CLINICAL CASE REPORT

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A critical-cultural-relational approach to rupture resolution: A case illustration with a cross-racial dyad

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Abstract

Ruptures are common in any therapeutic relationship and their successful resolution is associated with positive outcomes. However, therapist and client differences with regard to power, privilege, identity, and culture increase social and cultural distance, contributing to alliance ruptures and complicating the repair process. Informed by critical race theories, cultural psychological perspectives, and relational principles, we highlight how power, privilege, identity, and culture shape the development of ruptures and thus, how analyses of these dynamics should inform the process of repair. We present an expanded critical-cultural-relational approach to rupture resolution that emphasizes essential skills of critical self-awareness, wise affect, and anti-oppressive interpersonal engagement, and extends Safran and Muran's (2000) general rupture resolution model to emphasize a critical analysis of the rupture and repair processes. We illustrate our approach through a case presentation involving a rupture in a cross-racial dyad with themes of racism and classism.

KEYWORDS
alliance, anti-oppressive practice, critical race theory, multicultural psychology, ruptures

1 | INTRODUCTION

A rupture in the therapeutic alliance refers to a tension or a breakdown in the collaborative relationship between therapist and client (Safran & Muran, 2000). Ruptures are a common feature of therapeutic relationships, and they offer an opportunity to work through important relational dynamics affecting clients' lives. While studies show that the successful repair of ruptures predicts the development of a strong alliance over time (Safran et al., 2001), this literature is overwhelmingly based on homogeneous samples of predominantly white therapists and clients. More research is needed to explore how these rupture and repair processes affect the development of the therapeutic relationship across diverse client-therapist dyads. In this article, we draw on the existing research and conceptual work by diverse voices in the field, as well as our own clinical experiences, to describe a critical-cultural-relational approach to rupture resolution.

2 | CONCEPTUAL FOUNDATIONS: TOWARDS A CRITICAL-CULTURAL-RELATIONAL APPROACH TO RUPTURE RESOLUTION

We write as a group of scholars and clinicians who have been influenced by interdisciplinary and multi-level analyses of race, power, privilege, and oppression as they manifest in everyday life, and in our intrapersonal and interpersonal worlds. As individuals, we identify as a second-generation Chinese American upper-middle class cisgender heterosexual woman, a white queer Jewish U.S.-born upper-middle class cis-man, and a second-generation British Iranian-Pakistani middle-class cisgender heterosexual woman. Most centrally, we draw upon the theoretical perspectives and contributions of critical theories, in particular critical race theory (CRT). CRT emerged in the field of legal studies and later crossed over into women's and gender studies, sociology, education, and more recently, the fields of social work and public health to address racism's contribution to disparities in employment, incarceration, education, wealth, health, and other life outcomes (Abrams & Moio, 2009; Ford & Airhihenbuwa, 2018; Graham et al., 2011; Ladson-Billings & Tate, 1995; Yosso & Solórzano, 2005). Notably, it is less frequently applied within the field of psychology (Salter & Adams, 2013).

CRT views racism not as a rare and extreme position characterized by neo-Nazis and the Ku Klux Klan, but as an ordinary and pervasive aspect of everyday life. Because racist ideologies undergird all of our basic structures and institutions—from health care, education, food delivery systems, housing, employment, the criminal justice system, laws and policies, to the arts—race becomes an epistemological position that shapes our very experience of the world. Thus as clinicians, it is impossible to be neutral, objective, or unbiased. A large body of evidence has shown that helping professionals hold persistent implicit biases towards members of marginalized groups that contribute to disparities in diagnosis and treatment, patient ratings of the clinician, treatment adherence, and outcomes (Penner et al., 2009; Thompson et al., 2019). Due to the repetitious and unconscious nature of these thoughts and feelings, implicit biases—or "habits of the mind"—are hard to consciously change or control despite non-prejudiced intentions (Burgess et al., 2017).

While centering race, CRT also recognizes that each of us is composed of multiple, shifting identities—gender, race, ethnicity, sexual orientation, nativity status, socioeconomic status etc.—that cannot be reduced to a "single easily stated unitary identity" (Delgado & Stefancic, 2017, p. 20). Within therapy, the salience of a client's various identities will vary across time and place, subject to the individual's specific history, geography, and social, political, economic, and cultural context (Hermens & Dimaggio, 2007). Intersectionality theory, which originated from the work of critical race theorist and legal scholar Kimberlé Crenshaw, articulates how racism interacts with other systems of oppression (e.g., sexism, classism, nativism, heterosexism, ableism, etc.) to adversely impact those who occupy multiple marginalized positions in society (Combahee River Collective, 1981; Crenshaw, 1989). Whereas "weak intersectionality" approaches focus on individual social identities (e.g., race and gender), a

"strong intersectionality" approach emphasizes how multiply minoritized individuals are impacted by interlocking systems of oppression.

As Adames et al. (2018) note, a strong intersectionality approach recognizes and helps clients to recognize that the distress that they experience is caused in part by these structures designed to perpetuate inequities in society. This view suggests the possibility of expanding our scope of practice to include oppressive structural conditions as a target of intervention, a point to which we will return later in this piece. A strong intersectional approach also reminds us that how we relate to our clients, and they to us—including assumptions, countertransference reactions, capacity for empathy, and trust—is likewise shaped by our positions vis-à-vis these systems. Thus, the therapeutic relationship must be a site of critical analysis and conscious resistance to the normative dynamics of oppressor and oppressed, perpetrator, and target.

Our critical-cultural-relational approach to ruptures and repairs also crucially recognizes that meaning-making is a *cultural* process, forged by our identities, cultural socialization, and how we have learned to adapt to the situational demands of our lives. At the level of lived experience, social identities and dynamics of oppression shape how we make sense of the world, which then shape how we interact in the world. Cultural psychological perspectives are grounded in the view that mind and culture are intertwined and mutually constitutive (Markus & Kitayama, 2010), such that we are both the products and makers of culture. As therapists have more power to assert their cultural perspectives (e.g., about what is good, what is normal, what is healthy) onto the client, we seek to monitor how culture and societal power are shaping our case conceptualizations and how we can co-construct a shared cultural understanding and treatment approach that is grounded in mutuality and respect.

