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RESEARCH ARTICLE

An Object-relations conceptual framework utilising Fairbairn and Masterson's Theories: A Malaysian case study on relational trauma

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ABSTRACT

This case study demonstrates the utility of the object-relations model in conceptualising and treating complex relational trauma, shifting the analytic perspective from an isolated individual psyche to a relational viewpoint. The paper first employs Fairbairn's structural theory of mind to understand the internal organisation of object-relations structures, specifically focusing on the splitting of the ego into traumatised and defensive aspects. It then integrates Masterson's self-triad theory as a practical clinical framework for working through these traumatic experiences. Masterson's model allows the clinician to accurately conceptualise the client's internal state, thereby determining the dynamic treatment strategy and enabling precise modulation between supportive and expressive interventions based on the client's position within the triad. A detailed case study of a 30-year-old Malaysian adult, who underwent five years of individual psychotherapy for severe relational trauma, is presented to illustrate the clinical efficacy and robust conceptual potential of employing this integrated object-relations model.

Keywords: Object-Relations; Case Study; Relational Trauma; Fairbairn; Masterson

1. Introduction

1.1. Relational trauma

Relational trauma is defined as the profound psychological injury resulting from repeated, cumulative adverse experiences within significant interpersonal contexts, most often originating during early developmental periods[1]. It is characterised not by the impact of a single catastrophic event, but by the chronic, patterned emotional abuse, neglect, abandonment, or significant failures in attachment provided by primary caregivers or key relational figures[1]. Because one's self-concept is theorised to emerge within the context of early interactions, the consistent pattern of deprivation and abuse fundamentally distorts the individual's internal belief system[2]. This process establishes maladaptive beliefs that determine the perception of the self, the expectation of treatment from others, and the ways the individual ultimately engages in all future relationships[2]. These complex impacts of relational trauma could be further elaborated

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through the lens of Object Relations Theory.

1.2. Object-relations theory

The object-relations approach is a psychoanalytic perspective centred on how individuals internalise their past interpersonal relationships. This process forms an intrapsychic template within the mind. Essentially, this template comprises an internal image of the self as it relates to others within relational contexts[2]. The key elements of this model are briefly outlined below.

1.3. The self and self-representation

The self refers to the person as they exist within a relationship. In contrast, the self-representation is viewed as an unconscious inner mental image of oneself, specifically as experienced in connection with important figures in one's life. Simply put, self-representation is an individual's subjective internal view of who they are[2,3]. For example, a person who was a victim (the self) in a distressing incident may develop an internal self-view (self-representation) characterised by feelings of weakness and vulnerability.

1.4. The object and object-representation

The object generally refers to the other participant in a relationship. While typically a person, it can also be a significant item, location, or symbol with which an individual establishes a relationship, such as a transitional object like a child's blanket[2,3]. Objects can be either external or internal. External objects are the real, tangible people (like an abuser) or things involved in a relationship. Internal objects, however, are the internalised representations or mental images of those external figures, also known as the object-representation[2,3]. For instance, a person might generate a parent's critical voice (an internal object) in their mind, which stems from their real interactions with the actual parent (the external object). The object-relations model places its primary emphasis on these internal objects, which are forged through engagement with external objects.

1.5. The object-relations unit

Object-relations theorists hold that the relationship between the self and the object is fundamentally bi-directional[4]. This is also known as the concept of intersubjectivity. This concept shifts the analytic focus from the perspective that intrapsychic is an isolated world to a relational perspective[4]. It suggests that the client's experience of the self and the object is never truly separate but is always formed and enacted within the bi-directional interplay between the two[4]. The theory mandates that all psychological phenomena, such as thoughts, feelings, and behaviours, must be viewed not as solely residing within the self, but as co-created and mutually influenced by the object, and vice versa. This means that a clinician cannot fully understand a client's anxiety without considering how that anxiety is shaped by the client's internalised objects and how it, in turn, influences the clinician.

