA) is frequently conceptualized as an impulse control disorder driven by dopaminergic dysregulation. However, in the context of left-behind children—those raised by grandparents due to parental migration—IA may function as a complex psychodynamic defense mechanism. This study aims to elucidate the role of the smartphone as a digital shield against the resurfacing trauma of Childhood Emotional Neglect (CEN) and attachment deficits. **Case presentation:** We report the case of a 23-year-old female in Eastern Bali presenting with acute dysphoria, elective mutism, and total insomnia following the confiscation of her smartphone. Assessment included the Internet Addiction Test (IAT), clinical interviews utilizing written communication during the mute phase, and family system analysis. The patient scored 58 on the baseline IAT, indicating moderate addiction. Clinical inquiry revealed a history of split-parenting, where the patient was reared by emotionally distant grandparents. The smartphone served a specific function of displacement, seeking safety in online relationships, and dissociation, used to numb loneliness. The device confiscation triggered a traumatic re-enactment of early childhood abandonment, resulting in physiological hyperarousal incompatible with the moderate IAT score. Treatment involved Fluoxetine (20mg), Clobazam (10mg), and psychodynamic psychotherapy focusing on attachment repair. At the 4-week follow-up, the IAT score decreased to 32, and verbal communication was fully restored. **Conclusion:** IA in young adults with developmental trauma functions as a maladaptive defense mechanism (The Digital Shield). Clinicians must address the underlying attachment wound rather than focusing solely on digital detoxification to achieve sustainable remission.

## 1. Introduction

The twenty-first century has been irrevocably transformed by the digital revolution, ushering in an era defined by a profound and disquieting paradox. We exist in a state of ubiquitous hyper-connectivity, where the barriers of time and geography have been dissolved by the instantaneity of the virtual realm.[1] Yet, simultaneous with this digital saturation is a rising tide of interpersonal fragmentation, profound loneliness, and emotional isolation in the physical world. As screens have become the primary mediators of human experience, the quality of direct, face-to-face dyadic connection has eroded, giving rise to a new spectrum of psychopathology. Among these, internet addiction (IA)—often interchangeably termed problematic internet use (PIU)—has emerged not merely as a behavioral nuisance, but as a significant public health crisis with global ramifications.[2]

This crisis is particularly acute in Southeast Asia, a region characterized by rapid digital infrastructure development and a mobile-first consumer culture.[3] In nations such as Indonesia, prevalence rates of IA have been reported as high as 47.4%, a figure that significantly outpaces global averages and suggests a unique susceptibility within this demographic. While the diagnostic and statistical manual of mental disorders (DSM-5-TR) has taken a tentative step by categorizing internet gaming disorder as a condition

for further study, this nomenclature fails to capture the full breadth of the phenomenon. The clinical reality is far more expansive than gaming alone; it encompasses generalized internet addiction, characterized by compulsive social media engagement, the mesmerizing loop of doom-scrolling, and a pathological dependency on digital validation.[4] In psychiatric practice, this generalized form of addiction is rarely an isolated diagnosis. Instead, it presents as a complex comorbidity, masked by—or acting as a driver for—major depressive disorder, generalized anxiety disorder, and severe social withdrawal (hikikomori-like syndromes), complicating both diagnosis and treatment.

To date, the scientific literature surrounding IA has been predominantly colonized by neurobiological perspectives.[5] The prevailing etiological model posits that IA mirrors the pathophysiology of substance abuse disorders. Through this lens, the screen is viewed as a digital drug, and the addiction is driven by dopaminergic dysregulation within the mesolimbic reward pathway—specifically involving the nucleus accumbens and the striatum. Research utilizing functional neuroimaging has robustly demonstrated that digital feedback loops (notifications, likes, and infinite scroll mechanics) trigger reward anticipation identical to that observed in cocaine or gambling addiction.

While this neurobiological perspective provides a crucial mechanistic explanation of reinforcement—explaining how the cycle of addiction is perpetuated—it remains insufficient in explaining the psychodynamic etiology of the object choice. It answers the question of how, but fails to answer why. Why does a specific individual, at a specific developmental juncture, turn to the screen as their primary source of solace? Davis's cognitive-behavioral model attempts to bridge this gap by suggesting that maladaptive cognitions about the self ("*I am worthless offline*") and the world ("*People are judging me*") are the proximal causes of PIU. However, even this model frequently overlooks the developmental roots of these cognitions. It treats the maladaptive thought as the starting point, neglecting the historical trajectory of childhood emotional neglect (CEN) and early attachment ruptures that fertilized the soil for these cognitions to take root.[6]

To truly understand the psychodynamics of IA in the Southeast Asian context, one must look beyond the brain and into the cultural fabric of the family. In Indonesia, a developing nation undergoing rapid urbanization, the phenomenon of the left-behind child has become culturally prevalent. This demographic shift is often driven by the deeply ingrained cultural practice of *Merantau* (circular migration), where parents leave their rural ancestral homes to seek economic opportunities in urban centers or abroad as migrant workers.[7] While economically pragmatic and often framed as an act of familial sacrifice, the psychological toll of this arrangement is profound.

Children in these split-parenting arrangements are typically left in the care of grandparents or extended family members. While these surrogate caregivers often provide adequate physical care—ensuring the child is fed, sheltered, and educated—there is frequently a critical gap in emotional attunement. Generational divides, physical limitations of elderly caregivers, and a cultural emphasis on obedience over emotional expression can lead to an environment of emotional invisibility. Research suggests that grandparents may lack the stamina for the consistent, responsive dyadic interaction required for optimal neuro-psychological development. Consequently, studies indicate that children raised in these arrangements are at a substantially higher risk for developing insecure attachment styles, harboring a silent grief that persists into adulthood.