Finally, our approach to negotiating ruptures is influenced by relational perspectives, including principles of relational-cultural therapy (RCT) and relational psychoanalysis. A feminist approach, RCT helps therapists understand the effects of power at both the interpersonal and societal level, including the impact of marginalization on relational disconnection (Jordan, 2010). Challenging the Western idealization of independent self-sufficiency, RCT asserts that the development of a healthy self emerges out of meaningful and mutual connections with others. With its emphasis on the relationship as a site of potential healing, the "relational turn" in psychoanalysis has been observed across modalities. According to relational theory, it is in the therapeutic interaction that each participant's embodied subjectivity emerges (Gentile, 2013). Each member is further understood as comprising multiple selves that interact and intersect both intrapsychically and interpsychically to create meaning (Hermens & Dimaggio, 2007). The relational approach dovetails with intersectionality theory by providing a space for the many shifting positions of both therapist and client by creating "a place of suture" (Frosh & Baraitser, 2008) for the psychological and social realms to coexist (Gentile, 2013; Tummala-Narra, 2018). Furthermore, by recognizing that therapists and clients unwittingly re-enact experiences of privilege and oppression in the therapy room, in accordance with their social categories and cultural socialization, these dynamics can be acknowledged and negotiated (Belkin & White, 2020; Holmes, 2016; Leary, 2000).

3 | UNDERSTANDING RUPTURES IN CONTEXT

The majority of research on rupture-repair cycles to date has focused on the interpersonal dimensions of the tensions that emerge in the therapeutic relationship with little consideration of the broader contextual factors that may inform their occurrence, expression, and resolution. However, a handful of scholars highlight the role that culture and context play in the breakdown of the therapeutic alliance (Gaztambide, 2012; Keenan et al., 2005; Lee, 2012; Liu & Pope-Davis, 2005; Owen et al., 2014). All take Safran and Muran's (2000) model of rupture-repair as their blueprint, extending it to include culture. Most also focus on the white therapist-minority client dyad with less emphasis on ruptures involving therapists of color.

While ruptures are an inevitable part of the therapeutic relationship and can occur in both racially/ethnically similar and dissimilar client-therapist dyads, they may be more common in cross-racial and cross-cultural

relationships. Lee (2012) defined cultural ruptures as "disjunctures in negotiating compatibilities of treatment goals and tasks between client and clinician due to misunderstandings of their cultural differences and misattunements in emotional engagement" (p. 26). Keenan et al. (2005) posit that a breakdown in the relationship can result from any of the following, independently or in combination: client maladaptive interpersonal patterns, personal qualities of the therapist and/or client, cross-cultural misunderstandings, and asymmetrical power relations that reflect broader sociohistorical intergroup tensions.

Although these approaches recognize the role that culture and power play, they fall short of acknowledging the full extent to which these factors permeate every facet of the therapeutic relationship. By pitching ruptures as either personal or cultural, an artificial stratification is imposed that in effect minimizes the role that culture plays. When both therapist and client are viewed as culturally embedded and culturally constructed, culture itself can be seen as an internalized object that shapes each individual's perspectives, beliefs, values, and their sense of self and other (Watkins & Hook, 2016). Using this lens, all ruptures can be regarded as inherently cultural. Second, power is a pivotal force in each individual's psychological development. Each member of the dyad's social locations are ever-present in the therapeutic relationship, with both the therapist's and client's identities reflective of broader, interlocking systems of power, privilege, and oppression, with implications for how ruptures are experienced, expressed, perceived, and addressed.

4 | A CRITICAL-CULTURAL-RELATIONAL MODEL OF RUPTURE AND REPAIR

Our critical-cultural-relational approach to rupture and repair engages a series of processes that occur within a larger backdrop of ongoing critical self-reflection and contemplation, to facilitate the observation of interpersonal events through multiple levels of analysis and reduce defensive responding during rupture events. We take as a starting point Muran et al. (2010) identification of three essential therapist skills for attending to ruptures and their repair, namely (a) self-awareness, (b) affect regulation, and (c) interpersonal sensitivity. *Self-awareness* is defined as the therapist's awareness of and bare attention to their internal experience, including affect. Self-awareness is viewed as an internal "compass" for helping the therapist understand their interactions with their clients. *Affect regulation* refers to the capacity to manage negative or distressing emotions, in the therapist as well as the client, that may be disruptive to the alliance. Finally, *interpersonal sensitivity* refers to therapists' capacity to empathize with their client's experience and sensitivity to the interpersonal dynamics in their relationship. These three components are viewed as "interdependent and critical to establishing an optimal observational stance" (Muran et al., 2010, p. 330).

We layer onto these basic skills a critical-cultural and explicit contemplative lens, which serves to broaden their scope. In our model, the essential skills are: (a) *critical self-awareness*: an awareness of how power, privilege, culture, and identity inform our internal experience and affective and behavioral responding in the moment, (b) *wise affect*: the capacity to both skillfully respond to negative emotions that lead to disconnection and othering, *and* generate positive emotions to promote care and connection; and (c) *anti-oppressive interpersonal engagement*: the capacity to empathize with the client's experience and sensitivity to the ways that the relationship may be shaped by dynamics of oppression. The therapist is committed to recognizing power dynamics in the therapeutic relationship and striving towards more emancipatory ways of relating.