For instance, an individual who develops a victim self-representation marked by helplessness and vulnerability. This is often because they also possess an internal abuser object-representation that fuels critical and punitive internal voices. This abusive object representation continuously engages and traumatises the victim's self-representation. Therefore, these two components are inseparable and actively sustain one another, and when a clinician focuses on the client's vulnerable 'self,' they must also simultaneously consider the abusive 'object'. This reciprocal view of both the self and the object is termed the object-relations unit[4].

1.6. The suitability of the object-relations model for relational trauma

The object-relations model is highly applicable for both exploring and treating interpersonal and relational trauma. The framework proposes that the ongoing effects of relational problems and traumatic experiences are sustained by internalised object-relations units that form in response to those events.

Therefore, the central goal of object-relations psychoanalysis is the therapeutic resolution of these dysfunctional units[2,3].

A key strength of this approach lies in its ability to address the bidirectional relationship between the self- and object-representations within the unit[4]. Unlike other approaches, object-relations therapy processes the two parts simultaneously, recognising that the internal self cannot be fully understood or healed without addressing its corresponding object. By processing this dynamic interplay together, the model offers a more holistic and complete picture of the individual's internal experience of trauma and relational issues.

Past studies consistently support the notion that the object-relations model is uniquely suited to conceptualise and treat interpersonal relational issues and the resulting impact of interpersonal trauma. For instance, the case studies provided by Lian and Bono[5] and Welch[6] both employed the object-relations framework with individuals presenting with complex interpersonal and relational issues, and both reported the achievement of significant clinical improvement. With this, the current study employs Fairbairn's and Masterson's theories as the two major theoretical underpinnings within the object-relations approach.

2. Fairbairn's object relations model and relational trauma

Fairbairn's object relations approach offers a unique perspective on the impact of traumatic experiences on human personality, proposing a structured model of the psyche[7]. **Figure 1** showcases the overview of Fairbairn's Object Relations Model.

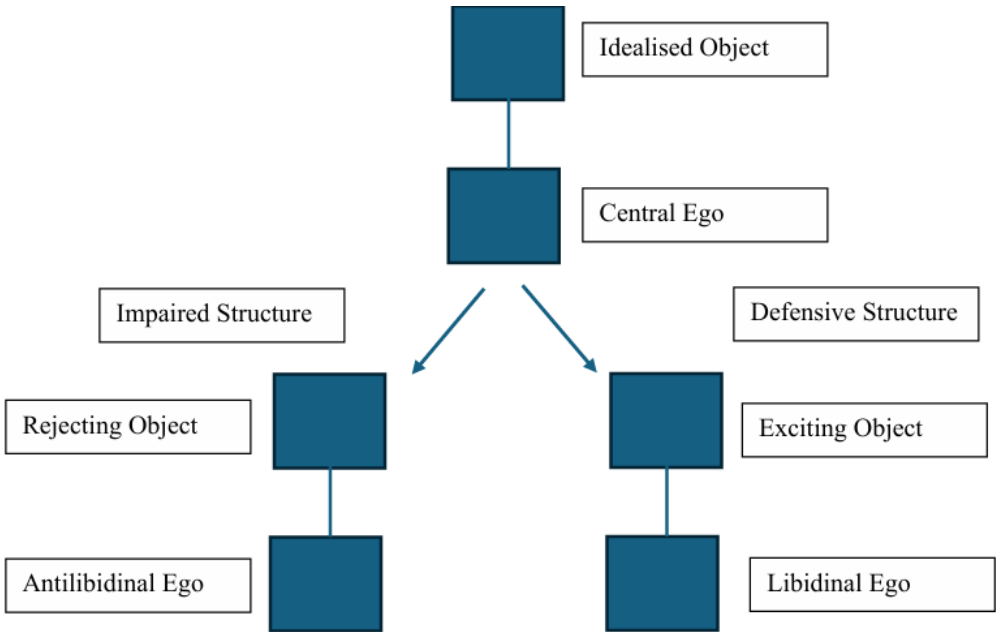

Figure 1. The Fairbairn's Object Relations Model

In a healthy, non-traumatic environment, individuals have a "good object" (or idealised object in Fairbairn's terms), which leads to a positive self-representation, including a strong self-image, personal identity, and self-esteem[7]. This healthy self-representation is what Fairbairn called the central ego[7]. Therefore, a healthy individual possesses a robust idealised object and a strong central ego.

