Applied & Preventive Psychology 10:51–68 (2001). Cambridge University Press. Printed in the USA.

The working alliance and the transference/countertransference relationship: Their manifestation with racial/ethnic and sexual orientation minority clients and therapists

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Abstract

Theoretical propositions are offered about the interrelations of three key concepts in psychotherapy: specifically, the working alliance, on the one hand, and both transference and countertransference, on the other. The role these concepts play, including the interactions between them, is extended to the areas of race/ethnicity and sexual orientation. We examine working alliance, transference, and countertransference considerations for therapy dyads in which at least one of the participants is a member of a racial/ethnic or sexual orientation minority group. Our hope is that this theoretical examination will generate further research and theory development on working alliance, transference, and countertransference where cultural factors such as race/ethnicity and sexual orientation are implicated in the therapeutic relationship.

Key words: Countertransference, Culture, Race/Ethnicity, Sexual orientation, Transference, Working alliance

The concept of working alliance in psychotherapy has received much attention during the past decade, both theoretically and empirically. Originating from classical psychoanalysis (e.g., Greenson, 1967), this concept has been extrapolated to virtually all theoretical approaches to treatment. Bordin (1979) was probably the first to make such an extrapolation, and since his seminal article, the working alliance (also called helping alliance, therapeutic alliance, or simply alliance) has been arguably the most vigorously investigated construct in psychotherapy (Gelso & Hayes, 1998).

Like working alliance, the constructs of transference and countertransference are historically situated within psychoanalysis. Freud's earliest and most influential theoretical statements on transference occurred shortly after the turn of the 20th century (Freud, 1905/1953, 1912/1959b). Likewise, his brief but incisive conceptions of countertransference originated as part of his early statements about psychoanalysis (Freud, 1910/1959a). Only within about the past decade or so have there been efforts to generalize these two interrelated constructs to approaches other than psychoanalysis and to study them empirically (see review by Gelso & Hayes, 1998).

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Transference, for example, has been studied in both psychoanalytic treatments (Gelso, Hill, Mohr, Rochlen, & Zack, 1999; Luborsky & Barber, 1994; Patton, Kivlighan, & Multon, 1997) and nonanalytic treatments (Barber, Foltz, & Weinryb, 1998; Gelso, Kivlighan, Wine, Jones, & Friedman, 1997). Programmatic research has also emanated from social psychology, which has explored transference phenomena in interpersonal relationships outside of psychotherapy (see review by Andersen & Berk, 1998).

In recent years, the first author has developed a series of theoretical propositions about the operation of working alliance, transference, and countertransference beyond the confines of psychoanalysis, including propositions regarding the interrelations of these three constructs (Gelso & Carter, 1985, 1994; Gelso & Hayes, 1998). The present article is an extension of that work. A major purpose here is to extend the first author's theoretical statements about the patterns of reciprocal influence between the working alliance and the transference/countertransference configuration.

During the past decade or so, another body of literature in psychotherapy has been growing at a rapid pace. Coming under the umbrella of diversity and cultural topics, investigators have begun to examine how sociocultural constructs such as race/ethnicity and sexual orientation influence the therapy process (Helms & Cook, 1999; Pope-Davis & Cole-

man, 1997; Thompson & Carter, 1997). In this literature, central questions revolve around how therapy process and outcomes are affected by various racial and sexual orientation pairings of therapist and client in which at least one participant in the dyad is a member of a racial/ethnic or sexual orientation minority group. For example, what is the effect on process and outcome of having a White therapist and an African American client? A gay male therapist and a gay male client? An African American therapist and a Latina client? Within this body of literature, there is also a nascent interest in how the psychological qualities of therapist and client moderate the effects of racial and sexual orientation pairings. Constructs such as racial identity (Helms & Cook, 1999; Thompson & Carter, 1997) and gay and lesbian identity (Fassinger & Miller, 1996; McCarn & Fassinger, 1996; Mohr & Fassinger, 2000) exemplify these psychological qualities. Despite the recent attention to a range of diversity topics in general and to race/ethnicity and sexual orientation within the context of psychotherapy, little theoretical or empirical work has evolved regarding the development of working alliance and transference/countertransference in therapy dyads in which one or both participants are members of racial or sexual minority groups.

In the present article, we seek to bring together recent theoretical work on the therapy relationship with emergent thinking about psychotherapy involving racial/ethnic or sexual orientation minorities. We begin by extending Gelso and Carter's (1994) and Gelso and Hayes' (1998) conceptualization of how working alliance and transference/countertransference interrelate across diverse approaches to psychotherapy. Second, we examine how these interrelationships are expressed in the context of psychotherapy in which at least one participant is a member of a racial/ethnic or sexual orientation minority group. In doing so, we also consider the role of racial/ethnic and sexual orientation identity factors as moderators. An overarching aim is to analyze how broad sociocultural factors related to societal oppression get expressed in one way or another in the working alliance, the transference/countertransference configuration, and the interconnection between the two.