5 | ESSENTIAL THERAPIST SKILLS

5.1 | Critical self-awareness

Recognizing that therapeutic relationships, like all relationships, are shaped by power, privilege, identity, and culture, we engage in ongoing critical awareness and interrogation of our social locations and standpoints as

part of broader efforts to deepen our critical consciousness (Pitner & Sakamoto, 2010). Through formal study and learning from those speaking from marginalized positions in society, we regularly reflect on how these dimensions shape our experience of the world and our clients, and seek to reduce the harmful impact of oppressive patterns of thinking and behaving on clients and ourselves. This includes reflecting on what Curry (1964) described as pretransference reactions, that is all of those associations—to Black clients for example—that are a result of a priori racial associations reflecting general sociocultural attitudes, and not the result of direct experiences with that group. Acknowledging that none of us are immune to the cultural biases of a society, we seek to bring them into our conscious awareness so as to reduce their adverse impact on the clients that we serve.

5.2 | Wise affect

We draw on contemplative practices, including formal and informal mindfulness and compassion practices, to cultivate a capacity to attend to our cognitive, affective, and bodily reactions in the moment with curiosity, openness, and compassion. We define *wise affect* as including two components, (a) the capacity to manage negative emotions and bodily stress responses as they arise and (b) the cultivation of positive, prosocial states such as compassion and interconnectedness. Mindfulness is associated with improved regulation of negative emotions, decreased reactivity and avoidance behavior, and improvements in aspects of executive functioning (Chambers et al., 2009; Gallant, 2016), which together can support the therapist in managing the anxiety that can arise during rupture events (Muran et al., 2010). Especially during discussions of race, mindfulness can help therapists observe and manage their defensive reactions, and allow them to engage in ways that are aligned with their antioppressive values and intentions (King, 2018).

A critical perspective further argues that it is equally important to cultivate positive states that foster a dissolving of in-group/out-group distinctions and promote greater inclinations to help (Verhaeghen & Alikman, 2019). We recommend mindfulness and compassion practices, which have been associated with increases in empathy, compassion, and prosocial behavior with outgroup members, and decreases in bias and prejudice (e.g., Berry et al., 2018; Lueke & Gibson, 2016).

5.3 | Anti-oppressive interpersonal engagement

The third essential therapist skill involves the capacity to empathize with the client and be sensitive to how the interpersonal relationship may be shaped by dynamics of oppression that both perpetrate and perpetuate sexism, ableism, heterosexism, ableism, racism, and other forms of subjugation. Empathy requires an understanding of the client in context, an understanding informed by critical self-awareness, cultural knowledge, and an ability to see beyond our own experience to adopt the perspective of another. Yet, individuals show weaker empathic responding to suffering in racial and other outgroup members (Avenanti et al., 2010). Whereas contemplative practices may improve empathic responding without prejudice, we do not rely solely on empathy as the precursor for compassionate action. Rather, we ground in our commitment to anti-oppressive practice principles, including structuring the therapeutic relationship in such a way that aims to empower the client by reducing the effects of social status hierarchies on the relationship. One study, for example, found that LGBT people living with depression experienced significant reductions in their symptoms after receiving a cognitive-behavioral group therapy intervention based on anti-oppression principles (Ross et al., 2007).

6 | RUPTURE RESOLUTION STAGES

Our critical-cultural-relational approach is based on Safran and Muran's (2000) general rupture resolution model but emphasizes a critical analysis of the rupture event and anti-oppressive approaches to negotiating the process of repair.

6.1 | Stage 1: Attending to the rupture marker

Cultural differences in communication style, as well as clients' motivation to conceal their true feelings due to cultural mistrust (Terrell et al., 2009), may make it difficult to detect when a rupture occurs. The therapist recognizes that there is cultural variation in rupture markers and takes care to attend to verbal and nonverbal signs that there is tension or a breakdown in the alliance.

6.2 | Stage 2: Analyzing the rupture

The therapist analyzes the rupture applying critical frameworks to consider the influence of power, privilege, identity, culture, and structural factors on the relationship. The therapist mindfully observes their own reactivity, ethnocultural countertransference reactions, and considers their contribution to the rupture with humility. This process happens internally and informs the therapist's approach to exploration and repair.

6.3 | Stage 3: Exploring the meaning of the rupture

The therapist facilitates a process of mutual exploration of the rupture event, with the goal of clarifying the meaning and significance of the rupture for the client. Acknowledging that cultural mistrust and disparities in social power may make the client reluctant to engage in the process, the therapist adopts an attitude of openness and humility. The therapist's willingness to be vulnerable, curtail their defensiveness, and facilitate the client's self-assertion may serve to deepen trust over time.

6.4 | Stage 4: Exploring the avoidance

The therapist explores the client's feelings and fears about the rupture event, while being mindfully aware of any judgments or assumptions that may arise. The therapist considers the potential adaptive function of the avoidance in the context of power relations and works to create an inclusive environment in which to explore these issues.

6.5 | Stage 5: Affirming the relationship

Recognizing the risks of speaking candidly about ruptures with one imbued with institutional power, the therapist validates and affirms the client's sharing of experience. Safran and Kraus (2014) emphasize the importance of "holding oneself accountable for the therapist's contribution to the rupture and apologizing if needed" (p. 383).

6.6 | Stage 6: Repairing the rupture

In addition to surface and deep repair strategies (Safran & Muran, 2000) and nurturing the client's efforts at self-assertion, the therapist also considers the potential benefit of interventions that help the client cultivate critical consciousness, or the ability to recognize, question, and challenge oppressive structures (including the treatment context) that adversely affect the client and perpetuate inequities in society. The therapist aims to promote client agency and shared decision-making in determining how the rupture may be resolved.

These stages may not necessarily proceed in a linear fashion, in some cases requiring multiple rounds of analysis, exploration, and repair attempts before the rupture may be resolved.