Fairbairn hypothesised that traumatic experiences weaken the ego, impairing an individual's functioning and causing the ego to split into two distinct structures: the impaired structure and the defensive structure[7]. The impaired structure contains the painful feelings, memories, and cognitions associated with the trauma. In contrast, the defensive structure serves to block and prevent the re-experience of these painful memories[7].

Traumatised individuals often oscillate between these two structures, exhibiting behaviours such as avoiding painful reminders at times and re-experiencing the trauma at others[7].

Within the impaired structure, Fairbairn suggested the traumatic experience creates the object-representation of an "abuser object" (or rejecting/attacking object in Fairbairn's term) and a self-representation of a "victim self" (or anti-libidinal ego in Fairbairn's term)[7]. In this object-relations state, individuals re-experience their trauma as if the abuser object is traumatising the victim self, leading to intense emotional pain. Masterson[8] termed these painful emotions 'Abandonment Depression', which encompasses six feelings like (a) rage, (b) depression, (c) panic and fear, (d) helplessness and hopelessness, (e) guilt and shame, (f) emptiness and a sense of void. Processing trauma necessitates working through these profound emotions. Although the sequence may vary individually, a specific layering of these emotions is posited: the more externalised affects of anxiety, panic, and rage generally present initially, while deeper, internalised states such as guilt, emptiness, hopelessness and depression appear later in the process[9,10]. **Table 1** describes the different types of Abandonment Depression.

Table 1. Description of each component in Expressive Therapies Continuum[10].

Abandonment Depression	Description
Rage	Intense anger and fury stemming from the realisation that the Object was abusive or engulfing, which required the True Self to diminish or surrender to survive.
Depression	Profound sadness and grief resulting from the painful recognition that the Object was consistently unavailable or failed to lovingly support the emerging True Self.
Panic and Fear	Overwhelming anxiety and terror rooted in the threat that the Object will either destroy (engulfment) or utterly abandon the Self for attempting self-assertion (expressing one's own desires, being independent).
Guilt and Shame	Shame and internalised blame felt specifically over the act of Self-Assertion, as this is perceived as violating the Object's wishes or loyalty requirements.
Helplessness and Hopelessness	A debilitating sense of futility and surrender resulting from the repeated failure of self-assertion. This leads to the True Self being sacrificed in a persistent, passive submission to the Object's demands.
Emptiness and Void	A terrifying state of inner numbness and hollowness due to the absence of a positive and available Object that would support the True Self.

Due to the intense pain associated with these emotions, individuals employ defences to avoid them. Fairbairn posited that this leads to the creation of a defensive object and a defensive self[7]. The self delusively fantasises and idealises its object as perfect and strong, a defence mechanism designed to block the painful realisation that the object is, in fact, an abuser. Fairbairn referred to this as the exciting object and the libidinal ego[7]. To access and process their Abandonment Depression, individuals must first work through these defences. Later, Masterson[8] expanded on this concept by developing distinct defensive object-self triads, positing that clients may employ various patterns of defensive blocking within these defensive object-relations, not just idealising. For instance, individuals operating within the defensive triad might employ avoidance and denial towards traumatic reminders, which include actively distancing or clinging onto their external object to avoid Abandonment Depression[8].

With the central ego weakened and split by trauma, the clinician becomes a new good object or idealised object, providing a healthy, non-threatening relationship to the central ego[7]. This supportive relationship encourages the central ego to self-actualise, fostering the development of self-concepts and identity, and enabling the individual to live an authentic life. To embody this restorative role, the clinician acts as a good and healthy object, establishing a space of psychological containment where the patient's overwhelming affects can be safely held and processed. The concept of containment, derived from Wilfred

Bion's Object Relations Theory, outlines a crucial three-step process: (a) Receiving: The clinician takes in the client's projected intolerable feelings (often called Beta Elements, such as Abandonment Depression), holding them without reacting defensively or retaliating. (b) Metabolising: The clinician internally processes and detoxifies these raw emotions through their own Alpha Function—transforming the unbearable affect into manageable, thinkable elements. (c) Returning: The clinician delivers this processed understanding back to the client in an empathic and interpreted form, making the previously overwhelming emotional experience understandable and bearable[11].