The theoretical lens of John Bowlby's Attachment Theory offers a powerful framework for deconstructing this trauma. Bowlby posited that the primary caregiver serves as a secure base from which the child explores the world. When this base is unavailable, inconsistent, or physically absent due to migration, the child develops a maladaptive internal working model (IWM).[8] They internalize a view of the Self as unworthy of love and attention, and a view of Others as unreliable or

rejecting. In the absence of a secure attachment figure to provide co-regulation of affect, the left-behind child experiences a primal wound—a fundamental rupture in their sense of safety. This results in chronic, ego-dystonic feelings of loneliness, rejection, and existential anxiety. As the child matures into a young adult, the need to maintain psychic integrity becomes paramount. To survive the intolerable weight of this emotional neglect, the developing individual is forced to employ sophisticated defense mechanisms. It is at this precise intersection of developmental trauma and modern technology that the smartphone ceases to be a tool and becomes a psychological crutch.

This study proposes a novel theoretical framework wherein the internet functions as a psychic retreat. This concept, originally described by the psychoanalyst John Steiner, refers to a pathological organization of the personality where the patient withdraws from the demands of reality to a sequestered world where they feel protected from anxiety, judgment, and guilt. In the analog era, such retreats were internal fantasies; in the digital era, the retreat has been externalized and solidified into the virtual world.

For the left-behind demographic, the smartphone acts as a high-fidelity transitional object. Donald Winnicott famously described the transitional object (such as a teddy bear or security blanket) as a bridge between the child's internal reality and the external world—a device used to soothe anxiety during separation.[9] However, a crucial distinction must be made: Winnicott's bear was inert. It could be hugged, but it could not hug back. The smartphone, conversely, is interactive. It responds. It creates a digital shield against loneliness by offering variable-ratio reinforcement and the illusion of connection without the terror of intimacy. Through the screen, the individual can engage in three distinct defense mechanisms simultaneously: (1) Idealization: Projecting a curated, perfect digital self that compensates for the feelings of worthlessness harbored by the real self; (2) Displacement: Shifting the desperate need for connection from unavailable parents onto safe virtual avatars and online communities; (3) Dissociation: Using the hypnotic flow of the algorithm to numb the pain of real-world rejection and silence the internal dialogue of abandonment.[10]

Against this backdrop of neurobiology, culture, and psychodynamics, this case report aims to elucidate the trajectory of a 23-year-old female patient. Her clinical presentation—characterized by moderate psychometric scores on the Internet Addiction Test (IAT) yet catastrophic physiological collapse (mutism and total insomnia) following phone confiscation—presents a diagnostic puzzle that standard addiction models fail to solve. The novelty of this study lies in three key areas: (1) Psychodynamic Reframing: It shifts the clinical focus from the symptom (addiction/screen time) to the function of the behavior (a defense against specific attachment trauma), challenging the dopamine-centric reductionism prevalent in current psychiatry; (2) Contextual Specificity: It specifically analyzes the left-behind child phenomenon in Indonesia, contributing rare qualitative data to the field of transcultural psychiatry and highlighting how macro-economic migration patterns imprint upon the micro-psychology of the developing child; (3) The digital shield metaphor: It operationalizes the concept of the smartphone as an active defense mechanism, offering clinicians a tangible framework to understand the disparity between psychometric addiction severity and the profound abandonment depression that surfaces during digital detoxification. By dissecting the loneliness-addiction loop through this comprehensive lens, this study seeks to offer a roadmap for clinicians to look beyond the glowing screen and identify the silent, intergenerational trauma it serves to conceal.

**2. Case Presentation**

Ms. N, a 23-year-old unmarried female of Javanese-Balinese descent, resides in a semi-rural district within the Karangasem regency of Eastern Bali. She is the eldest of two siblings in a family whose socioeconomic structure is defined by agricultural

labor and circular migration. At the time of her admission, Ms. N was unemployed, having recently been terminated from a clerical position—a job loss that was retrospectively linked to her digital behaviors.

In adherence to the ethical standards of the Declaration of Helsinki and the specific guidelines of the institutional review board, written informed consent was obtained from both the patient and her legal guardians. This consent explicitly covers the publication of this case report and the accompanying clinical data. To ensure strict confidentiality and protect the privacy of the patient within her close-knit community, all identifiable details, including specific village names and extended family identifiers, have been anonymized.

The patient presented to the Psychiatric Outpatient Clinic of Karangasem Regional General Hospital as an urgent referral, accompanied by her visibly distressed parents. The primary reason for consultation was a constellation of acute behavioral regressions manifesting as refusal to speak (elective mutism), a total refusal to consume food or water (acute anorexia), and episodes of uncontrollable, inconsolable crying persisting for a duration of one week. The parents described a rapid decomposition of functioning, transitioning from a communicative, albeit distracted, young adult to a state of near-catatonic withdrawal within a span of days (Table 1).

The onset of the current crisis was acute and clearly demarcated, precipitated by a severe domestic conflict occurring seven days prior to admission (T-7 Days). According to heteroanamnesis provided by the parents, the conflict centered on the patient's obsessive and compulsive smartphone usage. The parents reported that Ms. N's circadian rhythm had become inverted, with the patient routinely staying awake until 04:00 AM to engage in online activities, resulting in profound neglect of her household responsibilities and personal hygiene.

Fearing for her health and frustrated by her lack of engagement with the family unit, the patient's father executed what we clinically term a digital amputation—the forcible and non-negotiable confiscation of her smartphone. This intervention, intended by the family as a corrective disciplinary measure, functioned instead as a psychological trigger for an immediate and catastrophic collapse. The removal of the device did not result in a return to reality, as the parents had hoped, but rather a violent recoil from it.