The Working Alliance and the Transference/Countertransference Configuration

Let us begin by offering working definitions of working alliance, transference, and countertransference. To do so, we provide a background summary of each construct: its history, current status, and empirical relationship to psychotherapy outcomes. As is perhaps true with all high-level constructs in the behavioral sciences, defining the three major constructs is no easy feat. Embedded in what seems to many to be the obscure and perhaps arcane language of psychoanalysis, clear (to say nothing about operational) definitions appear to be even more difficult to arrive at than is typical.

The Working Alliance

Although the roots of the concept of working alliance may be found in Freud's earliest writings (Freud, 1905/1953, 1913/1958) as well as in that of several other early analysts, it was Ralph Greenson (1965, 1967) who formally labeled and defined the construct and explored its central role in psychoanalysis. Outside of psychoanalysis proper, Bordin (1979) probably had the greatest influence in generalizing the working alliance concept so as to be meaningful in all forms of counseling and psychotherapy.

Drawing on the work of Greenson and Bordin, the first author has defined the working alliance as *the joining together of the reasonable self or ego of the client and the therapist's analyzing or "therapizing" self or ego for the purpose of the work* (Gelso & Carter, 1994; Gelso & Hayes, 1998). This definition relies on the psychoanalytic concept of the split ego (Sterba, 1934). The ego can be thought of as divided into two sides: an experiencing side and an observing side. The experiencing side allows the client to feel and experience; the observing side permits reasonable observation and understanding of that experience as well as of the external world. It is the latter—the reasonable side or ego—that is most implicated in the working alliance. This side fosters client and therapist joining together, despite internal forces that may operate against doing so (e.g., negative transference or countertransference), for the purpose of the work, which itself aims to help the client solve problems, gain insight, change behavior, etc. When the working alliance is sound, as Bordin (1979) noted, client and therapist tend to have a solid working bond. They also tend to agree on the goals of treatment as well as the tasks needed to accomplish those goals.

Although there are several different definitions and measures of what we call the working alliance, two elements seem to cut across all of these: collaboration and attachment. That is, the fundamental idea of the therapy participants collaborating in the process and forming a healthy attachment to one another seems to be present in virtually all conceptions and measures. Regarding the effects of the working alliance, a large body of empirical evidence points to the clear conclusion that the alliance has a significant positive impact on the outcomes of brief and longer term psychotherapy (Martin, Garske, & Davis, 2000). Particularly in brief therapy, the alliance that is formed within the first few sessions is predictive of outcome. (for a discussion of the particular ways in which alliance affects outcome, see Gelso & Hayes, 1998, pp. 34–35).

The Transference/Countertransference Configuration

Whereas there appears to be general agreement that the working alliance is a key relational factor in effective psychotherapy, the concepts of transference and countertransference remain controversial. Transference, in particular, may be one of the most controversial constructs in psychotherapy. Depending on one's theoretical orientation, it may be seen as a vital aspect of successful therapy, an irrel-

evant construct, or an artifact of the therapist's stance toward the patient. In all versions of psychoanalytic and psychodynamic treatments, transference is seen as a key concept. To other major theory clusters, such as humanistic-experiential or cognitive-behavioral, its importance ranges from modest to trivial. Within these general systems, there is often acknowledgment that transference occurs and occasionally needs to be dealt with; but it is rarely seen as central, and it usually does not need to be focused on directly.

Based on empirical studies, the first author theorized that transference occurs and is important in all forms of psychotherapy (Gelso & Carter, 1985, 1994; Gelso & Hayes, 1998) and suggested ways in which it operates in different treatments. Drawing on both classical (e.g., Greenson, 1967), interpersonal (e.g., Fromm-Reichmann, 1950), and postmodern intersubjective (Orange, Atwood, & Stolorow, 1997; Stolorow, 1998) theories, transference is defined as "the client's experience of the therapist that is shaped by the client's own psychological structures and past, and involves displacement, onto the therapist, of feelings, attitudes, and behaviors belonging rightfully in earlier significant relationships" (Gelso & Hayes, 1998, p. 51). Although the client's experience of the therapist is shaped by the client's structures and past, the therapist does contribute something to this experience (Gelso & Hayes, 1998). In this sense, no two therapists have exactly the same transferences from the same client; to a degree, all transferences are cocreated by therapist and client. At the same time, some core issues within the client become attached to any therapist who permits the transference to occur. In other words, as has been empirically documented, each client carries with him or her a very limited number (often one) of core conflictual relationship themes (Barber et al., 1998; Luborsky & Crits-Christoph, 1990; Luborsky, Popp, Luborsky, & Mark, 1994), and from these themes emanate the transferences to essentially any therapist with whom he or she works.