These positive interventions aim to strengthen the client's central ego, providing the acceptance often absent from their traumatic experiences with abusers. As the central ego gains strength, the individual ideally reduces splitting, thereby resolving the "impaired" and "defensive" structures[5]. Masterson called this process self-activation[8,10]. A healthy, fully realised central ego is characterised by emotional vitality, manifested through spontaneity, creativity, joy and the capacity for love[9]. This is also known as the 'True Self[7]. This self emerges only upon the completion of mourning and grieving for the abandonment depression[9]. This self possesses a continuous sense of identity ("I") over time, supported by healthy self-entitlement and the ability to autonomously regulate emotions and soothe pain. Ultimately, this functions through self-activation—the ability to pursue unique wishes and commit to goals—while maintaining the capacity for intimacy without the "impaired" and "defensive" structures[10].

3. Masterson's self-triad theory and the healing process

Masterson's self-triad theory summarises this therapeutic process, as showcased in **Figure 2**.

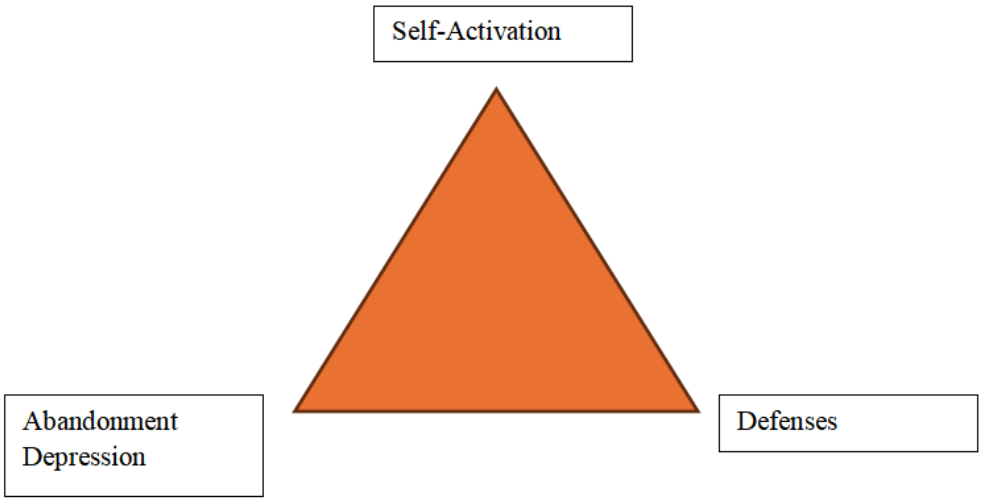

Figure 2. The Masterson's Self-Triad Theory

The theory suggests that processing trauma involves encouraging the individual to self-activate and build their central ego[8,10]. Each time a client self-activates, their unfulfilled needs are addressed by the supportive clinician, which in turn can reactivate memories of their traumatic experiences, thus triggering Abandonment Depression[8,10]. The individual must then process this Abandonment Depression in the presence of the clinician. If this process becomes too painful, the client may revert to their defences; avoiding, blocking, or delusionally justifying the traumatic experiences[8,10]. The clinician's role is to help the client work through these defences, encouraging them to build their true self (central ego) and process their Abandonment Depression[8,10]. This cyclical process continues throughout object-relations psychotherapy until the client has sufficiently built their central self and reduced splitting[5].

4. Summary

Fairbairn's structure of mind theory provides a crucial framework for understanding how trauma diminishes the central self and leads to the splitting of the ego into traumatised and defensive aspects. Masterson's self-triad theory, on the other hand, offers a practical framework for working through these traumatic experiences. Combining these two theories provides a holistic theoretical and conceptual framework for comprehending and treating the human psyche affected by trauma. **Figure 3** showcases the integration between these two theories.