7 | CASE ILLUSTRATION

7.1 | Client description

Ms. D is an African American woman in her early 30s who had moved to New York City several years earlier with her 8-year-old daughter. A survivor of domestic violence, she identified as psychiatrically disabled. She moved from the rural South where she characterized the local social services as uncaring and neglectful, where she recalled whites refusing her housing even when she could pay, and where she and her daughter had been homeless for 2 years until her disability application was approved. She moved North in pursuit of more resources. She was eventually placed in supportive housing. In what she felt was a cruel irony, it was upon becoming permanently housed that she began to be reported for what social services workers perceived as problem drinking and verbal altercations, alleging abuse or neglect of her daughter, who for a time was placed in foster care following police involvement in a violent encounter with a romantic partner. She would often say, "Why didn't they take her away when we were dirty, living in the streets? Where were they then? Why do they do this now?"

7.2 | Presenting problem

These events led to her referral to the community mental health clinic where I (J.D.) worked with her. She had worked with multiple therapists, having abruptly ended each treatment for reasons which were not clear. She was ambivalent about being in therapy yet was motivated to demonstrate compliance and finally bring an end to a family court case that was still ongoing. The goals she and I coconstructed—with some difficulty, as she felt that others needed to change, not her—were (1) to reduce child protective services' involvement by understanding their expectations and why cases continued to be opened on her and (2) to understand an interpersonal pattern where she would end up in conflict situations based on facial expressions which she experienced as neutral but others experienced as hostile.

Ms. D. was warm and pleasant in the room, but would often miss sessions, even when they were scheduled biweekly in acknowledgment of her ambivalence about attending. She had a long history of being disciplined and underserved by social service agencies informing her mistrust toward the clinic. Even though I typically started our sessions on time, she often met this with surprise, saying she expected to be kept waiting, greeting me saying, "Wow, just wow."

8 | CLINICIAN BACKGROUND

At the time, I was a doctoral-level trainee early on in my training. I identify as a white queer cis-male, ethnically Jewish, U.S.-born, and upper-middle class. I am psychodynamically and multiculturally oriented and am particularly influenced by integrative harm reduction therapy, which acknowledges the complexity of stigmatized behaviors and honors ambivalence about changing them (Tatarsky & Marlatt, 2010). This was a match for the clinic's stated mission, which was to keep underserved clients engaged and stabilized to minimize relapse and rehospitalization. I was eager to apply what I had been learning and was motivated by a wish to be an understanding presence within systems that are often dehumanizing and criminalizing. I often experienced my idealism to be in conflict with the reality of the low-resource setting, where the high volume of cases made it difficult to meet clients' needs. In multiple activist contexts, I was engaged in antiracist solidarity work, informed by a critical analysis of liberal white dominance in community organizing (Villalobos, 2015). Yet, I found this hard to apply at the clinic.

9 | CASE FORMULATION AND COURSE OF RUPTURE AND REPAIR

9.1 | Stage 1: Attending to the rupture marker

The rupture took place in what was temporally the middle of the treatment, but what is best characterized as a prolonged engagement phase of the therapy. Ms. D had seemed to warm to coming to therapy, and there seemed to be a bond. In particular, we would resonate with each other when talking about themes of unfairness, discrimination, and social exclusion. Yet, she was beginning to miss sessions, leading me to conduct outreach. The phone call took place during the second consecutive session she had missed:

Ms. D: Hello? (sounding pleasant and slightly surprised by the phone call)

T: Hi, Ms. D? This is Jordan.

Ms. D: Oh, hi.

T: I'm calling to check in—we have an appointment right now, but you're not here yet. I'm calling to see what's going on. Are you on your way in?

Ms. D: Oh, there's a lot of ice on the sidewalk today, and I don't really feel like making the trip. I'll come next time. *[Patient withdrawal]*

T: I see. Well, we can reschedule today's session—I have this same time open next week. It's been four weeks since your last session.

Ms. D: Oh, well I think I'll just stick with our usual schedule, every other week.

T: Well, if you're not coming for another two weeks, it's actually changing our schedule from every two weeks to every four weeks, do you see that? You've only been coming every four weeks. How about coming next week so we can see what's going on? It seems important. *[I try to bring her back to mutually (?) agreed upon goals but did not acknowledge her ambivalence or welcome other reasons she may not want to come in—for example, not finding her therapist helpful? I put the onus on her to come in person and not "reward" absenteeism with a prolonged phone conversation.]*

Ms. D: Well, I think I'd rather just stick with our plan for the usual every other week time.

T: I'm feeling concerned about this, Ms. D. How do you think this is going to look for your ACS (Administration for Children's Services) case? I know you want to come every other week and I'm trying to hold you to that—I think it would help for you to come next week. This is letting four weeks go between sessions, not two. *[Therapist antagonizes]*

Ms. D: Jordan, I'd like to speak to your director. I'm going to get a new therapist. [click]

T: Ms. D?...

I felt my stomach clench. Her usual easygoing, sing-song, Southern dialect had become flat, cold, and commanding. I walked down the hall to my supervisor's office and sat down, clutching a piece of comfort food to my chest. Ms. D usually regarded me as "nice," in contrast to other people in the system—her daughter's teachers, her former therapist, her child protective services worker—whom she felt were out to get her. It felt very dysregulating that Ms. D was now perceiving me as one of these bad objects. I was concerned that the therapy was over.

9.2 | Stage 2: Critical self-reflection and analysis of the rupture

In discussing what had just happened with my supervisor, I realized that I had exceptionalized myself in thinking Ms. D would not abruptly end therapy with me as she had with multiple previous therapists. I had felt overly confident in our bond and overidentified with her (Comas-Díaz & Jacobsen, 1991). We often resonated with each other in discussing themes of social rejection and otherness, themes which connected to my individual experience as queer. My supervisor, a queer immigrant South Asian cis-woman, helped me recognize the overidentification by sharing her experience of feeling aware of her privilege in relation to clients who are criminalized due to anti-Black racism and classism. By modeling a bold, frank curiosity and awareness of her own anti-Black racism as a multiply oppressed Brown woman, she normalized the experience of misattuning to Ms. D, whose life had been shaped by pervasive anti-Black racism. Although I shared my supervisor's commitment to critical self-awareness, and indeed had cultivated it and applied it in other clinical cases, something had obscured the vastly different stakes for noncompliance and nonbelonging for Ms. D and myself in this instance.