Following the confiscation, Ms. N exhibited a severe withdrawal syndrome that mimicked the physiological intensity of substance cessation, characterized by: (1) Acute dysphoria and affective lability: The patient experienced persistent weeping spells lasting hours, marked by deep, pervasive sadness and flashes of irritability when family members attempted to intervene; (2) Vegetative disruption (Total Insomnia): Perhaps the most alarming symptom was the onset of total insomnia. Parents verified that for five consecutive days and nights following the phone confiscation, the patient did not sleep. She was observed pacing the confines of her bedroom throughout the night, exhibiting a state of hyper-arousal and vigilance typically associated with acute threat responses; (3) Behavioral regression and elective mutism: The patient retreated to the sanctuary of her bedroom, locking the door and refusing to shower or change clothes. Most significantly, she ceased all verbal communication with her parents and siblings. This mutism was not aphasic in nature but volitional and defensive—a deliberate sealing off of the self from the external world that had deprived her of her coping object.

Upon her initial evaluation in the clinic, Ms. N maintained her elective mutism. She sat with her head bowed, avoiding all eye contact, and refused to respond verbally to the nursing staff's intake questions. Recognizing this behavior as a defensive posture—a wall of silence erected to protect a fragile ego—rather than a neurological deficit, the attending psychiatrist opted to bypass standard verbal interrogation methods. Adopting a non-intrusive, Winnicottian approach to creating a holding environment, the psychiatrist placed a notepad and pen on the table between them. The clinician

acknowledged the patient's pain without demanding she break her silence, stating, it seems like your voice has been taken away along with your phone. You can write here if that feels safer. This intervention proved pivotal. It offered the patient a mode of communication that mimicked the text-based mediation of the internet, providing a bridge between her internal isolation and the therapeutic dyad. After a long pause, Ms. N picked up the pen and wrote a single, devastating sentence: *"They took my life. It's too loud in my head now"*. This written statement provided the first critical clinical insight: the smartphone was not merely a source of entertainment but a prosthetic regulation device used to silence intrusive internal thoughts. Through this written exchange, therapeutic rapport was tenuously established. By the second session (Day 2 of admission), as the patient's anxiety began to de-escalate with pharmacological support, she began to whisper. By Day 3, full verbal volume was restored, allowing for a comprehensive psychodynamic interview to reconstruct her history.

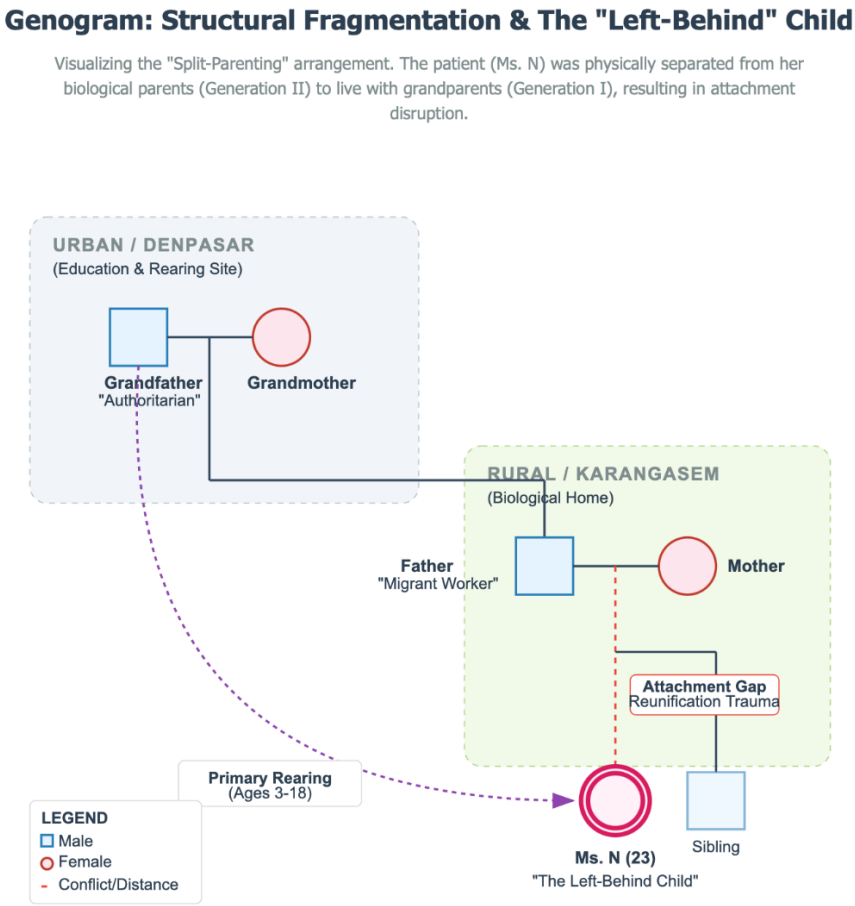


Figure 1. Family genogram of the patient.

The reconstruction of Ms. N's developmental history revealed a classic, trans-generational narrative of the left-behind child—a phenomenon increasingly prevalent in Indonesia's shifting socioeconomic landscape. Analysis of the family genogram revealed a structural fragmentation marked by chronic physical separation. The patient represents generation III of a family divided by the necessity of labor migration (Figure 1). From the tender age of three until eighteen, Ms. N was sent to live with her grandparents

(Generation I) in the urban center of Denpasar to access better schooling. Meanwhile, her parents (Generation II) remained in their rural village in Karangasem to tend to agricultural work. This split-parenting arrangement meant that the patient's formative years were spent geographically and emotionally severed from her primary attachment figures.