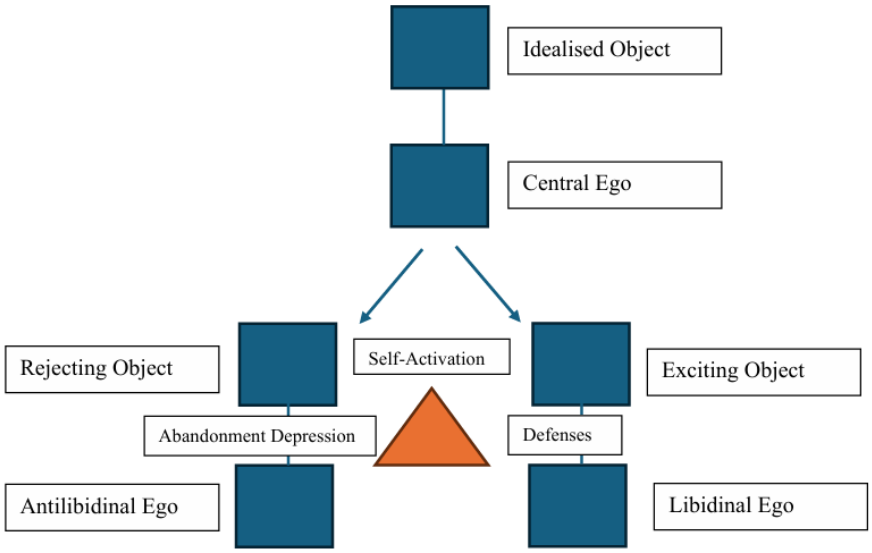

Figure 3. The Integration Between Fairbairn and Masterson's Theories

Nevertheless, the use of such a conceptual framework is not common in Asia, as Object Relations are not commonly practised here. Object Relations theory is uniquely well-suited for Asian and collectivist contexts because it fundamentally views the "self" not as an isolated entity, but as a construct formed entirely through relationships with others. Object Relations theory validates the Asian experience of the interdependent self, where one's identity is inextricably woven into the family and community[12]. The way relational trauma unfolds in a collectivistic culture is particularly complex; when the perpetrator is a family member, the intense emphasis on collectivism values and group identity often mandates the victim's silence and suppression (defences) towards the abuse to protect the collective self-image (central ego). The current study aims to illustrate the use of Fairbairn and Masterson's conceptual framework through a case study with relational trauma in Malaysia.

5. Case introduction

Shawn (pseudo-name), a 30-year-old Malaysian young adult, initiated five years of continuous individual psychotherapy to address severe social anxiety that significantly impaired his vocational and social functioning following the completion of his college education. The treating clinician is a recognised Psychoanalytic Psychotherapist under the American Psychoanalytic Association, who has been formally trained and supervised in Object-Relations Psychotherapy through the Object Relations Institute (ORI).

6. Presenting complaints

Shawn presented with the major complaint of intense social anxiety, which led to a complete cessation of employment and social engagement. This anxiety manifested as profound functional impairment: he distanced himself from everyone, remaining hidden in his room, avoiding conversation, and spending the majority of his days playing video games. He systematically avoided all work opportunities and any incident that necessitated socialising. He explained this extreme avoidance as simply being uninterested and unmotivated by these activities.

7. Etiological context: relational trauma

Shawn's psychopathology is significantly rooted in extensive relational trauma experienced throughout his developmental period.

Parental Abuse and Neglect

His father was an extremely abusive figure, inflicting both physical and severe emotional harm. His father continually subjected Shawn to physical beatings and relentless criticisms, targeting everything from his intelligence to his physical attributes (height and appearance). Furthermore, the family endured significant financial instability and fear due to the father's severe gambling addiction, which forced the family to flee from creditors.

Shawn's mother, while physically present, was emotionally neglectful. She remained obsessively focused on her marriage, displaying a pattern of repeatedly forgiving her father and becoming emotionally engulfed in her marriage. Consequently, Shawn experienced deep neglect from his mother, despite her being his closest family member.

