Journal of Contemporary Psychotherapy (2021) 51:341–348
https://doi.org/10.1007/s10879-021-09508-5

ORIGINAL PAPER

Progress in Resolving Splitting Tendencies: A Qualitative Case Report of Facing Conflicting Fears with Relationality, Humility, and Patience

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Accepted: 15 May 2021 / Published online: 21 May 2021

Abstract
Splitting as a psychological defence by patients who struggle to process dichotomies remains an important focus in current therapy trials. Such case research done in a cross-cultural context of therapist and patient is limited. The present qualitative case report involves a 44-year-old male who had two conflicting fears, inherently making those fears inaccessible since resolving one fear exacerbated the other opposing fear. We provide a narrative discussion of the case learning from the therapist-in-training and her supervisor. Building a solid relational focus grounded in a social constructionist approach played a vital role in the therapeutic and supervisory process. In this process, attention to therapy as a performed conversation, humility, patience, dialogue, persuasion and self-awareness were crucial concepts. This case report marks how a developmental space for both patient and therapist was co-created and how resolving of splitting tendencies could commence.

Keywords Humility · Patience · Postmodern therapy · Radical relationality · Splitting

Introduction

Historically, the concept of splitting has its roots in psychoanalytic theory and practice, contributed explicitly by Melanie Klein in the context of object relations theory (Cf Klein, 2015). This remains a concept in progress even though researchers have done comprehensive studies on it as a defence mechanism (Weiss, 2015). Splitting is a psychological defence mechanism that entails focusing selectively on positive or negative aspects of beliefs, actions, objects, or persons to separate good from the wrong aspects that conflict with one's relational boundaries (Richardson & Boag, 2016). This defence becomes complex to resolve when it entails conflicting wishes and fears that compels acting out for or against and dissociating from persons or objects (Weiss, 2015). Although splitting could be valuable in psychic differentiation and decision making, relational conflict and reactions such as isolation, hatred, relationship violence, and disruption may be extreme (Mieda & Oshio, 2020). Studies have associated such pathological splitting with a person's focus on simplification and short-term benefit (Suor et al., 2017), growing up in a harsh environment (Suor et al., 2017), aggression and antagonistic behaviour (Doom et al., 2016), antagonistic characteristics (Mieda & Oshio, 2020), and not only cluster B personality disorders, but also wide ranging personality disorders (Mieda & Oshio, 2020).

Researchers have added strong relational and sociocultural frames to the object relations view that describe splitting as a process of *othering* another person's attributes (Brons, 2015; Staszak, 2009). The person who frames another person's otherness uses inaccurate cognitive biases from sociocultural stereotypes rather than others' actual attributes (Staszak, 2009). In relational terms, splitting is a process of valuing the self and devaluing the other and places the self and the other in separate categories that include an overt or underlying unwillingness to bridge these separate categories (Brons, 2015). Categorising others (and sometimes even the self) entails both an internalising and externalising process that is contextually and relationally bound (Brons, 2015; Staszak, 2009). Indeed, a social constructionist and postmodern approach to therapy lends credence to viewing pathological splitting as rigidly embodied sociocultural perspectives on how people should behave and relate to others in society (Gergen, 1994; Staszak, 2009).

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Indeed, this shows strong links to the isolation and disconnection that splitting could bring about in an individual's life.

Discourses and narratives cannot exist in isolation. Splitting, or rather suffering (Cf Gibson, 2015), as created, performed and lived between and among people relationally and maintained by a patient may be resolved among patients and therapists. Newman and Holzman (2003) explain that the zone of emotional development is performatory in nature in that patients develop as they perform beyond themselves with the therapist's help. This zone of emotional development comes about through the therapist-patient activity of building an environment conducive to development. The therapist and the patient co-create a new context and relational performance. This performance activity is both the source and the product of the patient's growth, which Newman and Holzman (2003) refer to as tool-and-result methodology. The focus on performance or the mutual activity of therapy, as described by Newman and Holzman (2003), served as a solid guiding principle and method in the present study's therapeutic approach.