The environment in the grandparents' home was described by the patient as sterile and authoritarian. While her grandparents provided for her physical needs—food, shelter, and tuition—they were described as emotionally impoverished. They were rigid disciplinarians who prioritized academic obedience and adherence to tradition over emotional connection or play. In a poignant recollection, the patient stated, *"I was a package they were storing, not a grandchild"*. She recalled spending her evenings alone in a quiet house as her elderly grandparents slept early, feeling chronically invisible and unheard. It was in this vacuum of intimacy that the silence of the house became a trigger for anxiety, a silence she would later learn to fill with digital noise.

The trajectory of trauma was compounded upon her graduation from high school. At age 18, Ms. N was forced to return to the rural village to live with her parents—a reunification she experienced not as a homecoming, but as an exile. Having spent 15 years apart, she possessed no emotional bond with her parents, viewing them essentially as strangers. Her request to return to the city and the life she knew was summarily rejected by her father. This rejection reinforced her core schema of lacking agency and being a pawn in the family's logistical arrangements.

During the clinical interview, once verbal communication was established, Ms. N displayed remarkable intellectual insight into the function of her internet usage. Her addiction was not driven by the pursuit of pleasure (hedonism) but by the avoidance of pain (negative reinforcement).

Anxiolysis and Affect Regulation: The patient explicitly identified the smartphone as her primary tool for mood regulation. She stated, *"When I scroll, the noise stops. The loneliness goes away"*. This confirmed the hypothesis that the continuous stream of digital content acted as a numbing agent, a digital pacifier that neutralized the anxiety of sitting alone with her own thoughts.

Identity Reconstruction: Ms. N revealed that she maintained three distinct social media accounts across Instagram, TikTok, and Twitter. On these platforms, she curated a meticulously crafted digital ideal ego. While her reality was that of an unemployed, lonely woman living in a rural village, her digital persona was that of a successful, urban-dwelling fashion enthusiast who was confident and popular. This split allowed her to live vicariously through her avatar, compensating for the deep sense of inadequacy she felt in her physical life.

Avoidance and Displacement: The internet provided a controlled environment for social interaction. Ms. N noted, *"Real people judge you. Online people just 'like' you"*. This statement highlights her use of the internet to bypass the complexity and risk of real-world relationships (where she feared rejection, mirroring her parental relationship) in favor of the simplified, transactional validation of the digital realm.

Upon physical examination, the somatic toll of her psychological distress was evident. Ms. N appeared her stated age but presented with notably neglected hygiene; her hair was unkempt and she carried a distinct body odor, physical correlates of her depressive withdrawal and refusal to bathe. Her vital signs revealed a physiological state of stress. Her blood pressure was elevated at 120/70 mmHg, and she was tachycardic with a heart rate of 90 beats per minute, reflecting a high sympathetic drive consistent with anxiety and sleep deprivation. Her respiratory rate was 16 breaths per minute, and her temperature was normal at 36.5°C. General status examination showed no signs of anemia, jaundice, or cyanosis. The thyroid gland was not enlarged, ruling out organic metabolic causes for her agitation. Thoracic examination was unremarkable, with symmetrical movement and clear vesicular breath sounds. Cardiovascular assessment

revealed regular S1 and S2 heart sounds with no murmurs. Neurologically, cranial nerves I-XII were intact, and there were no focal motor or sensory deficits. Deep tendon reflexes were physiological (+2) and symmetrical, and her extremities were warm with a capillary refill time under 2 seconds, indicating adequate peripheral perfusion despite her refusal to eat.

The Mental Status Examination provided a snapshot of her acute psychiatric state during the initial crisis phase: (i) Appearance and Behavior: Ms. N was dressed in casual, disheveled clothes. Her eye contact was fleeting and actively avoidant, scanning the room rather than engaging with the clinician; (ii) Psychomotor Activity: She appeared outwardly calm but exhibited signs of underlying tension and restlessness (akathisia-like movements), such as wringing her hands, consistent with her history of total insomnia; (iii) Mood and affect: Her mood was reported and observed as deeply dysphoric. Her affect was broad but restricted in range; she was capable of expressing emotion but it was predominantly negative and defensive; (iv) Speech: As previously noted, her speech was initially absent (elective mutism). When she began to communicate, there was a significant latency in response, and her volume was low and monotonous, requiring the listener to lean in to hear; (v) Thought Process and Content: Despite the severe behavioral regression, her thought process remained coherent, logical, and realistic. There was no evidence of loosening of associations or flight of ideas. Her thought content, however, was heavily preoccupied with the loss of her smartphone and her online status. There were no delusions or perceptual disturbances such as hallucinations; (vi) Suicidality: Passive suicidal ideation was present. She admitted to "*wishing I didn't exist*" or hoping she would not wake up, framing death as a relief from the noise in her head, but she denied active intent or a specific plan; (vii) Insight: Her insight was graded as Level 4 (Intellectual Insight). She possessed the awareness that her reaction was excessive and that she had a problem, but she attributed the etiology largely to external factors (loneliness, parental cruelty) rather than internal dynamics, and she felt powerless to control the emotional flood.