Early Abandonment and Relational Deficit

Shawn's older brother was a source of closeness, yet his intense drive to become "independent" and escape the toxic family system led to his focused pursuit of work and eventual departure. This left Shawn feeling isolated and deeply alone. Compounding this neglect, Shawn was often placed in the care of relatives who were verbally abusive, critical, or otherwise cruel toward him. These repeated experiences established a pervasive internal belief of rejection, criticism, and abandonment, directly informing his current severe anxiety toward social interaction.

8. Conceptual framework

The clinician conceptualised Shawn's case based on Fairbairn and Masterson's Theories, as showcased in **Figure 4**.

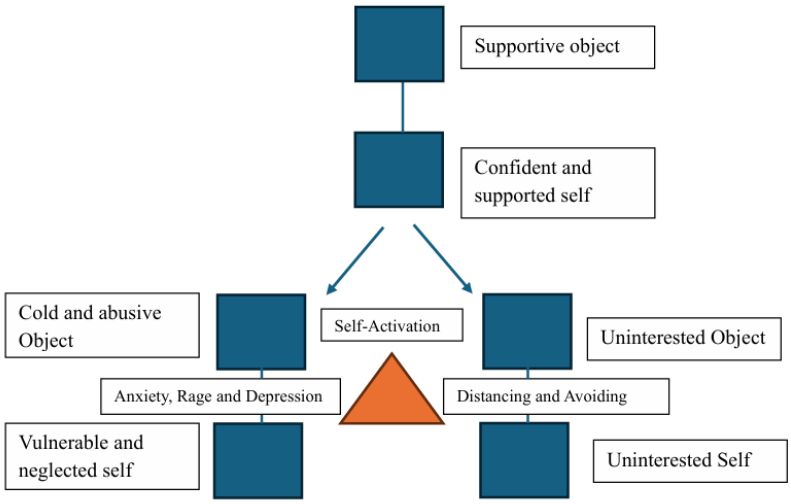

Figure 4. The conceptual framework based on Fairbairn and Masterson's theories.

According to Object Relations Theories, if Shawn had internalised a good, stable object, his central ego would have been sufficiently supported, allowing for self-activation. This strong ego structure would have granted him the necessary confidence and resilience to endure anxiety, thus enabling engagement in social and vocational activities. However, the lack of such a stable object led to the pathological splitting of his central ego into two defensive structures: the impaired structure and the defensive structure.

The impaired structure contains the negative object-representation, established by his cold, abusive, and threatening parents. This punishing object-representation is paired with a corresponding vulnerable and neglected self-representation. This object-relations triad generates the Abandonment Depression, which manifests as (a) intense anxiety and panic regarding relational injury, expressed clinically as his fear of socialising; (b) profound rage and anger at being abused; and (c) pervasive depressive and empty feelings associated with being the unloved, vulnerable child.

To prevent the terrifying onset of this Abandonment Depression, Shawn retreats into his defensive structure. Here, he engages in avoidance and emotional distancing to defensively disconnect from the world. In this object-relations triad, Shawn pathologically projects onto others, perceiving everyone as an uninterested and distant object with whom he has no desire for connection. Consequently, he assumes the complementary self-representation of the uninterested child who prefers isolation, thereby maintaining control and preempting the anticipated pain of real or imagined relational abuse.

9. The course of treatment

The initial phase of therapy was characterised by Shawn's significant resistance, specifically manifesting through his defences of distance and avoidance. Shawn's engagement was highly passive; he presented as cold, affectively flat, and resistant to attempts at therapeutic connection and intervention. Consequently, early progress was slow, with minimal sharing or active participation.