Moreover, concerning the concept of a performed conversation, Newman and Holzman (2012) took from Wittgenstein that patients would benefit from therapy similar to philosophers who need to get themselves disentangled from their perspectives through a process of reflection and deconstruction (Newman & Holzman, 2012; Wittgenstein, 1953). Indeed, Newman and Holzman have pioneered social therapeutics in contemporary approaches, not only to psychotherapy but also to emotional development in general. Wittgenstein (1953) emphasised that humans evolved to use language to categorise and manipulate their environments relationally as inter-subjective construction of reality occurs. In contemporary literature, Tonner (2017) also draws ideas stemming from Wittgenstein. In particular, the activity of using language and co-creating perspectives culminates into a multiplicity of forms of life (Tonner, 2017). Multiple perspectives come to exist in using language, and this activity does not take place in isolation. In turn, such activity indicates that forms of life are open to continuous co-construction instead of being a fixed internal entity.

Multiple perspectives and continuous co-construction of life forms are practical-critical concepts within the therapist and patient's cross-cultural context, which further concern their socio-historically situated forms of life (Tonner, 2017). Tonner (2017) explains that human beings are free to travel within their forms of life and among others' forms of life and thereby construct and co-construct forms of life. In the present case study, the therapist found this concept helpful in navigating and developing a therapeutic relationship in the cross-cultural therapeutic context. She also found valuable the idea proposed by Tonner (2017) that '(d)ialogue, persuasion and self-awareness' (p.17) are essential to Wittgenstein's notion of disentangling and reconstructing language games that underline the forms of life of both therapist and patient as real human beings in relationship with one another.

The focus is on the patient's relational engagement with the therapist as a development unit, rather than focusing on the patient alone (Anderson & Gehart, 2012). Postmodern therapies mainly include the therapist in the patient's world (Cf. Fleuridas & Krafcik, 2019). In light of this, Newman and Holzman (2012) view therapy as a performance of using language to co-construct development. Moreover, Slife and Wiggins (2009) describe that radical relationality, as a philosophical movement, is a form of therapy and a way of life. In this sense, it is integrative as opposed to exclusive. Thus, a radical relational approach does not exclude other therapeutic techniques and practices, although these practices may change within such integration (Slife & Wiggins, 2009; Wachtel, 2008). Indeed, as Green (2018) argued, psychoanalytic practices' criticisms exist regarding their individual and pathological focus. Green (2018) argues that modern applications and psychoanalytic psychotherapy practices lack in-depth relational elements described in psychoanalytic theory. Green (2018) further argues for relational innovations to understand and uncover the meaning of splitting entirely. Moreover, Fleuridas and Krafcik (2019) argue from a postmodern perspective for creativity and innovation in psychotherapy to address diverse individual, community and global needs. The present article explores practical examples of incorporation of relationality, innovation and creativity in the psychotherapeutic process.

Patience and humility may help therapists to practice strong relationality and creativity in therapy. Firstly, the complex nature of splitting may require patience from the therapist. In this process, practising patience can help the therapist, and the patient becomes attentive and tolerant of the developing process in therapy and its challenges (Egan, 2014; Worthen, 2018). Hanks and Stratton (2007) explain that a sense of urgency from the therapist can become counterproductive, especially when a patient faces relational difficulties. Patience implies slowing down the therapeutic process and considering various possibilities regarding change relevant to the individual's life. Patience provides a way to reduce stress while also mobilising the patient's strengths (Hanks & Stratton, 2007; Worthen, 2018).

Secondly, humility may aid in communicating patience in therapy. Humility fosters an attitude of acceptance that the patient's proposal of solutions may be most valuable in therapeutic change (Rowden et al., 2014). Humility is other-oriented and has a solid relational component, thus encouraging relational change (Drinane & Worthington, 2017). Moreover, humility constitutes a relationship with the self and relationships with others, and thus it may impact personal and interpersonal change in therapy (Harris &

Didericks, 2014). Harris and Didericks (2014) also explain that humility in a therapeutic context may foster honesty and openness towards a realistic view of the self and propose that therapists study how humility in a therapeutic setting can affect therapeutic change in this regard.