In the rupture, I switched from my usual curiosity about the stigmatized, "noncompliant," parts of Ms. D into being an unreflective authority figure. Greater openness about her reasons for not attending may have welcomed in ways the therapy was not feeling relevant or useful to her, or ways in which I was not understanding aspects of her experience. Instead, I focused on her poor attendance and the negative consequences for not attending. Trying to maintain the frame, I felt that an outreach call was not the space to process these issues and that Ms. D needed to come in so that processing could happen. Yet, when working with low-income clients, momentary flexibility with the therapy frame can be seen as evidence that the therapist is sincerely in their corner (Thompson et al., 2012).

In light of her negative institutional transference, I had felt cautious about wanting to maintain Ms. D's trust and also felt pressure to be unlike her previous therapists who had seemed to miss her needs and focus on her faults. The idea of persecuting her felt intolerable, leading me to split off the power and privilege I held in society and in the clinic, yielding a false egalitarian sense of shared otherness. While feelings of otherness may have been a point of convergence and mutual engagement between us, we were also brought together by the fact that Ms. D faced the prospect of losing her daughter if she did not comply. Also, her resistance to societal demands was informed by trauma and stigma, in which case "noncompliance" can be an expression of agency within the constraints of racist, patriarchal, and classist regulatory norms (Gentile, 2013).

Reflection with a supervisor who did not exempt or exceptionalize herself, and who could tolerate frank reflection on how she inevitably can reinforce oppressive dynamics with her clients helped me in turn to process the emotionally charged experience. This restored a capacity to witness how societal forces and structural violence conferred meaning to the exchange with Ms. D. After processing in supervision, I felt emotionally prepared to not expect Ms. D to return.

9.3 | Stages 3 and 4: Exploring the meaning of the rupture and the avoidance

I was surprised when Ms. D's name lit up in green on my computer screen, indicating she was in the waiting room for our next scheduled session, just as she had said she preferred. Ms. D explained that she had thought about

moving on to another therapist but decided to give me another try. Although she was surprised at how I had "changed" in the phone conversation, she recalled that I had been "nice" up until then. In an effort to make room for her doubts and to try to integrate an idealized, split off the notion of myself as the "nice" white therapist with the contrasting representation of the oblivious, persecutorial bad white therapist, I reminded her of her intention to speak to my director (which she did not act on). I suggested that something really unsatisfactory must have happened, I must have done something that seemed wrong in her eyes. "It was confusing, I thought you weren't like that," she said.

Disclosing some confusion and anxiety I had felt around the situation, I named it as a power struggle that escalated. Trying to be accountable for my contribution to the rupture, I said, "I may have come down on you, like so many of these other caseworkers, therapists, your daughter's teachers, have done." As we talked, it became clear that the contradictions I had highlighted over the phone, getting into precise details about scheduling and the 2 weeks versus 4 weeks, did not speak to her experience. She was more relativistic, feeling like at least she was coming to some sessions whereas for the previous year she had not come to the clinic at all. Clashing worldviews came into play in our disparate interpretations of her behavior.

9.4 | Stages 5 & 6: Affirming the relationship and repairing the rupture

As we continued to talk, I gained a better appreciation of how important it was to Ms. D to be able to have more autonomy and agency over the requirements of her treatment. She endorsed how this clinic and other clinics in the past had treated her like a criminal for being poor, manifesting anti-Black racism, and making threats to separate her from her daughter and not seeing how much effort she was making or supporting her efforts. It felt that a shift needed to be made in our relationship. The incidents she associated to our mis-understanding, including feeling judged and attacked by prior therapists, some of whom had been Black women, helped make clear the salience of structural violence (e.g., being refused housing, excessive demands placed on her compliance with limited resources, criminalization of poverty) and structural vulnerability (e.g., being subject to anti-Black welfare systems; Hansen & Metzl, 2019) in conferring meaning to the role of therapy. Therapy was another demand placed on her to be in two places at the same time. The clinic was far from her public housing complex which was far from her daughter's school. She spoke to feeling that a variety of institutions, including the clinic, imposed their own agendas on her rather than offering her any kind of supportive or collaborative resources.

As the person who documented her therapy attendance, I could not simply or consistently be "nice" even though I showed an interest in her identities and her individual oppression. I needed to navigate the split between "nice" and what seemed to be another cruel, uncaring figure in her life. I came up with the idea of creating the progress note each session with her still in the room, so we could go over it and co-sign it together. Offering this possibility to her, she said she liked the idea, her face softening as she nodded and took it in.

The rationale for the idea was not thought out at the time so much as it being a spontaneous expression of a wish to be more accountable, transparent, and horizontal about power in the relationship, along with a hope to engage her more and clear up misunderstandings as they occurred. A proposed shift in tasks felt like a way to communicate a true willingness to rethink accountability for my role and make room for a more active, involved role for her.

Although she liked the idea of cosigning notes and agreed to it, when I actually initiated this toward the end of the session, she said, "It's okay. I don't think we need to do that. I think you're alright." It felt like the bond had been strengthened, and I wanted to be receptive to her gesture, so I accepted this with a smile. I facilitated some reflection on how we each saw our relationship now.

10 | OUTCOME AND PROGNOSIS

Similar ruptures happened in the months that followed, but after this session, we had a better understanding of how to navigate them and a confidence that we could. I was able to show more curiosity about her ambivalence, inviting in more than the surface rationalizations for not coming to sessions. These reasons would be explicitly structural (e.g., transportation and lack of childcare), ethnoracial and cultural (e.g., expressing mistrust about whether coming to sessions could expose her to an agenda to separate her, a low-income Black mother, from her young daughter), and interpersonal (e.g., the "nice" therapist will be accommodating). It became possible to be more upfront about limits and with greater transparency, she experienced this less as a threat and more as an opening for collaboration. She began to exercise more agency by coming up with possible solutions to the impasses. In the summer months, she came up with the idea to manage her lack of childcare by bringing her daughter to the clinic on the days of our sessions. This was an outgrowth of the trust that was developing through our work together, as she often bitterly recounted how she and her daughter had been misperceived at the clinic before, her parenting style criticized. A new way of relating seemed to be emerging.