Regarding the effects of transference across therapies, there is some emerging but still very tentative evidence that transference has a positive effect when it is combined with insight on the client's part (Gelso, Hill, & Kivlighan, 1991; Gelso, Hill et al., 1999; Gelso, Kivlighan et al., 1997; Graff & Luborsky, 1977), and this effect seems to occur across different theoretical approaches to treatment. In the absence of client insight, however, transference (especially when it is negative) appears to have an adverse effect on outcomes. (It should be noted that, in virtually any conception of transference, reactions may be seen as existing on a continuum from positive to negative. At the midpoint in the continuum, some would conceive of transference as neutral with respect to valence.) We return to the effects of transference later in the article.

Regarding countertransference, although the term is a psychoanalytic one, it seems to us that there is a consensus that, at least in a general sense, the therapist's emotional reactions and issues are a significant consideration in any approach to treatment (Gelso & Hayes, 1998). The valuing of such relational factors has become notable even in therapies that were once decidedly nonrelationship oriented, such as the behavioral therapies (Cahill, Carrigan, & Evans, 1998). Despite the emerging agreement, it is important to understand that countertransference itself has been variously defined over the years. Gelso and Hayes (1998) delineated three fundamental definitions. The first (the classical psychoanalytic one) understands countertransference as the analyst's transference to the analysand's transference. This definition reflects Freud's belief that countertransference represented the analyst's inappropriate displacement of material from previous relationships onto the patient, and that it should be eliminated due to its likely pernicious effects on the analysis (Freud, 1910/1959a). The analyst's own personal psychoanalysis was seen as perhaps the best road to minimizing countertransference reactions.

A second conception of countertransference is often referred to as the totalistic definition. Here countertransference is seen as virtually all of the therapist's emotional reactions to the patient. Countertransference is viewed by totalists as inevitable and potentially useful if the therapist pays close attention to his or her inner workings in response to the patient. Through studying one's internal reactions, the therapist can gain insight to how the client affects others and how others react to the client. To many psychoanalytic therapists, the therapist's self-inspection of his or reactions can also yield understandings about the patients' early conflicts with transference sources (e.g., parents).

Criticisms of the classical definition revolve around its being too narrow. Similarly, complaints with the totalistic definition usually pertain to its being too encompassing. In an attempt to reconcile these definitional differences, we espouse an intermediate conception. Countertransference is defined as "the therapist's transference to the client's material, both transference and nontransference communications presented by the client" (Gelso & Carter, 1994, p. 297). In maintaining the view that countertransference represents the therapist's transference, this conception is narrower than the totalistic one. Countertransference is seen as rooted in the therapist's own unresolved conflicts and issues. Yet it may be a response to any material offered by the client, transference or otherwise.

Although the intermediate conception of countertransference locates this phenomenon in the therapist's unresolved issues (even while triggered by something in the client), countertransference is still seen as potentially invaluable if the therapist pays close attention to his or her inner workings and seeks to grasp how these relate to the client, the client's issues, and the client's enactments during treatment. Along with being potentially useful, countertransference has been viewed as inevitable and universal (Gelso & Carter, 1985, 1994; Gelso & Hayes, 1998). No matter how well analyzed a therapist may be, there will always be unresolved issues or what may be called "soft spots." These are often touched on

in the intimate and emotionally demanding experience of psychotherapy and require understanding and management. It is when the countertransference is not understood (i.e., the acted out countertransference) that it becomes pernicious. The understood countertransference can be extremely helpful.

It should be added that reactions that are not countertransference (e.g., realistic dislike of an abusive and arrogant patient where the therapist's feelings are not rooted in earlier conflict) are also important and need to be understood. We believe, however, that it is useful to differentiate these from countertransference, such that countertransference is seen as a phenomenon that is specific rather than representing any and all therapist reactions to the client.

In recent years, there have been increased efforts to study countertransference empirically (Gelso & Hayes, in press). Still, very few studies have attempted to link countertransference to outcome. In putting together the pieces of process studies that indirectly linked countertransference to outcome, Singer and Luborsky (1977, p. 449) concluded that "uncontrolled countertransference has an adverse effect on therapy outcome. Not only does it have a markedly detrimental influence on the therapist's techniques and interventions, but it also interferes with the optimal understanding of the patient." Hayes, Riker, and Ingram (1997) uncovered a direct link of countertransference to outcome, finding the expected adverse effect. Similarly, a recent study (Gelso, Latts, Gomez, & Fassinger, in press) revealed that therapists' ability to manage their countertransference resulted in more favorable therapy outcomes in a university counseling center.

The Interrelation of Working Alliance and Transference/Countertransference

What are the connections between working alliance, on the one hand, and both transference and countertransference, on the other? Are there salient patient, therapist, and treatment factors that moderate these connections? We begin with a general theoretical proposition about working alliance and transference, and then elaborate the more specific ways in which the two are interrelated.

Proposition 1: Working alliance and transference have a reciprocal impact on one another, with each influencing and being influenced by the other. If there is a foundational construct in psychotherapy, we propose that it is the working alliance. It is hard to imagine a therapeutic relationship in the absence of at least a "good enough alliance," and, as we have noted, considerable empirical evidence has accumulated to support the importance of the working alliance. Regarding the reciprocal relation of alliance and transference, let us first examine how transference affects the alliance and its formation. We look at this causal direction first because, in our view, transference precedes the formation of alliance in psychotherapy. That is, transference occurs from the first moment of contact between therapist and patient and even in fact prior to such contact in the form of preformed transferences. These transferences occur in response to the therapist of the patient's fantasies as the patient considers beginning treatment and in response to the initial phone contact.