Furthermore, clients in cross-cultural contexts have expressed positive feelings towards therapists who show humility and openness to the client's cultural identity and values (Drinane & Worthington, 2017; Morales, 2019). The therapist's humility, along with patience, is essential to developing a sound therapeutic relationship. Patience and humility do not only play an essential role in establishing a therapeutic alliance, but it also aids in a relational change in psychotherapy (Rowden et al., 2014). Moreover, the therapist's subjective characteristics, including humility and patience, could arguably affect the therapeutic relationship and therapy outcome. Indeed, Lingiardi et al. (2018) conducted a systematic review related to the influence of the therapist's subjective characteristics on psychodynamic psychotherapies' outcomes and identified this as a lacuna in the literature. They concluded that a complex interplay exists between therapist's and patient's subjective characteristics and therapeutic outcome and acknowledged the importance of further future research regarding the interplay between patient and therapist's subjective characteristics in the context of psychotherapy. Our present case report offers an example of this complex interplay. In light of this, our case report further serves to add to a lacuna in literature.

The Therapeutic Approach

The therapist used the framework of radical relationality as proposed by Slife and Wiggins (2009) and Wachtel (2008), including concepts of dialogue, persuasion, and self-awareness (Tonner, 2017), patience (Egan, 2014; Worthen, 2018), and humility (Morales, 2019; Rowden et al., 2014). Other established psychotherapeutic techniques such as psychodynamic reflection, guided relaxation exercises, and couples therapy sessions also played a role within this reference frame. The therapist's therapeutic focus was on the co-created relationality of therapist and patient in order to address the patient's suffering (Cf Gibson, 2015). This relationality represented a context in which both the therapist and the patient could develop as interconnected beings in a shared world, which was not limited to the therapeutic time and space. Radical relationality marked a shift from the patient's development towards the inclusion of the focus on therapy's mutual activity to reflect on *what are we doing* and *how are we doing it* (as described by Holzman & Mendez, 2003). Our framework in the present study does not aim to explain *the way* of psychotherapy, but rather *a way* of psychotherapy, in line with postmodern philosophy regarding the multiplicity of realities and that there is no one or final truth (Gergen, 1994). This framework highlights the psychotherapeutic methods and process and particularly the unique creative interplay between patient and therapist.

Case Example

The case presentation concerns a 44-year-old man with a tendency to resort to splitting as a defence mechanism. As related to his presenting problem, splitting as a defence mechanism had a notable negative impact on his mental health and wellbeing. In particular, the patient had split two conflicting fears, inherently making those fears inaccessible since resolving one fear exacerbated the other opposing fear. The patient attended psychotherapy at the outpatient Clinical Psychology Unit of a Government Hospital in South Africa.

His occupational history included military training. He reported that in his past, he engaged in frequent aggressive behaviours towards others concerning moral disputes. According to him, reportedly, at the time of coming to therapy, these aggressive behaviours ceased, primarily due to becoming older and less physically agile. He reported a history of his father abusing alcohol and physically abusing his mother. His idealisation tendency was evident from how his focus on his mother's constant care giving overshadowed the concern of his father's abuse.

He shared that he experienced intense and unstable romantic relationships starting from adolescence and continuing into adulthood. He divorced in his past and had a child born out of wedlock after marrying his second wife, which caused devastations in his life. He described self-harming tendencies in response to interpersonal conflict with romantic partners. More recently, self-destructive behaviours had become apparent and included impulsive gambling, neglect over healthy eating, and over-use of alcohol and tobacco. He recounted that these behaviours were not present before his presenting problem, which he described as his present wife's confession that she had an affair with another man three years ago. After this confession, he broke a mirror and stabbed himself in the neck multiple times in the presence of his wife. This incident led to his admission to a Government Hospital. He admitted that he had thoughts of harming her but instead turned violent thoughts against himself.

Scars were visible on his neck upon his presentation to therapy. After this incident, he reported obsessive and intrusive thoughts surrounding his partner's infidelity. He presented a fragmented view of his partner, which he described as the ideal wife who rescued him from his past 'bad' ways, and as the 'worst wife' due to the affair. This fragmented view and rigid either-or thinking were also evident in his history, starting with his view of his mother, continuing in how he viewed his romantic partners throughout his life and in his actions of reprimanding wrongdoers in the community.

Despite splitting tendencies, the patient was committed to therapy throughout the entire process, as he did not miss any sessions and was on time for every session.

The first author was a student clinical psychologist and the patient's therapist at the time of the study; she discussed the psychotherapy case in supervision with a qualified clinical psychologist, the co-author. The co-author of this case study is trained in social therapy, including radical relationality, and was thus in a suitable position to coach the first author to incorporate an intensely relational approach into her therapy practice. In this case study, we considered the cross-cultural and socio-political context of both patient (a black man with isiZulu as his vernacular) and the therapist (a white woman with Afrikaans as her vernacular) essential elements in the relational development of therapy. Thus, the therapist and patient built their therapeutic relationship cross-culturally in a second language, namely English. In addition to this, the socio-political complexities also emerged and formed a critical developmental aspect of the therapeutic process.