Guided by psychoanalytic theory, the treatment strategy was conceptualised on the supportive-to-expressive continuum of therapeutic intervention, moving gradually from low to high intensity. The supportive-to-expressive continuum is a psychodynamic and psychoanalytic treatment model that describes

the range of technical interventions a clinician may employ, varying the depth and intensity of the therapy based on the client's needs and current capacity[13]. At the beginning, the clinician will initiate at the supportive end of the continuum; this involves gently promoting adaptation, offering validation and empathy, reducing anxiety, and building a strong therapeutic alliance—the primary goal here is stabilisation and symptom relief without overwhelming the ego[13]. Conversely, as the therapeutic alliance strengthens and the client's resilience grows, the clinician can move toward the expressive end of the continuum; this involves confronting or analysing defences, interpreting transference patterns, linking present behaviour to past relational experiences, and fostering insight into unconscious conflicts; constructively encourage for deeper insight and structural change[13].

The clinician began the treatment within the supportive continuum, focusing on establishing a foundation of trust and safety to mitigate Shawn's defensive distance. This involved gentle support and consistent empathy, alongside deliberate, low-intensity connection-building techniques, such as inquiring about Shawn's favourite items, hobbies, games, and music. Once Shawn demonstrated a shift toward relaxation, the clinician cautiously began moving along the continuum toward a more expressive stance. The clinician initiated the process by inviting Shawn to present material for discussion, such as feelings, thoughts, dreams, fantasies, and free associations. In this process, the clinician explored any materials brought into the therapy with a curious mind, while carefully emphasising and validating the Abandonment Depression/emotions, and the object-relations dynamic arises. For instance, the clinician began to gently point out manifestations of his anxiety (the first layer of Abandonment Depression), both within the session (e.g., his unwillingness to engage relationally) and outside the session (e.g., his avoidance of work and social interaction); the impaired object-relations dynamic of a vulnerable child (self) who is anxious of the cruel and abusive world (object). This technique allows Shawn to gain insight into the first layer of his Abandonment Depression (manifesting as anxiety) and his self-representation (object-relations dynamic). This process facilitates the fuller emergence of Shawn's anxiety within the therapeutic space, thereby enabling its deeper processing and resolution.

As Shawn's anxiety became more accessible within the therapeutic space, the clinician advanced the treatment toward the expressive end of the continuum. This shift involved empathically interpreting Shawn's core defences—specifically his patterns of distancing—and illuminating the link between his rising anxiety and his social avoidance. The clinician also carefully identified the defensive object-relations dynamic: Shawn maintained a distant self and perceived others as uninterested, distant objects with whom he had no desire for connection. Subsequently, the clinician utilised confrontation to demonstrate how this defensive structure sabotaged Shawn's self-activation: whenever he attempted adaptive behaviours like working or socialising, the resulting anxiety triggered an immediate retreat into his established defences. He immediately perceived work and social figures as uninteresting.

During this treatment phase, Shawn reported a significant dream: he was visiting an underground cinema that played intensely violent movies, yet they lacked both colour and sound, and the other patrons were universally distant and cold. The interpretation yielded the realisation that his defence mechanism was repressing or neutralising all intense affect, rendering his own emotions "colourless and tasteless" as a form of protection from the raw, "violent" nature of his internal conflicts. As this defensive structure began to yield, Shawn entered deeper layers of Abandonment Depression, marking a crucial therapeutic breakthrough with the emergence of his rage. To facilitate the working through of the Abandonment Depression, the clinician advanced the treatment more toward the expressive end of the continuum. This phase involved utilising genetic interpretations to address Shawn's object relations, early childhood trauma, and unmet attachment needs—all of which had been concealed by his defences.

As Shawn opened up deeper layers of Abandonment Depression, his repressed rage and anger began to surface powerfully. For instance, the anger surfaced vividly in his dream where a gigantic monster rampaged through a city, causing widespread destruction and fire, with terrified people fleeing. The interpretation quickly established the monster as a representation of Shawn himself, projecting the belief that his expressed anger would be so "intense that it would burn everyone he loves and cares about." Interestingly, the clinician noticed the bi-directional object-relations unit manifested in Shawn's dream, where the monster was also the representation of the abusive object in his life.