11 | DISCUSSION AND CONCLUSIONS

This case highlights the importance of going beyond an interpersonal formulation of the rupture to contextualize the relationship within power dynamics and the client's history of structural violence. Focusing repair efforts on interpersonal factors alone would have likely missed what was at stake for Ms. D, in light of her prior history of racial trauma at the hands of clinics and social services. This case also illustrates the ease with which societal power asserts itself in relationships, despite the therapist's good intentions, resulting in missteps that require corrective action.

Although the therapist's anxiety about the negative consequences of Ms. D's spotty attendance was well-intentioned, his steps to suddenly pull rank and invoke the consequences of her absenteeism can be understood as the use of antagonism. Antagonism is one typical way that racially privileged individuals manage stress in interracial interactions, trying to regain a sense of control over the situation (Trawalter et al., 2009). Encouraged by Ms. D's frequent comments that he is "nice," contrasting him favorably with her previous therapists, the therapist cast himself as one who would not misunderstand her or punish her like the previous "bad" white therapists had.

Exceptionalizing himself in this way, the therapist dissociated from his usual awareness of privilege and of the common pitfalls of liberal white dominance (DiAngelo, 2018; Helms, 2019). The supervisor, a queer immigrant woman of color, offered a holding environment for processing the charged affect which validated the bona fide bond between the therapist and Ms. D. Critically, she approached such ruptures as inevitable missteps which reveal inequity and limits to the therapist's understanding due to privilege, moments where it is possible to learn and attune to the patient's experience from a stance of accountability. Rather than exceptionalize herself, she conveyed an ethics of responsibility and curiosity about such ruptures. She modeled how therapists must continually challenge themselves to be aware of how they are complicit in racism, classism, and other systems of oppression. This helped the therapist integrate the representations of being "good" or "bad" which had become split off in his thinking in relation to Ms. D. From the perspective of strong intersectionality, whiteness is inherently a part of a system predicated on anti-blackness and white supremacy. Leaving aside notions of being interpersonally "nice" or "mean" or "good" or "bad," Adames et al.'s (2018) call for strong intersectionality articulates a vision in which being therapeutic requires being accountable for unequal societal power and structural violence enacted through white supremacy and neoliberalism.

Mindful consideration of structural, cultural, relational, and individual factors helped the clinician to analyze the layered meanings of the rupture event and its significance for the relationship while promoting empathy and perspective-taking. Repair entailed not only interpersonal curiosity but also a critical examination of the therapist's

own role in perpetuating racism and other forms of oppression, reducing the therapist's level of shame and anxiety as he took steps to be more accountable and transparent. Critical self-reflection went hand-in-hand with structural humility, reflected in the supervision, in which the therapist started asking his supervisor more questions about ACS, family court, and other forms of structural violence in Ms. D's life. Drawing on our notion of *wise affect*, the strong affect the therapist experienced in response to Ms. D's statements can be taken as a cue to slow down, reflect, and try to explore the rupture, separately and together, rather than intervening without a clear understanding. As he was able to recenter in his harm reductionist values and intentions, and exercise self-compassion for this misstep, he was able to restore the curiosity, respect, and compassion he had earlier in the therapy. Greater empathic attunement was achieved through awareness of differences, as opposed to splitting and denial of power and privilege. While exceptionalizing himself as a "good" white therapist was a distortion, we argue that attention to these combined factors and validation of Ms. D's experiences and reasons for her mistrust in the early phase of therapy, helped to develop a bond which led her to return and attempt to repair the rupture.

Although the clinician, in this case, was a trainee, we submit that the desire—to see oneself as somehow unaffected by the cultural racism that shapes ourselves and the institutions of which we are a part—is pervasive among seasoned clinicians as well. While he had the benefit of a supervisor who could help him to process his defensive responses and see more clearly the history of structural violence that shaped his client's behavior, we recognize that not all clinicians have access to this kind of support. We recommend that clinicians interested in this approach seek opportunities to learn about structural racism and antiracist approaches to mental health care (see, e.g., Cénat, 2020).

In conclusion, the critical-cultural-relational model of rupture resolution that we outline here is designed to be applicable and adaptable to different types of psychotherapy, theoretical orientations, and constellations of identities in our clients and in ourselves. Building on Safran and Muran's (2000) general rupture resolution model, our approach applies critical frameworks to analyzing the rupture event and adopts an anti-oppressive approach to negotiating the process of repair. While critical theories, for example, CRT, intersectionality theory, structural competency, etc., have been previously applied to therapeutic relationships, empirical investigations of the efficacy of adopting these approaches is limited.

Research is needed to empirically test the effects of the critical-cultural-relational approach to rupture resolution among diverse patient-therapist dyads, compared with alternative models to rupture resolution. However, there is growing evidence that constructs consistent with an anti-oppressive approach to repair-- including therapist multicultural orientation, cultural self-awareness and humility, sensitivity to clients' experiences of discrimination and marginalization, and comfort discussing race, racism, and other forms of oppression—are associated with client satisfaction, perceptions of therapist credibility, and the working alliance (for a recent review, see Davis et al., 2018). The contemplative thread that runs through our model is also supported by studies showing that among therapists, mindfulness practice is associated with increases in empathy, compassion, self-awareness, counseling skills, and attunement (Davis & Hayes, 2011). In this current sociopolitical moment, as cries for racial justice reverberate in the streets, we must broaden our perspective to examine which of our actions promote equity and which may unintentionally cause harm. Ruptures are crucial moments in the therapy; we offer this approach as a way to transform them into opportunities for healing, justice, and connection for our clients and ourselves.