Positive Transference and the Working Alliance

Early in treatment, positive transferences are very common, often in the form of projections onto the therapist of the wished-for good mother or good father that the patient never had and at times the all-good mother or father (as in idealizing transferences) (Kohut, 1977, 1984; for empirical support for positive transference early in therapy, see also, Gelso et al., 1997; Patton et al., 1997). Early positive transferences were referred to by Freud (1912/1959b) as "unobjectionable positive transferences." Freud suggested that they may aid the therapist in forming a sound initial working alliance. To the extent that they aid the work and are not intensely positive or eroticized, our observations suggest that such transferences are often not even seen as transferences, especially by nonanalytic therapists, who by definition are not on the lookout for signs of transference.

Although positive transference can be an aid to the working alliance, transference may be seen as an untrustworthy ally or what Greenson (1967) referred to as a treacherous ally. In fact, we would consider working alliances that are built solely on a foundation of transference to be pseudo-alliances. The problem with working alliances that are based on transference alone is that transferences can dissipate; in fact, they do tend to dissipate in the course of therapy, whether the treatment is brief or long-term therapy and whether it is psychoanalytic or theoretically heterogeneous (see studies by Gelso et al., 1997; Graff & Luborsky, 1977; Patton et al., 1997). When transference dissipates, a working alliance based on transference also tends to erode. The following case vignette exemplifies an eroding working alliance that was solely based on transference.

> The client was a 27-year-old doctoral student in English literature. She experienced debilitating anxiety around work and interpersonal issues and was described early in treatment as a "deeply frightened woman, frightened of her aggressive impulses, frightened of deep dependency issues, and frightened of what may be a very shaky cohesiveness." After an initial series of sessions, her therapist, an experienced psychoanalytic therapist, noted that due to her fears "she uses every defense imaginable to discount and minimize her therapist." He went on to note, however, that she did have some insight into this pattern, and that at least a part of her "clicked" with the therapist. He noted a beginning working alliance, but said that perhaps the clicking was coming out of "some transference basis that he would pay for later in the work." As work progressed it became apparent that the client imbued the therapist with magical powers, while at the same time being disappointed that he would not solve her problems. The positive transference gradually eroded as the client's issues around primitive dependency emerged, along with a belief that no one could ever provide her with the safe haven she des-

perately needed but never experienced. Because no genuine working alliance had formed, apart from that based in the positive transference, the work ended with the client feeling unhelped after a year of treatment in what at that time was her fourth attempt at therapy.

In this example, what seemed like a working alliance really was a transference (again, pseudo-alliance seems apt), and when the "magical transference" eroded nothing positive was left in the overall therapeutic relationship. On the other hand, we would maintain that a strong working alliance, one based on realistic rather than transference perceptions of the therapist, can be spurred on by positive transference. The dissipation of transference, then, would not destroy the therapeutic relationship because the alliance would already have been solidified by a realistic connection between therapist and client.

Negative Transference and the Working Alliance

Just as positive transferences can aid the working alliance, early negative transference can not only threaten the alliance, but also bring the therapy to an unsuccessful ending. The client's negative perceptions of and feelings toward the therapist, which are the defining features of negative transference, can infect the working alliance, to use a medical analogy, and the disease can be fatal. The deleterious effects of early negative transferences are especially notable under certain conditions. First, when the therapy is time-limited and/or brief, there is often too little time for such distortions to be resolved. This became clear to the first author in his empirical study of time-limited therapy (eight-session limit) at a university counseling center. Semistructured interviews with a small number of clients whose therapy outcomes were especially positive revealed that a positive early relationship, marked by the near absence of negative transference, was a striking characteristic of these clients' reactions to their therapists (Adelstein, Gelso, Haws, Reed, & Spiegel, 1983). Moreover, in a series of studies comparing time-limited versus unlimited counseling, the ability to form a positive relationship very early in the work appeared to be a key factor in successful outcome in time-limited treatment (Gelso & Johnson, 1983). In contrast, a retrospective study of successful long-term cases suggested that the early stages of treatment were just as likely to feature negative transferences as positive transferences (Gelso et al., 1999).