This rage was soon transferred to the therapeutic relationship. He began to express anger toward the clinician, criticising the therapy as ineffective and insufficient to handle his symptoms or supportive enough to manage his emotional needs. The worsening symptoms during this phase were understood as a typical intensification that accompanies the processing of traumatic feelings within Abandonment Depression. During this stage, a crucial intervention was the application of containment[11]. The clinician received Shawn's projected, intolerable feelings without reacting defensively or retaliating, thus allowing Shawn to safely process his intense rage. The clinician then interpreted this transference enactment as the playing out of a split object-relations unit: the clinician was cast into the role of the cold/abusive object, and Shawn experienced himself as the vulnerable, neglected self. The clinician continued to link this object-relations dynamic to Shawn's early childhood trauma and unmet attachment needs, highlighting that his parents had been cold, abusive, and dominant, preventing him from ever feeling safe. This work allowed Shawn to express profound frustration, repeatedly asking, "How can they do this to me?"

As the clinician continued to contain and interpret, Shawn began to open up further and recalled more incidents of abuse from his parents and relatives. He eventually achieved the core realisation that his intense social anxiety was a learned object-relations pattern: he had internalised that all figures in his life were cold, dominant and abusive objects, and he was the submissive, victimised self. This insight led to a crucial moment of catharsis, as he articulated, "No wonder I am so anxious and scared!"

Following the cathartic realisation of the abusive relational patterns, Shawn regressed into experiencing deeper, more painful affects, including intense depression, hopelessness, and pervasive emptiness. He became significantly more emotional in sessions, confronting the reality of his parents' lovelessness and his core belief that he was fundamentally unwanted. Experiencing this acute pain led to a further loss of motivation, necessitating a shift back toward the supportive continuum. The clinician amplified the use of empathy and support, continuing the function of containment by receiving, metabolising, and interpreting his intolerable feelings to make them bearable. As emotional processing continued, Shawn reported a significant dream: he was in an oppressively small, tight tunnel that evoked feelings of heaviness and depression. He climbed through this confined space until the tunnel gradually widened, allowing him to stand and move freely, eventually leading him out into a beautiful garden. This dream was interpreted as a direct metaphor for his processing of the Abandonment Depression: his continued emotional work allowed him to regain the capacity to "stand" (achieve psychological autonomy) and move (regain functional energy), finally emerging from the constricted emotional state.

By the fourth year of therapy, Shawn demonstrated substantial clinical progress marked by self-activation. He initiated a new business venture with his brother, dedicating significant time and effort to research and entrepreneurial education. The clinician continued to nurture the newly emerged central ego, emphasising Shawn's ability to grow and function beyond his defences. While Shawn still experienced intermittent relapses of anxiety, rage, and depression—which are typical in the processing of chronic

trauma—the continued therapeutic support enabled him to function well, process these resurfacing emotions adaptively, and sustain his relational and vocational gains.

10. Summary

The course of treatment with Shawn was effectively guided by the integrated theoretical framework of Fairbairn's and Masterson's object-relations theories. The initial phase focused on overcoming the client's defences of distance and surrender by employing the supportive continuum, a necessary step to establish the therapeutic trust required to safely confront the deep-seated relational trauma. As trust was established, the shift to the expressive continuum allowed the emergence of Masterson's Abandonment Depression, marked first by panic and anxiety, then by rage, and finally by depression, hopelessness and emptiness. This crisis phase was successfully navigated through the consistent use of Bion's containment[11], which managed the intense transference of the client's relational trauma. With this, the clinician was able to successfully work through the abandonment depression, thus led to significant clinical gains, where Shawn showed an achievement of self-activation.

Crucially, Fairbairn's structure of mind theory provides a way to understand Shawn's object-relations unit, and shows the clinician how his relational trauma diminishes the central self and leads to the splitting of the ego into traumatised and defensive aspects. Masterson's self-triad theory, on the other hand, offers a practical framework for working through these traumatic experiences, allowing the clinician to determine the dynamic treatment strategy, enabling the clinician to modulate between supportive and expressive interventions based precisely on Shawn's immediate emotional status. This case study successfully demonstrated the clinical efficacy and conceptual potential of employing the object-relations model when treating cases of relational trauma.

Conflict of interest

The authors declare no conflict of interest.

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