The student psychotherapist and her supervisor noticed an important change involving the patient's use of this defence mechanism. Our research question concerned how a change in splitting tendencies, rigid either-or thinking, came about. We aimed to explore how the patient came to the point of willingness and motivation to explore the mentioned conflicting fears. There have not been many in-depth case study explorations regarding dissolving splitting tendencies in psychotherapy. Such research done in a cross-cultural context of therapist and patient, as in the present case study, is also limited. Therapy consisted of ten sessions, which progressed through different phases. We discuss these phases next.

Findings and Discussion

In doing therapy as a performed conversation, we identified progressive phases within which the patient started dissolving his splitting tendencies and his wellbeing improved noticeably.

Initial Phase: Performer-Audience Activity

Upon entering the therapy, the patient obsessively talked about his wife's infidelity. At times, he immersed himself so in his problem he seemed dissociated from reality, staring blankly into space. Moreover, he mostly ignored the therapist's presence while speaking in monologue for several beginning sessions. The therapeutic context did not seem developmental in these sessions, and the therapist discussed this concern in supervision. During supervision, the supervisor and therapist discussed the importance of humility and being open to what the patient offers. The supervisor also encouraged the therapist to slow the conversation down, which the therapist made sense of concerning patience. She realised that both therapist and patient had to engage in therapy's relational activity for the therapy to work, as the therapy is a performed conversation, as described by Newman and Holzman (2012). In these beginning sessions, the therapy activity appeared as a performer-audience activity, one in which the therapist mainly was an audience for the patient.

In terms of humility, reflections during this stage were non-threatening and content-based. Indeed, the therapist responded with and encouraged further elaborations from the patient by responding with content reflections on his pain instead of process reflections that might have challenged the patient. In this, trust in that the patient knows what he needs and that these elaborations were a part of his healing process took prevalence. This process highlighted the importance of humility in this case study, similar to the ideas of Harris and Didericks (2014), Morales (2019), Rowden et al. (2014) and Drinane and Worthington (2017).

In terms of patience, as reflected on in supervision, the therapist became aware and steered clear of her sense of urgency influencing the therapeutic space. The therapist also related patience to the importance of self-awareness that Tonner (2017) described. In this way, the therapist acknowledged and let go of her instrumental approach to the patient's progress by allowing the patient and herself to co-create onto what the patient offered instead. The activity centred on creating space for the patient to verbalise and create in the therapeutic space. As mentioned in the introduction, Egan (2014), Hanks and Stratton (2007) and (Worthen, 2018) also emphasise the importance of patience in therapy. The sessions marked by this activity took one and a half to two and a half hours, which were longer than the average psychotherapeutic session of forty-five minutes to one hour.

In terms of relational activity, concerns discussed in supervision included the possibility that the patient would fall into a pattern of idealising and devaluing the therapist. In addition to patience and humility, the therapist encouraged open and honest relational reflections with the patient. The therapist reflected, for example, 'sometimes we will disagree, and even sometimes I might say things that make you angry, and it is of importance that we discuss that and be open about how we are feeling throughout this therapy'. This strongly correlated with concepts concerning dialogue and persuasion discussed by Tonner (2017). These relational reflections aided in setting the context for relational development for both the patient and the therapist. Sequentially, the therapist noticed a transition in therapy performance when the patient acknowledged the therapist's presence.

Performer-Audience Activity Transitions to Interactive Performance

The psychotherapeutic process's first shift occurred when the patient directly acknowledged the therapist ('because everyone has flaws, *even you*'), which was not present in excessive elaborations before. The therapist responded with a congruent answer, admitting her humanity as the patient admitted his. The therapist replied 'yea' with an attitude of normalisation and acceptance of her humanity. This therapy moment showed the patient performing beyond himself with the therapist's help, referred to as a zone of emotional development by Newman and Holzman (2003). This socially therapeutic process also marked the therapist's activity showing herself to be a real person in the therapy with the patient, which features a relational approach. Even though the patient still elaborated excessively, he became more responsive to the therapist's reflections instead of detached from the therapeutic dialogue. This development transitioned the therapeutic process to the next phase.