A second condition under which the adverse effects of negative transference are especially notable occurs when the therapist is unable to recognize that the patient's reactions are from another time and place. Although the concept of transference emanates from psychoanalytic theory and is most prominently addressed in that theoretical approach, and although it is overwhelmingly clear that effective therapy can and does occur in the absence of direction attention to transference by the therapist (Lambert & Bergin, 1994), we maintain that there are times when transference must be dealt with if therapy is to be effective. Perhaps the most important time is when there is strongly negative transference in the initial stage of treatment. If the patient is not aided in understanding the source of these negative reactions and does not come to see that such reactions are not fitting of the therapist, it is hard to see how the work can proceed effectively. When there are such negative transferences, we believe that the therapist, at a minimum, needs to work at understanding and helping the patient understand where he or she is coming from. Something in the therapist may well have triggered the reaction, and that needs to be empathically understood and owned; but the core of the negative reaction must be understood as belonging more fittingly in an earlier time and place in the patient's life. In sum, our proposition is that early negative transference, especially when it is intense, needs to be understood as such if the therapy is to move forward and succeed. If the client does not come to understand the transference on his or her own, in the context of an empathic ambience, then it behooves the therapist to make interventions that aim at fostering such understanding (e.g., interpretations). If such negative transference is not understood early on (e.g., in brief therapy) and erodes the working alliance, there is evidence to indicate that transference interpretations in the later part of treatment not only do not help, but also may lead to the premature termination of treatment (Piper et al., 1999).

The need to examine initial and intense negative transference is illustrated in the following case vignette.

Within minutes of the initial greeting between therapist and patient, the patient, a woman in her mid-20s, began to verbally attack the therapist, indicating that she had a sense that the therapist (also a female) was cold and mean. The patient saw this in the therapist's eyes. When asked what the therapist's eyes reminded her of, the patient revealed that they looked strikingly like the eyes of the patient's mother. An exploration of the patient's experience of the mother's coldness ensued Although negative transference reactions naturally were not eliminated, the exploration of the basis for the patient's initial reactions helped solidify the beginning alliance and prevent intense negative transference from poisoning the therapeutic relationship.

It should be added that often the patient's transference creates affects in the therapist that serve to confirm the patient's feelings and perceptions. As an example, the patient who feels the therapist harbors underling negative feelings for him or her that may very subtly behave in a way during the hour (e.g., respond in a passively critical manner) to stir up negative affects in the therapist. In such an instance, the initial perceptions are still transference-based, but the therapist's reactions (reality-based and/or countertransference-based) hook into the transference. We suggest that in such instances the therapist generally should acknowledge his or her affective reaction and then help the patient explore where the patient was coming from, how he or she served to stir up that reaction in the therapist, and how this relates to early and present patterns in the patient's life.

We have already implied the third condition under which

the adverse effects of early negative transference are especially notable. Let us now be explicit. The adverse effects of negative transference are especially realized when the patient lacks insight into the transference and its source. In fact, patient insight has been found to be a critical moderator of the effects of transference, negative and otherwise (Gelso et al., 1991; Gelso et al., 1997; Gelso et al., 1999; Graff & Luborsky, 1977). This transference × patient insight interaction effect has been found to occur in both analytic and nonanalytic treatments. In fact, it appears that, when the patient has good insight, the effects of negative transference on the outcome of a given hour or the therapy as a whole are quite positive. However, when there is negative transference and poor insight, the effects are especially negative.

So far, we have focused on the effects of transference on working alliance and have begun to address a related topic: the effects of transference resolution on the alliance. As the displacements and distortions of transference, especially negative transference, become worked through and resolved, the patient takes a step toward appreciating and taking in what the therapist is in fact providing and feeling. When this occurs, the working bond between patient and therapist becomes strengthened.

The Impact of Working Alliance on Transference

As part of the reciprocal relationship of transference and alliance, the working alliance significantly influences and alters the transference. We suggest that there are two primary means through which this effect occurs. First, the working alliance facilitates the emergence of transference-based affects and perceptions both into consciousness and into verbal expression in the treatment hour. This effect of the alliance was evidenced most clearly in our qualitative study of the factors mediating the resolution of transference in successful, long-term psychodynamic therapy (Gelso et al., 1999). Virtually all of the 11 therapists we studied pointed to the working alliance as being crucial to allowing otherwise too-threatening affects into consciousness and into the patient's verbal expression, as well as to sustaining the therapy relationship through the stresses and strains that often occur when working with transference. Similarly, a quantitative study of time-limited psychoanalytic psychotherapy indicated that increases in the therapeutic alliance preceded patient's expression of transference (Patton et al., 1997). (It is worth noting that this study provided no evidence that changes in the alliance led to changes in transference levels.) In short, in the language of attachment theory (e.g., Bowlby, 1979), solid working alliances and real relationships seemed to provide the client with a safe haven and a secure base—a place from which to venture out (or perhaps, more aptly, to venture in) to explore otherwise too threatening feelings.

Just as alliance fosters the emergence of transference into the hour, so does it foster the resolution of transference. This was a central findings of the aforementioned qualitative study (Gelso et al., 1999). Thus, the stronger the working alliance is between therapist and patient, the more likely it is that the patient will recognize transference displacements as such. And such recognition is always the key to the resolution of the transferences.