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REFERENCES

Abrams, L. S., & Moio, J. A. (2009). Critical race theory and the cultural competence dilemma in social work education. *Journal of Social Work Education*, 45(2), 245–261.

Adames, H. Y., Chavez-Dueñas, N. Y., Sharma, S., & La Roche, M. J. (2018). Intersectionality in psychotherapy: The experiences of an AfroLatinx queer immigrant. *Psychotherapy*, 55(1), 73–79. https://doi.org/10.1037/pst0000152

Avenanti, A., Sirigu, A., & Aglioti, S. M. (2010). Racial bias reduces empathic sensorimotor resonance with other-race pain. *Current Biology*, 20(11), 1018–1022. https://doi.org/10.1016/j.cub.2010.03.071

Belkin, M., & White, C. (2020). *Intersectionality and relational psychoanalysis: New perspectives on race, gender, and sexuality*. London: Routledge.

Berry, D. R., Cairo, A. H., Goodman, R. J., Quaglia, J. T., Green, J. D., & Brown, K. W. (2018). Mindfulness increases prosocial responses toward ostracized strangers through empathic concern. *Journal of Experimental Psychology: General*, 147(1), 93–112. https://doi.org/10.1037/xge0000392

Burgess, D. J., Beach, M. C., & Saha, S. (2017). Mindfulness practice: A promising approach to reducing the effects of clinician implicit bias on patients. *Patient Education and Counseling*, 100(2), 372–376. https://doi.org/10.1016/j.pec.2016.09.005

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 1989(1), 139–167.

Cénat, J. M. (2020). How to provide anti-racist mental health care. *Lancet Psychiatry*, S2215-0366(20), 30309-6. https://doi.org/10.1016/S2215-0366(20)30309-6

Chambers, R., Gullone, E., & Allen, N. B. (2009). Mindful emotion regulation: An integrative review. *Clinical Psychology Review*, 29(6), 560–572. https://doi.org/10.1016/j.cpr.2009.06.005

Comas-Díaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry*, 61(3), 392–402. https://doi.org/10.1037/h0079267

Combahee River Collective. (1981). A black feminist statement. In C. Moraga & G. Anzaldúa (Eds.), *This Bridge Called My Back* (pp. 210–218). Persephone Press.

Curry, A. E. (1964). Myth, transference and the black psychotherapist. *Psychoanalytic Review*, 51(4), 7–14.

Davis, D. M., & Hayes, J. A. (2011). What are the benefits of mindfulness? A practice review of psychotherapy-related research. *Psychotherapy*, 48(2), 198–208. https://doi.org/10.1037/a0022062

Davis, D. E., DeBlaere, C., Owen, J., Hook, J. N., Rivera, D. P., Choe, E., Van Tongeren, D. R., Worthington, E. L., & Placeres, V. (2018). Multicultural orientation framework: A narrative review. *Psychotherapy*, 55(1), 89–100. https://doi.org/10.1037/pst0000160

Delgado, R., & Stefancic, J. (2017). *Critical race theory*. New York: New York University Press.

DiAngelo, R. (2018). *Why it's so hard for white people to talk about racism*. Boston: Beacon Press.

Ford, C. L., & Airhihenbuwa, C. O. (2018). Commentary: Just what is critical race theory and what's it doing in a progressive field like public health? *Ethnicity & Disease*, 28(Suppl 1), 223–230. https://doi.org/10.18865/ed.28.S1.223

Frosh, S., & Baraitser, L. (2008). Psychoanalysis and psychosocial studies. *Psychoanalysis, Culture & Society*, 13(4), 346–365. https://doi.org/10.1057/pcs.2008.8

Gallant, S. N. (2016). Mindfulness meditation practice and executive functioning: Breaking down the benefit. *Consciousness and Cognition*, 40, 116–130. https://doi.org/10.1016/j.concog.2016.01.005

Gaztambide, D. (2012). Addressing cultural impasses with rupture resolution strategies: A proposal and recommendations. *Professional Psychology: Research and Practice*, 43(3), 183–189. https://doi.org/10.1037/a0026911

Gentile, K. (2013). You don't recognize me because I'm still standing: Exploring the impact of participating in action research with women survivors of domestic violence. In C. Raghavan, & S. J. Cohen (Eds.), *Domestic violence: Methodologies in dialogue*. Boston, MA: Northeastern University Press.

Graham, L., Brown-Jeffy, S., Aronson, R., & Stephens, C. (2011). Critical race theory as theoretical framework and analysis tool for population health research. *Critical Public Health*, 21(1), 81–93. https://doi.org/10.1080/09581596.2010.493173

Hansen, H. & Metzl, J., (Eds.). (2019). *Structural competency in mental health and medicine: A case-based approach to treating the social determinants of health*. Cham: Springer Nature Switzerland.

Helms, J. E. (2019). *A race is a nice thing to have: a guide to being a white person or understanding the white persons in your life* (3rd ed.). San Diego, CA: Cognella Academic Publishing.

Hermens, H. J. M., & Dimaggio, G. (2007). Self, identity, and globalization in times of uncertainty: A dialogical analysis. *Review of General Psychology*, 11(1), 31–61.

Holmes, D. (2016). Culturally imposed trauma: The sleeping dog has awakened. Will psychoanalysis take heed? *Psychoanalytic Dialogues*, *26*(6), 641–654. https://doi.org/10.1080/10481885.2016.1235454

Jordan, J. V. (2010). *Relational-cultural therapy*. Washington, DC: American Psychological Association.

Keenan, E., Tsang, A., Bogo, M., & George, U. (2005). Micro ruptures and repairs in the beginning phase of cross-cultural psychotherapy. *Clinical Social Work Journal*, *33*(3), 271–289. https://doi.org/10.1007/s10615-005-4944-7

King, R. (2018). *Mindful of race: Transforming racism from inside out*. Boulder, CO: Sounds True.