**Table 1. Summary of Clinical Findings on Admission**

Overview of physiological, behavioral, and psychological status at Day 0 (Presentation).

| DOMAIN | SPECIFIC FINDING | CLINICAL INTERPRETATION |
|---|---|---|
| General Appearance | **Self-Neglect**<br>*Unkempt hair, distinct body odor, refusal to shower for 7 days.* | Correlates with severe depressive withdrawal and behavioral regression. |
| Physiological Status | **Sympathetic Hyperarousal**<br>• BP: 120/70 mmHg<br>• HR: **90 bpm (Tachycardic)**<br>• Sleep: **Total Insomnia (5 days)** | Indicates acute stress response and hyper-vigilance (Fight or Flight) triggered by device confiscation. |
| Behavioral | **Elective Mutism**<br>*Total refusal to speak to family/staff; communicated via writing initially.* | **The Shield Defense:** Regression to an infantile state to punish caregivers and protect the fragile ego. |
| Mood & Affect | **Acute Dysphoria**<br>*Uncontrollable crying spells, irritability, empty mood.* | Consistent with *Abandonment Depression* triggered by the Digital Amputation. |
| Thought Content | **Passive Suicidality**<br>*"Wishing I didn't exist"; denial of active intent/plan.* | Expression of hopelessness and loss of agency rather than intent to harm. |
| Psychometrics | **IAT Score: 58**<br>*Young Internet Addiction Test (Indonesian Version).* | **Diagnostic Discrepancy:** Score indicates Moderate addiction, contradicting the severe/catastrophic clinical presentation. |

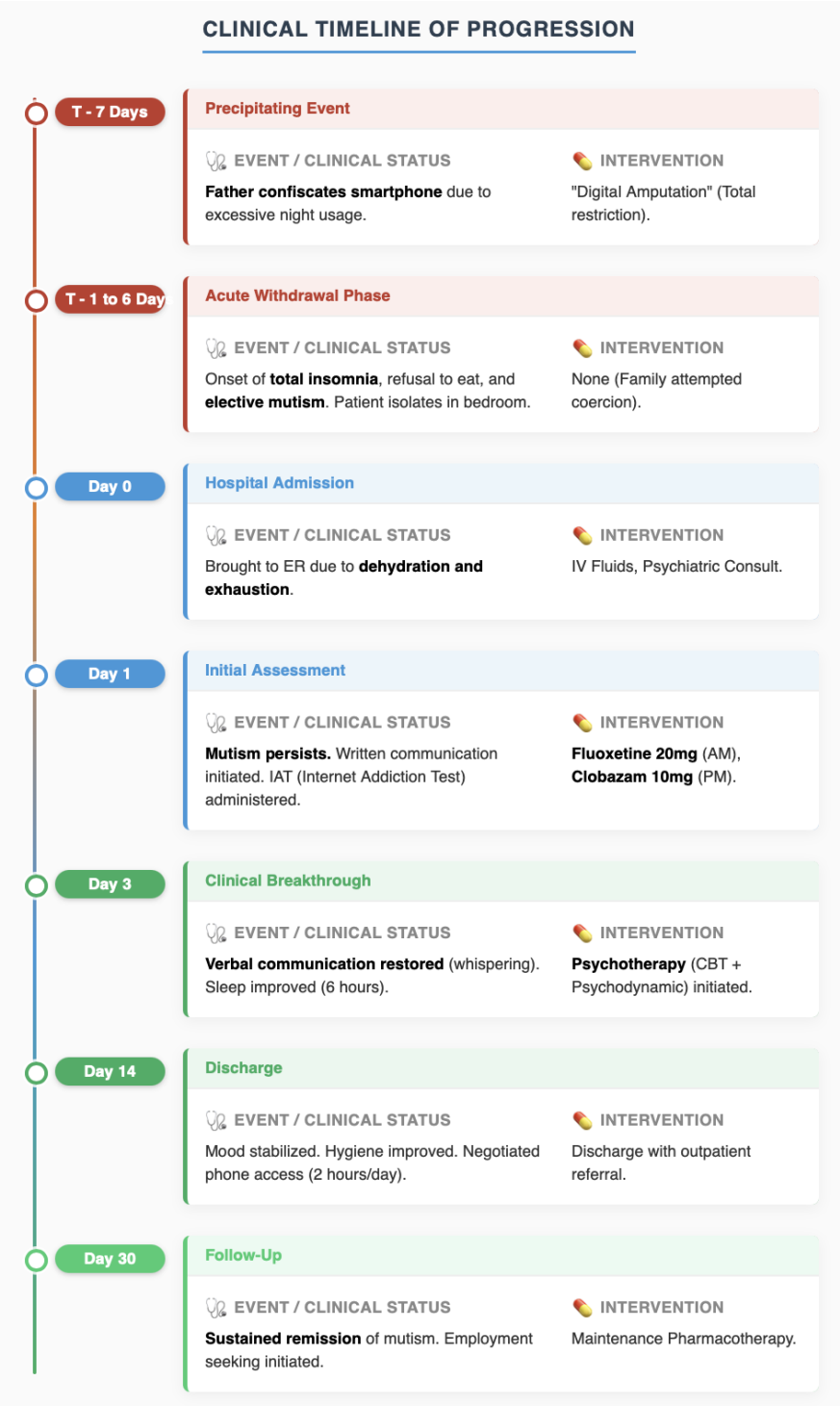


Figure 2. Clinical timeline of progression.