Second Phase: Interactive Performance

The performance-audience activity, wherein the patient was the sole performer disconnected from the audience, changed to an interactive performance, in which the patient added and built onto the therapist's words ('answers to why'), including her into his talk. A dialogue was beginning to emerge between the therapist and the patient. Indeed, Tonner (2017) also acknowledges the importance of dialogue, as Newman and Holzman (2012) similarly acknowledge the importance of co-creating therapy. In this, the patient was still alone on the stage. However, inputs from the audience (the therapist) were accepted and incorporated into the therapy activity. During supervision, the therapist and supervisor recognised how the patient had built onto the therapist's words. They reflected that this being a critical relational shift, going forward, it would be important that the therapist not only reflects on how the patient feels and thinks but also enquires from him if he wants to know what the therapist had to say about what he expressed.

This relational shift marked the therapist's shift in line with a radical relational approach described by Slife and Wiggins (2009) and Wachtel (2008). The therapist's shift to a radical relational activity allowed her to see and acknowledge the patient for an essential shift that he took—Therapist: 'I have noticed a change taking place – initially you were consumed with your problems, and there was limited space for me to talk with you. Now there is more space for me, and I feel that this is good for the work we are doing here.' The patient responded positively to this acknowledgement—Patient: 'Yes, it is true…it is true…but now it is good that we talk together because I also want to learn from you.' Although the sessions marked by these relational performances were still long in duration, on a process level, the patient appreciated the therapist's inputs and, in turn, also started speaking more about his feelings in the here-and-now and expressed his point of view, as opposed to just recounting past events.

Interactive Performance in the Transition to Co-performer Activity

The transition from this phase was marked by reflections on the patient's conflicting fears: 'It sounds like you have many conflicting doubts about the future that are keeping you stuck; fearing leaving Z [his partner] but also fearing getting closer to Z'; and the patient responded in agreement: 'I am at a crossroad, yes.' These two fears related to his splitting tendency, in which he altered between idealising his partner and devaluing her. Initially, it was difficult for him to admit to having problems in the here-and-now, as he preferred to obsess over past events. Verbalising acceptance of his current difficulty played a key role in further development.

In this way, the therapist reflected on two conflicting fears while steering clear of pathologising the patient's splitting tendencies as merely an internal process. Similar to the non-pathologising process described by Gibson (2017), the therapist instead placed this tendency within the patient's real-life relational context. Such radical acceptance of his conflict might have made it easier for both therapist and patient to become accepting of these feelings while avoiding portraying them as part of a disorder, a disease, or something bad. In turn, this relational process allowed space for more critical reflections from both parties in the therapeutic process, moving therapy to the third phase.

Third Phase: Co-performers

Moving forward, the therapist could become more demanding and confrontational concerning content and feelings as presented by the patient. She was explicitly more demanding related to confronting contradictions presented by the patient in therapy. Critical and confrontational reflections may have seemed to be opposed to the non-judgemental stance of the therapist. Instead, the therapist made her discernments overt as she reflected honestly on the therapeutic process and concurrently encouraged the patient to relate in a radically relational manner to what both he and the therapist were talking about in therapy. This openness to honesty marked a further development of a strong relational approach in the therapy described by Slife and Wiggins (2009) and Wachtel (2008).

Self-awareness on the part of the therapist was a key aspect in the therapist taking the risk of becoming more confrontational. Tonner (2017) also emphasised the importance

of self-awareness within a radical relational approach. As discussed in supervision, self-awareness on the therapist's part guarded against the process of being confrontational and critical arising from only the therapist's frame of reference and personal wishes for therapy. Instead, confrontations and critical reflections flowed from the therapeutic process and the radical involvement of both therapist and patient as congruent or authentic persons in the therapy. In supervision, continuous reflection on the therapist's process of being present in therapy was of importance.