Proposition 2: The working alliance and the countertransference also have a reciprocal impact, with each influencing and being influenced by the other. Just as the working alliance fosters the experience and expression of transference (positive and negative) in a way that diminishes its potentially harmful effects on the therapy relationship, so too does it modulate the effects of countertransference. Let us examine the reciprocal impact of working alliance and countertransference that we have hypothesized.

The Effects of Alliance on Countertransference

Although it is not generally acknowledged, we believe that therapists do more effective work when they, just like the patient, experience a sense of safety in the therapeutic relationship. Also just as for the patient, the agreements and bonds that occur within the working alliance tend to foster such a sense of safety. In terms of the effects on countertransference, the therapist's experiencing safety in the relationship diminishes the extent to which unresolved conflicts are triggered and, in particular, the extent to which such conflicts are acted out in the hour. By acting out countertransference we mean simply the therapist's direct or indirect expression in the treatment hour of his or her own unresolved issues. Such expression may reflect numerous contents (e.g., aggressive remarks, exaggerated friendliness, seductive warmth) and forms (e.g, nonverbal expression, allusion, volume of speech). By the same token, the sound alliance and the sense of safety implicit in a good alliance foster an ease of expression in the therapist that is very different from acted out countertransference. Such expression does not contain the anxiety elements that we maintain are evident in virtually all instances of acted out countertransference, perhaps because it is relatively free of the therapist's emotional issues and conflicts.

It is probably easier to demonstrate the effects of alliance on countertransference that we have been discussing by a negative example. Consider the situation in which there is a poor working alliance. Although countertransference issues surely contribute to the formation of a poor alliance, we suggest that the poor alliance itself tends to stimulate major countertransference difficulties. This effect can be often observed in psychotherapy supervision, when working with inexperienced therapists. The next case vignette demonstrates such an effect.

> The therapist, a 27-year-old doctoral student in counseling psychology with considerable experience for her training level, was conducting therapy through a practicum in psychoanalytically oriented therapy. By all counts, she displayed considerable overall effectiveness, and was highly self-aware. However, in working with a client (20-year-old male) who avoided close emotional contact and had difficulty owning his problems, she was not able to develop a working bond, and they could not reach agreement on

> goals and tasks of treatment. Given this lack, the therapist felt anxious during the hour and handled the anxiety by vacillating between excessive sympathy and cool detachment, which itself made alliance formation difficult. The anxiety was rooted in more general fears of being insufficient, as was her way of handling the anxiety.

In this example, one can clearly see the reciprocal influence of alliance and countertransference. The lack of safety due to a poor alliance formation and the effects of this lack are also evident.

In addition to fostering a sense of safety in the therapist, the good working alliance allows the overall relationship to survive countertransference problems. Despite the fact that the alliance fosters a sense of safety and diminishes countertransference acting out, there is an extent to which countertransference is universal. The intimate exploration of another person's conflicts, in the context of a relationship that seeks to provide emotional help, is bound to touch on the therapist's personal and unresolved conflicts. This cannot *not* happen. What we can hope for is that such conflicts are grasped by the therapist and are not acted our during the hour. And yet here too there is bound to be a certain amount of seepage, wherein the therapist's issues emerge into the treatment. When the alliance is solid, however, not only is this seepage kept to a minimum, but also its potentially deleterious effects are minimized. In other words, because of the working alliance, the overall relationship can survive some degree of countertransference acting out, provided that such acting out is not too intense or extensive. Consider the following vignette from the first author's casework (see Gelso & Hayes, 1998, p. 144).

> The patient (a 35-year-old woman) and the therapist had worked together twice a week for 2 years in analytically oriented therapy. It was clear that they had developed a sound working alliance. However, during one phase of the work, each time the client discussed her difficulties with her children, the therapist seemed to respond unempathically, often offering unneeded suggestions and at times appearing even critical. The patient perceived the therapist's expressions realistically and responded with realistic hurt and frustration. She expressed these feelings to the therapist, along with her impressions of his reaction during one session, and the therapist became aware that, in fact, his conflicts surrounding his own parenting, as well as earlier issues with the parenting he received, were impeding the empathic process with this patient. Once the countertransference issues were grasped, the therapist was able to regain his empathic stance during the client's exploration of her parenting.

Here, the sound working alliance allowed the relationship to withstand the therapist's acting out of countertransference. Indeed, it permitted the patient openly to express her concerns about the therapist's behavior and to cue the therapist that something was amiss. Of course, this positive effect of alliance on countertransference assumes that the therapist gains an understanding of the countertransference issues. To do so, the therapist must appreciate the importance of self-reflection, countertransference, and what we believe to be the vital importance of dealing with one's countertransference issues.

The Management of Countertransference

The preceding example leads us to our final suggestion about the connection of working alliance to countertransference. That is, if countertransference is not understood by the therapist or effectively managed in one way or another, it is likely to impede the formation of working alliance and erode an existing alliance. Ununderstood or unmanaged countertransference can produce irreparable ruptures in the alliance. In so affecting the alliance, unmanaged countertransference indirectly produces negative therapy outcomes. (In the path analytic sense, we have a direct effect of countertransference on outcome and an indirect effect in that countertransference affects outcome through its effects on alliance.) Although research bearing on these assertions is almost nonexistent, one recent study (Ligiero & Gelso, 2001) did discover that greater amounts of both positive and negative countertransference were related to poorer working alliances in brief therapy.