Table 2 provides a granular psychometric evaluation of the patient's digital usage patterns utilizing young's internet addiction test (IAT). The patient obtained a cumulative score of 88 out of 100, placing them firmly within the Severe Dependence classification range (80–100). This quantitative metric corroborates the qualitative clinical presentation of acute withdrawal and functional impairment observed upon admission. A domain-specific analysis of the IAT responses

elucidates the pathology driving the addiction: (i) Salience and preoccupation: The patient recorded maximal scores (5/5) in items related to mental preoccupation, indicating that the internet dominates cognitive processes even when the patient is offline. This suggests a high degree of psychological displacement where digital interaction has superseded physical reality as the primary source of stimulation; (ii) Emotional regulation and withdrawal: Crucially, the patient reported always (5/5) utilizing the internet to block out disturbing thoughts and experiencing dysphoria (depression, moodiness) when offline. This highlights a maladaptive coping mechanism where digital consumption serves as a primary emotional crutch, explaining the severe rebound behavioral disturbances (such as mutism, refusal to eat) observed during the forced abstinence period; (iii) Functional and social impairment: The breakdown reveals profound neglect of daily responsibilities, including academic performance and household duties (Score 4–5). Furthermore, the high scores in the conflict and concealment domains reflect the erosion of familial relationships, characterized by defensive aggression when access is threatened and deceptive behaviors regarding usage duration; (iv) Physiological impact: The maximum score in sleep deprivation confirms that the addiction has disrupted circadian rhythms, likely contributing to the physical exhaustion and dehydration noted at the initial emergency room presentation. Collectively, these data points characterize a pathological attachment style to digital media, necessitating aggressive multimodal therapeutic intervention.

**TABLE 2. INTERNET ADDICTION TEST (IAT) BREAKDOWN**

Detailed item analysis and domain categorization

88 SEVERE

| # | DOMAIN | ASSESSMENT ITEM | SCORE (0-5) |
|---|---|---|---|
| 1 | Salience | How often do you find that you stay on-line longer than you intended? | 5 |
| 2 | Salience | How often do you feel preoccupied with the Internet when off-line, or fantasize about being on-line? | 5 |
| 3 | Neglect of Duty | How often do your grades or school work suffer because of the amount of time you spend on-line? | 4 |
| 4 | Neglect of Duty | How often do you neglect household chores to spend more time on-line? | 5 |
| 5 | Social Isolation | How often do you prefer the excitement of the Internet to intimacy with your partner/friends? | 4 |
| 6 | Social Isolation | How often do you form new relationships with fellow on-line users? | 3 |
| 7 | Emotional Coping | How often do you block out disturbing thoughts about your life with soothing thoughts of the Internet? | 5 |
| 8 | Lack of Control | How often do you try to cut down the amount of time you spend on-line and fail? | 5 |
| 9 | Concealment | How often do you try to hide how long you've been on-line? | 4 |
| 10 | Conflict | How often do you snap, yell, or act annoyed if someone bothers you while you are on-line? | 5 |
| 11 | Sleep Deprivation | How often do you lose sleep due to late-night log-ins? | 5 |
| 12 | Withdrawal | How often do you feel depressed, moody, or nervous when you are off-line, which goes away once you are back on-line? | 5 |

Key: 1=Rarely 2=Occasionally 3=Freq. 4=Often 5=Always

⚠ CLINICAL INTERPRETATION: SEVERE DEPENDENCE

**Total Score: 88/100.** (Range 80-100 indicates Severe Internet Addiction). The patient exhibits maximum severity (Score 5) in **Emotional Coping** and **Withdrawal**, consistent with the presenting symptoms of elective mutism and aggression upon device removal.

The clinical management of this case was predicated on a multidimensional understanding of the patient's pathology, moving beyond simple addiction to address the underlying structural and neurobiological deficits. The primary diagnosis of internet gaming disorder (Axis I) was conceptualized not merely as a behavioral excess, but as a maladaptive compensatory mechanism. This behavior served to regulate the affective lability and profound fear of abandonment associated with his Borderline Personality traits (Axis II). Contextually, the diagnosis was framed within the Left-behind Child Syndrome (ICD-10 Z62.8), suggesting that the digital environment had effectively substituted parental attachment figures during critical developmental periods. The smartphone was not simply a leisure device but a transitional object providing the consistency and validation that his early environment lacked.

The treatment protocol employed a tripartite approach. Pharmacologically, the strategy targeted the neurobiological substrates of impulsivity. Fluoxetine (20 mg/day) was introduced to enhance serotonergic transmission, thereby strengthening prefrontal cortical control over impulsive urges and stabilizing mood (Figure 2). Concurrently, a short course of Clobazam (10 mg) was utilized to rapidly quell autonomic hyperarousal, breaking the cycle of insomnia that often exacerbates psychiatric crises. The psychodynamic component focused on validation rather than confrontation. Therapy acknowledged the patient's subjective reality: the confiscation of his device was experienced as the loss of his primary emotional support system. Crucially, the intervention pivoted to the familial system. Parents were counseled on the pathology of infantilization, recognizing that their method of discipline—confiscating property from a 23-year-old adult—constituted a severe boundary violation. This parental overreach was identified as a precipitating factor for the patient's regression into mutism, necessitating a shift toward negotiating adult autonomy rather than imposing juvenile restrictions.

**3. Discussion**

This case provides a poignant clinical vignette illustrating the complex, multidimensional interplay between early childhood attachment trauma and the manifestation of behavioral addictions in early adulthood. While the patient's clinical presentation—characterized by profound autonomic arousal and withdrawal symptoms upon the cessation of internet access—phenomenologically mimics substance withdrawal, the specific content and context of her addiction reveal a far more intricate psychodynamic function. The digital device did not merely serve as a source of entertainment; rather, it functioned as a psychological prosthesis, a digital shield erected against the ego-dystonic and intolerable reality of profound loneliness. The following sections dissect the bio-psycho-social mechanisms driving this pathology.