Moreover, the patient's development of self-awareness also aided his tolerance towards confrontation and critique. Although confrontation and critique could enhance anxiety, confrontation and critique now played a crucial role in positive psychological change and strengthening the therapeutic relationship instead of harming it. In this activity, the therapist and the patient became co-performers. Both the therapist and the patient became more active in deconstructing the patient's narrative while simultaneously building a reconstructive and therapeutic dialogue (as described by Tonner, 2017). The therapist would remind the patient firmly that therapy is a space where 'both the good and the bad are welcome.' As reflected upon during supervision, the patient's emerging tendency was to present himself as a good patient. The therapist thus started overtly rejecting the patient's shying away from the 'bad', for example, if the patient attempted to avoid unpleasant emotions or the 'bad' the therapist would comment: 'if we cannot be open and honest here about both aspects, the good and the bad, these sessions will go nowhere.'

Furthermore, humility mainly was a prominent feature of this phase. Humility was practised by following the patient and the problems he presented in each new session with an attitude of 'solving problems together', described by Drinane and Worthington et al. (2017), Harris and Didericks (2014), Morales (2019) and Rowden et al. (2014). Supervision included reflecting on 'solving problems together' to encourage the patient to engage with the therapist in doing the therapy work. This relational engagement also had built onto his initial presenting complaint of feeling powerless and his attempts to do his healing independently, talking disconnectedly to the therapist. During this stage, the therapist would move with the patient and address his varying difficulties therapeutically by following his lead, for example, by using guided relaxation techniques to address sleeping difficulties. His ability to have collaborated and improved on his difficulties, for example, in sleeping, played a prominent role in positive psychological change. Furthermore, both therapist and patient adopted a flexible approach by also incorporating couples therapy sessions for him and his wife, allowing acknowledgement of mutual influences and interactional patterns in their relationship. The therapist had taken seriously every problem and narrative that transpired and built the therapy activity around that. This radically relational process further aided in setting the context for the therapeutic process while it also encouraged the patient to give that which he brought to therapy serious consideration.

Moreover, the patient, out of his own, started exploring coping mechanisms known to him before. These dexterities included writing, travelling places he had not been to before and just relaxing by himself, choosing to watch television programs that he enjoyed instead of programs that reinforced obsessional thoughts, and realising that he had the power to think before he acts. Both the therapist and the patient took a more active stance in exploring solutions than the initial therapy stages. These sessions were shorter than the long sessions at the beginning of therapy, however still longer than one hour and progressed to the last therapy phase.

Co-performer Activity in Transition to Co-authorship

Change and development were becoming more prominent as the patient became more active, co-creating his therapy transformation. Increasing openness and honesty in therapy emerged during this stage, while the therapist reinforced an open and honest context with encouragements that included phrasing therapy as 'a place for the good and the bad. The more open and honest you are, the more benefits you will reap from the therapeutic process. It does not even matter if sometimes we like each other or not. It matters more that we talk about that.' The patient also responded to the therapist's talk of: 'That which happens within this room does not stay in this room', with: 'I can take it outside to make it useful for me in life.' This mirroring of the therapist marked a significant emergence of the patient's engagement in critical reflections that were deconstructing and reconstructing life forms, following Tonner (2017) and Wittgenstein (1953).

The Final Stage: Co-authorship

The above example of continuously building the relational activity of therapy with the patient marked the co-creative therapy process (as described by Newman & Holzman, 2003; Wittgenstein, 1953). The therapist built the therapeutic space with the patient, which allowed for more intense reflections on the patient's relational development in therapy and everyday life. This work was relationally challenging for the therapist and patient. For example, when the patient shared developing hatred for women, the therapist risked asking how he felt being in therapy with her, a woman. In this instance, the patient responded by reflecting on the therapist being a white woman while he was a black man. This reflection opened up space for growth, in which therapist and patient shared power and responsibility in the therapeutic context of co-creating change and sharing their forms of life towards development (see Wittgenstein, 1953 regarding

forms of life). At this moment in therapy, the therapist experienced that engagement as real persons created a context for further intensifying and deepening therapeutic reflections. In this transition, both therapist and patient engaged in critical relational reflection, as illustrated below.

> Therapist: Hmmm. And how does it feel like with me as your therapist being a woman? Is it difficult for you?
> Patient: No. It is not difficult. Why be? It is not difficult because of your race. To be honest, because of your race. That makes it simple. You are not in my culture. I can just...you will not judge me as those others judge me. And to be quite honest, I am not attracted to white women. You can't hurt me like they do.