The first author and his collaborators have been involved in theoretical and empirical work on the topic of countertransference management. Theoretically, it has been proposed (Gelso & Hayes, 1998; Van Wagoner, Gelso, Hayes, & Diemer, 1991) that countertransference management relies on, and in certain ways is composed of, five factors or constituents: self-insight, empathy, self-integration, anxiety management, and conceptual ability. Briefly, self-insight refers to therapists' ability and willingness to look inward and understand themselves and their issues as they relate to the therapeutic relationship; empathy reflects the capacity to identify partially with the client (i.e., to climb into the patient's shoes and experience the world, to an extent, as the patient does, both in a cognitive and an affective sense); self-integration indicates the capacity to be separate from the patient, to understand where the therapist stops and the patient starts, without being distant from the patient; anxiety management relates to the therapist's ability to deal effectively with anxiety in the treatment hour (it does not imply an absence of anxiety); and conceptualizing ability refers to the conceptual understanding of the dynamics of the relationship and how the patient's and therapist's feelings and issues inform those dynamics. It should be noted that these five factors have been conceptualized to have trait-like qualities in that they are a part of the therapist and tend to be exhibited across patients. At the same time, it also true that these factors will vary to an extent from client to client and in this sense may be construed as states as well as traits.

In a series of empirical studies (done in both the laboratory and the field), each of these five factors, separately and

combined, has been found to be related to treatment process (Friedman & Gelso, 2000; Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1991, 1993; Hayes, McCracken, McClanahan, Hill, Harp, & Carozzoni, 1998; Latts & Gelso, 1995; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Sharkin & Gelso, 1993) and to treatment outcome (Gelso et al., in press; Hayes et al., 1997; Rhodes, Hill, Thompson, & Elliott, 1994). Interestingly, these five factors, in combination, have been found to relate negatively to the expression of countertransference behavior in a given hour or what we have been referring to as the acting out of countertransference (Friedman & Gelso, 2000).

We now shift our attention to how working alliance and transference/countertransference are experienced and expressed in treatment dyads in which one or both participants are members of a racial/ethnic or sexual orientation minority group. Here we are mapping new territory. There is a paucity of theoretical work on this topic, and we are aware of few empirical investigations directly pertinent to our focus.

The Working Alliance and the Transference/Countertransference Configuration in Cultural Pairings

In developing our thinking about how working alliance and transference/countertransference are moderated by racial/ethnic and sexual orientation factors, we were sharply aware of our own status as nonminority males. Despite the fact that we have worked with racial/ethnic minority patients and have conducted research on diversity related topics (e.g., Miville et al., 1999; Fuertes & Gelso, 2000; Mohr & Rochlen, 1999), we felt that it would be profitable to explore the topic with recognized experts in the area of race/ethnicity and the psychotherapy relationship. With this in mind, we conducted semistructured telephone interviews of approximately 1 hour in duration with Donelda Cook, Cheryl Thompson, and Peggy Rios. Each of these psychologists is known to be an expert in the area of race and ethnicity, and each has been involved in research, theory, and training related to issues of race and ethnicity in psychotherapy (see, e.g., Helms & Cook, 1999; Rios, Corbett, Pannu, Kanitz, & Miville, 1998; Thompson, 1995). We believed that interviewing a recognized expert on the topic of sexual orientation and the therapy relationship would also be helpful, although we have also had experience in working with gay, lesbian, and bisexual patients and one of us identifies as a gay man. We thus conducted a 1-hour semistructured phone interview with Jack Drescher (see Drescher, 1998).

Several questions were mailed to the experts in advance of the phone session, with the suggestion that they reflect on them prior to the interview. These questions were as follows.

1. In what ways does race, ethnicity, and sexual orientation play a role in the development of transference, development of working alliance, and interplay between transference and alliance?
2. How do the dynamics related to transference and alliance differ in your work with clients of different races, ethnicities, and sexual orientations?
3. How might these dynamics differ for therapists who are different from you in race, ethnicity, or sexual orientations?
4. Describe one or more cases that help to elucidate the ways in which race, ethnicity, and sexual orientation affect the interplay between transference and alliance or the development of transference and alliance.

As we began our theoretical exploration, we were certain that the relationships of alliance to transference/countertransference, as postulated earlier in this article, would be influenced and altered by race, ethnicity, and sexual orientation. And yet in no way were we or the experts able to articulate such a moderating effect. Thus, we offer a proposition that we fully expect to be controversial. We offer this proposition with the knowledge that it requires further theoretical and empirical exploration, and we welcome such exploration.