Ladson-Billings, G., & Tate, W. F. (1995). Toward a critical race theory of education. *Teachers College Record*, *97*(1), 47.

Leary, K. (2000). Racial enactments in dynamic treatment. *Psychoanalytic Dialogues*, *10*(4), 639–653. https://doi.org/10.1080/10481881009348573

Lee, E. (2012). A working model of cross-cultural clinical practice (CCCP). *Journal of Clinical Social Work*, *40*(23), 23–36. https://doi.org/10.1007/s10615-011-0360-3

Liu, W. M., & Pope-Davis, D. B. (2005). The working alliance, therapy ruptures and impasses, and counseling competence: Implications for counselor training and education. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling, Vol. 2, Training and practice* (pp. 148–167). John Wiley & Sons Inc.

Lueke, A., & Gibson, B. (2016). Brief mindfulness meditation reduces discrimination. *Psychology of Consciousness: Theory, Research, and Practice*, *3*(1), 34–44. https://doi.org/10.1037/cns0000081

Markus, H. R., & Kitayama, S. (2010). Cultures and selves: A cycle of mutual constitution. *Perspectives on Psychological Science*, *5*(4), 420–430. https://doi.org/10.1177/1745691610375557

Muran, J. C., Safran, J. D., & Eubanks-Carter, C. (2010). Developing therapist abilities to negotiate alliance ruptures. In J. C. Muran, & J. P. Barber (Eds.), The therapeutic alliance: An evidence-based guide to practice (pp. 320–340). New York, NY: Guilford Press.

Owen, J., Tao, K. W., Imel, Z. E., Wampold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology: Research and Practice*, *45*(4), 283–290. https://doi.org/10.1037/a0037420

Penner, L. A., Dovidio, J. F., West, T. V., Gaertner, S. L., Albrecht, T. L., Dailey, R. K., & Markova, T. (2009). Aversive racism and medical interactions with black patients: A field study. *Journal of Experimental Social Psychology*, *46*(2), 436–440. https://doi.org/10.1016/j.jesp.2009.11.004

Pitner, R., & Sakamoto, I. (2010). The role of critical consciousness in multicultural practice: Examining how its strength becomes its limitation. *American Journal of Orthopsychiatry*, *75*(4), 684–694. https://doi.org/10.1037/0002-9432.75.4.684

Ross, L. E., Doctor, F., Dimito, A., Kuehl, D., & Armstrong, M. S. (2007). Can talking about oppression reduce depression? Modified CBT group treatment for LGBT people with depression. *Journal of Gay & Lesbian Social Services*, *19*(1), 1–15. https://doi.org/10.1300/J041v19n01_01

Safran, J. D., & Kraus, J. (2014). Alliance ruptures, impasses, and enactments: A relational perspective. *Psychotherapy*, *51*(3), 381–387. https://doi.org/10,1037/a0036815

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York, NY: Guilford Press.

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2001). Repairing alliance ruptures. *Psychotherapy: Theory, Research, Practice, Training*, *38*(4), 406–412. https://doi.org/10.1037/0033-3204.38.4.406

Salter, P., & Adams, G. (2013). Toward a critical race psychology. *Social and Personality Psychology Compass*, *7*, 781–793. https://doi.org/10.1111/spc3.12068

Tatarsky, A., & Marlatt, G. A. (2010). State of the art in harm reduction psychotherapy: An emerging treatment for substance misuse. *Journal of Clinical Psychology*, *66*(2), 117–122. https://doi.org/10.1002/jclp.20672

Terrell, F., Taylor, J., Menzise, J., & Barrett, R. K. (2009). Cultural mistrust: A core component of African American consciousness. In H. A. Neville, B. M. Tynes, & S. O. Utsey (Eds.), *Handbook of African American Psychology* (pp. 299–309). Thousand Oaks, CA: Sage Publications, Inc.

Thompson, M. N., Chin, M. Y., & Kring, M. (2019). Examining mental health practitioners' perceptions of clients based on social class and sexual orientation. *Psychotherapy*, *56*(2), 217–228. https://doi.org/10.1037/pst0000222

Thompson, M. N., Cole, O. D., & Nitzarim, R. S. (2012). Recognizing social class in the psychotherapy relationship: A grounded theory exploration of low-income clients. *Journal of Counseling Psychology*, *59*(2), 208–221. https://doi.org/10.1037/a0027534

Trawalter, S., Richeson, J. A., & Shelton, J. N. (2009). Predicting behavior during interracial interactions: A stress and coping approach. *Personality and Social Psychology Review*, *13*(4), 243–268. https://doi.org/10.1177/1088868309345850

Tummala-Narra, P. (2018). Considering culture from a psychoanalytic perspective. In R. E. Barsness (Ed.), *Core competencies of relational psychoanalysis: A guide to practice, study, and research* (pp. 283–301). London: Routledge/Taylor & Francis Group.

Verhaeghen, P., & Alikman, S. N. (2019). How the mindfulness manifold relates to the five moral foundations, prejudice, and awareness of privilege. *Mindfulness*, *11*, 241–254. https://doi.org/10.1007/s12671-019-01243-2

Villalobos, J. (2015). Applying white followership in campus organizing: A leadership tool for Latinx students working for racial justice. In A. Lozano (Ed.), *Latina/o college student leadership: Emerging theory, promising practice.* Lexington Books.

Watkins, C. E., Jr., & Hook, J. N. (2016). On a culturally humble psychoanalytic supervision perspective: Creating the cultural third. *Psychoanalytic Psychology, 33*(3), 487–517. https://doi.org/10.1037/pap0000044

Yosso, T. J., & Solórzano, D. G. (2005). Conceptualizing a critical race theory in sociology. In M. Romero, & E. Margolis (Eds.), *The blackwell companion to social inequalities* (pp. 117–146). Oxford, UK: Blackwell Publishing.