The core pathology in this case is not rooted in technology per se, but rather in a fundamental attachment deficit. The patient fits the classic profile of the left-behind child (LBC), a sociological phenomenon prevalent in rapidly developing economies where parents migrate for work, leaving children in the care of extended family.[11] Raised by grandparents who likely provided adequate physical sustenance (food, shelter) but lacked the capacity for emotional attunement or mirroring, the patient appears to have developed an Insecure-Avoidant or Disorganized attachment style.

According to Bowlby's Attachment Theory, early separation from primary caregivers creates a primal wound. A child requires a secure base from which to explore the world; in its absence, the child suffers from chronic emotional dysregulation. Donald Winnicott famously posited that in the absence of the mother, the child seeks a transitional object (a blanket or teddy bear) to soothe the anxiety of separation. In the contemporary clinical landscape, the smartphone has effectively supplanted traditional transitional objects. However, a crucial distinction exists: unlike a teddy bear, which is inert, the smartphone interacts back.[12]

Neurobiologically, this interaction creates a potent cycle of reinforcement. The device provides a variable

ratio schedule of reinforcement (VRSR) through likes, comments, and unpredictable notifications. This unpredictability is highly addictive, triggering dopaminergic release in the mesolimbic pathway, specifically projecting from the ventral tegmental area (VTA) to the nucleus accumbens (NAc).[13] We hypothesize that this patient's brain was starved of oxytocin—the neuropeptide of bonding—due to the rigid, non-affectionate rearing style of her grandparents and the absence of her parents. In this neurochemical vacuum, the high-frequency dopamine spikes provided by the internet served as a surrogate for genuine human connection. The screen became a digital pacifier, artificially regulating a stress response system (HPA axis) that had been hypersensitive since childhood.[14]

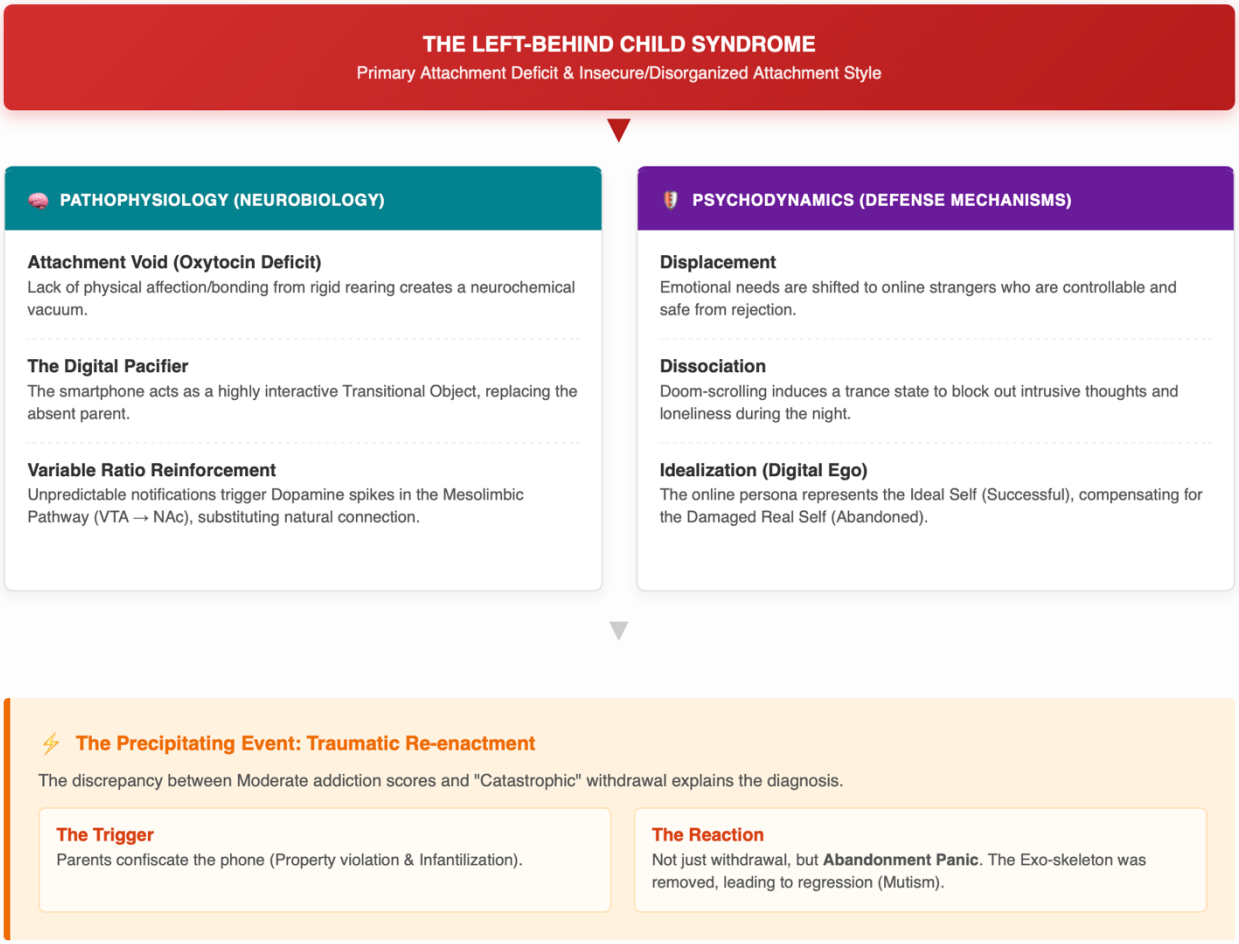


Figure 3. Psychopathological mechanism.