The therapist first thought the patient might have dissociated her from his troubles, categorising her as 'other' or idealising her. Simultaneously, she experienced his honesty, relating to her realness, not as an object to project on (Cf. Slife & Wiggins, 2009; Wachtel, 2008). This honesty marked a critical turn in the therapy to acknowledging relational activity that conveyed a new perspective by and for both the patient and therapist; an acceptance of self and others as socially and historically connected. This turn provided the patient's new performance, co-authoring the therapeutic space and the therapist's relationship. Verbalising his co-authorship of the therapeutic space, reflecting on whom the therapist and the patient were as real people to each other for him, allowed him to voice out what he felt so the therapist could hear him and a sense of his empowerment and co-ownership of the developmental process.

Furthermore, such a reflection was also developmental for the therapist, as it seemed daunting at first. As an invitation to relate more directly, the patient's feedback on the therapist's person marked the realisation that both therapist and patient were real people interconnected in a social–historical context. In the therapeutic process, this, for the therapist, marked risk in her growth concerning the culturally and racially loaded context of South Africa. During the therapy's final stage, she became intensely aware that therapy and life's performance (see Newman & Holzman, 2003; Wittgenstein, 1953) took place for both therapist and patient. After this session, the patient also brought his diaries to therapy for the therapist to read. This process was also not easy for the patient; however, it was another significant aspect of the therapeutic developmental process. This process also illustrates the importance of building trust in the cross-cultural therapeutic relationship.

The patient was also able, in the subsequent sessions, to recognise his changes and verbalise that others (neighbours and friends) also recognised his changes. His narrative changed from carrying themes of hopelessness and distress to themes of taking control of his own life and acknowledging the changes that had come about. This development marked a significant shift in the forms of life he embodied. Moreover, his conflicting fears dissipated, and the patient was not only mobilised in therapy but also his everyday life. His self-acknowledgement and affirmations that projected a balanced outlook on his future with an awareness of possible obstacles were all changes that were noteworthy of his progress in therapy and made tangible by the change in his narrative.

During this phase, therapy sessions never progressed for longer than an hour. This new performance with time spent with the therapist might have indicated that the therapeutic space, which initially filled a void for the patient, became a helpful development tool, co-created in a relational process (as described by Newman and Holzman, 2012). Before the therapist noted this new time utilisation, the patient recognised that therapy was no longer needed and space to return to should it be needed. During the last therapy session, the therapist also observed that the scars in his neck have healed well – to such an extent that they were hardly visible.

Conclusion

The present case report highlighted how the therapist's strong focus on relational development with the patient, and practicing patience and humility, assisted both the patient and therapist to engage in a process of facing and resolving complex emotions such as those in splitting tendencies. Through this process, the therapist observed the patient's improvement in wellbeing, while her own professional development was also possible. Towards the end of therapy, both patient and therapist took full responsibility for building the therapeutic space in a radical relational fashion. A strong relational approach became part of the therapy process and way of life for both therapist and patient, leading to development within the therapeutic context and beyond.

We conveyed how this relational process was co-created by patient and therapist and realise that a different therapist would likely have had an entirely different experience with the same patient. We thus offer the following guiding principles from our case observations, without intending it as a prescription. Firstly, we recommend a strong relational approach to assist supervisors, therapists and patients in cross-cultural context. A radically relational approach entails slowing down the conversation to attend with openness to each other's inputs. Dialogue, persuasion of the other, and both self- and relational awareness all are important elements of attending to the therapy as a performed conversation. Following a radical relational principle means slowing down and attending to therapy as a relational conversation. We finally recommend the integration of radical relational approaches and theory into existing training and therapy practices and more research in this regard could be valuable.

Although the case report is limited, it presents a start. We trust that our data description and practitioner self-reflection, incorporating theory and written narrative, provided transparency as to how we reached these principles and their relevance to other cases and contexts.

Authors Contribution All authors contributed to the study conception, design and data analysis. Kyli Benadie performed material preparation and data collection. She wrote the first draft of the manuscript, and both authors commented on previous versions of the manuscript. Both authors read and approved the final manuscript.

Funding The authors have no relevant financial or non-financial interests to disclose.

Declarations

Ethical Approval Ethical clearance from the Sefako Makgatho Health Sciences University Research Ethics Committee was received. The researchers also obtained approval from the hospital's CEO, to report on the case.

Research involving Human/Animal participants This retrospective case study involving a human participant was under the ethical standards of the institutional and national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Informed Consent The patient signed informed consent regarding publishing the information relevant to the current qualitative case study research.

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