The patient's reliance on the digital sphere can be mapped onto specific ego defense mechanisms, as categorized by Vaillant. These mechanisms demonstrate how the addiction served a vital protective function, maintaining her fragile psychological homeostasis (Figure 3). The patient utilized displacement to manage her innate, frustrated need for parental connection. Unable to extract love or validation from her absent parents or stoic grandparents, she displaced this libidinal investment onto online strangers. The online community represents a safer object relation because it is controllable; the user can disconnect at will, avoiding the pain of rejection.[15] In this dynamic, digital likes and shares become a displaced, quantifiable substitute for parental love. The ping of a notification

serves as a temporary assurance that she exists in the minds of others, a confirmation she rarely felt in her physical home.

The clinical finding of total insomnia and doom-scrolling until the early hours of the morning suggests a reliance on dissociation. Nighttime is frequently the most psychically dangerous time for the lonely individual, as the distractions of the day fade and intrusive negative thoughts emerge. The endless scroll induces a flow state that borders on hypnotic trance, effectively blocking out the superego's critical voice and the intrusive thoughts regarding her perceived worthlessness. This is not merely entertainment; it is an anesthetic against the silence of the night. The creation of an online persona allowed for the manifestation of an ideal ego. Self-psychology (Kohut) suggests that when the real self is damaged by criticism and neglect—as this patient felt in her village context—the psyche attempts to compensate. Online, she was not the abandoned daughter or the failure; she was a success, curated and perfected. The smartphone became the vessel containing this Ideal Self. To remove the phone was to annihilate the only version of herself she liked, leaving her trapped in the damaged self she could not tolerate.[16]

A critical and highly instructive finding in this case is the discrepancy between the moderate internet addiction test (IAT) score (58) and the catastrophic, psychotic-like reaction to the phone confiscation. Typically, a moderate addict retains some capacity for inhibition and does not suffer a complete break from reality upon withdrawal.[17] This anomaly suggests that the IAT measures the frequency of the behavior, but fails to capture the attachment depth of the object relation.

We propose that the parents' confiscation of the phone acted as a Traumatic Re-enactment of the original childhood abandonment. When the parents physically took the device, they were not simply removing a piece of hardware; symbolically, they were severing her connection to the world for a second time, mirroring the traumatic moment they left her in the city with her grandparents years prior. The resulting physiological hyperarousal was not merely dopaminergic withdrawal; it was Abandonment Depression (Masterson) and panic, characteristic of borderline personality organization. The phone functioned as an exo-skeleton for her psyche. Without it, she felt psychically skinless and vulnerable. The subsequent elective mutism should be interpreted as a regression to a pre-verbal, infantile state. It was a cry for help without words, but also a potent weapon of passive-aggression. By refusing to speak, she punished the parents with the same silence they had imposed on her during their years of absence. It was a reclaiming of control: *You can take my phone, but you cannot make me speak.*

The dynamics of the left-behind family reunification often present a paradox of distance and intrusion. The fact that the parents felt entitled to unilaterally confiscate the personal property of a 23-year-old adult woman indicates a pathological family dynamic characterized by Enmeshment and Infantilization. This dynamic is frequently observed in reunification scenarios. Parents, burdened by the guilt of their years of absence, attempt to parents the adult child to compensate for lost time. However, this often manifests as authoritarian overcompensation. By treating the patient like a delinquent teenager rather than a young adult, they reinforced her dependence and lack of agency. This is a boundary violation that perpetuates the patient's regression. The identified patient (the daughter) becomes the symptom bearer for the dysfunction of the entire system. Therefore, the treatment protocol required a systemic shift: not only medication for the patient to lower arousal but extensive boundary training for the parents to transition from an authoritarian model to a negotiated, adult-to-adult relationship.[18]

Finally, this case underscores the dangers of treating Internet Addiction via simple abstinence or digital detoxification alone. Because the addiction serves a structural function—filling the void of the attachment deficit—removing the device without addressing the underlying pathology creates a high

risk of symptom substitution. If the internal void remains unfilled, the patient is at high risk of switching to other maladaptive soothing mechanisms to regulate her dysphoria. These could manifest as binge eating (oral fixation), non-suicidal self-injury (to feel something other than numbness), or substance abuse. The long-term prognosis, therefore, depends on the success of psychodynamic therapy in helping the patient internalize a secure base. The goal of therapy is to transform the patient's reliance on an external digital shield into an internal sense of self-worth, allowing her to tolerate solitude without dissolving into abandonment panic.[19]

This study is subject to the inherent limitations of a single case report design, which restricts the generalizability of the findings to broader populations. While the diagnosis utilized the validated Indonesian version of the IAT, the assessment relied heavily on self-report and retrospective family history, which are subject to recall bias and social desirability bias. Furthermore, this study was limited to clinical phenomenology; we did not have access to functional neuroimaging (fMRI) or biomarker analysis (plasma oxytocin or cortisol levels) to empirically visualize the craving pathways or stress responses described.[20] Future research into the left-behind adult population would benefit from longitudinal designs that track the conversion of attachment trauma into process addictions using both psychometric and neurobiological indices.

## 4. Conclusion

Ms. N's case illustrates that Internet Addiction in young adults—particularly those with histories of left-behind rearing and emotional neglect—is frequently a symptom of unresolved developmental trauma rather than an isolated behavioral disorder. The smartphone served as a maladaptive defense mechanism, a digital shield protecting a fragile ego from the intolerable affects of loneliness and insecure attachment. The study highlights that the severity of withdrawal may exceed psychometric predictions when the device serves as a primary attachment substitute. For clinicians, this implies that treatment must be multimodal. Successful remission requires biological stabilization, psychological reconstruction addressing the trauma of abandonment, and, critically, family systems intervention to resolve enmeshment. Ignoring the attachment deficit risks the patient merely substituting the digital shield for a more dangerous defense.

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