Proposition 3: The interrelations that we have proposed between the working alliance and the transference configuration are fully generalizable to all patient–therapist pairings, including those in which at least one participant is a member of a racial/ethnic or sexual orientation minority group. Whereas we do not believe that racial/ethnic or sexual orientation minority (RSM) status moderates the relations of working alliance and transference/countertransference, we do propose that RSM status does itself influence the development of both working alliance and transference/countertransference. Indeed, writers have noted the importance of attending to RSM status in understanding the dynamics related to these components of the therapy relationship (e.g., Chin, Liem, Ham, & Hong, 1993; La Roche, 1999; Morrow, 2000). Thus:

Proposition 4: The particular pairings representing RSM status influence the specific ways in which working alliance, transference, and countertransference emerge and unfold in all forms of psychotherapy. Before exploring the ways in which RSM status enters these aspects of the therapy relationship, some clarification of terms is necessary. The concepts of transference and countertransference take on added meanings when race, ethnicity, and sexual orientation enter into the relationship. We examine these added meanings in the text that follows. Our conceptions are part of a nascent body of theoretical and clinical literature that explores how transference and countertransference are affected by such cultural factors (e.g., Comas-Diaz & Jacobsen, 1995; Lijtmaer, 2000; Napoli, 1999; Tang & Gardner, 1999). It should be noted, however, that the concept and definition of the working alliance appear to us to be essentially the same whether or not RSM status is part of the equation. At the same time, the issues involved in forming the alliance, as well as impediments to the alliance, may be quite different.

So that we may clarify how traditional conceptions of transference and countertransference are altered when RSM status becomes part of the process, it may be worth reiterating our earlier definitions of these two constructs. Following Gelso and Hayes (1998), we defined transference as the client's experience of the therapist that is shaped by the client's own psychological structures and past and that involves displacement onto the therapist of feelings, attitudes, and behaviors belonging rightfully in earlier significant relationships. Along the same lines, we defined countertransference as the therapist's transference to the client's material, both transference and nontransference communications presented by the client. These definitions have essentially nothing to do with culture (the umbrella term we use for race, ethnicity, and sexual orientation, the complexities of "culture" notwithstanding) (see Phinney, 1996). At the same time, cultural factors certainly may enter into transference and countertransference as so defined. Such cultural factors provide some of the content of transference and countertransference reactions, and they continually shape these reactions.

When cultural factors become a part of the transference and/or countertransference, however, these definitions are insufficient. Two additional conceptions of transference and countertransference appear to us to be central, perhaps vital. The first conception is referred to as cultural transference and countertransference. We define cultural transference as the culture-related distortions of or rigid interpersonal behaviors in response to the therapist that are rooted in the patient's experiences, direct or vicarious, with members of the therapist's RSM group. Likewise, countertransference may be seen as the therapist's culture-related distortions of the patient or rigid interpersonal behaviors rooted in his or her direct or vicarious experiences with members of the patient's RSM group.

To understand the concept of cultural transference (and countertransference), it is important to discuss a characteristic of all transference reactions. Because of their roots in conflict and trauma, transferences have a quality of tenacity—they are not easily given up. Thus, transference and countertransference reactions are more than simple misperceptions of or incorrect generalizations about the therapist based on figures in the patient's past. If this were the case, they could be readily corrected. Instead, transference represents misperceptions that resist correction in the face of disconfirming evidence, and these may be changed only gradually. Transferences are thought to be maintained in the face of contrary data because they protect the patient's self-esteem, avoid anxiety, and provide a way of experiencing others that is familiar and predictable for the patient (for a discussion of the bases for this tenacity, see Gelso & Hayes, 1998). Following this line of thinking, cultural transferences, like transferences that are not culturally based, are maintained with tenacity and need to be treated with the same sensitivity and understanding as noncultural transferences.

This concept of cultural transference has crept into the psychotherapy literature in recent years, as an increasing number of theoreticians have concerned themselves with cultural issues in psychotherapy. For example, Helms and Cook (1999) offered the following observation.

> In addition to avoiding the imposition of her or his racial or cultural biases on the client, the therapist must always be aware of herself or himself as a potential transference symbol for the client. After all, based on the therapist's appearance, the client will decide to which racial group the therapist belongs. More than likely, the client will also make assumptions about other characteristics of the therapist (including socioeconomic status, racial attitudes, cultural traditions) based on the therapist's "racial" appearance. . . . Therefore, the therapist should not ignore the client's perceptions of the therapist's race and culture as aspects of the transferential relationship. It may be difficult for the client to develop transference related to parents (however "parents" are defined) if racial transference develops as an overriding concern. Under such circumstances, the therapist may come to symbolize whatever past traumatic experiences or socialization—personal or vicarious—that the client or the client's salient identity groups have had with members of the therapist's racial or cultural group(s). *Sometimes it is necessary to work through this racial-cultural transference before the more mundane issue of parental transference can even be expected to occur.* (pp. 137–138; emphasis added)

Although we do not see the issue of parental transference as"mundane" or more mundane than cultural transferences, we do share Helms and Cook's (1999) conception that cultural transferences (and countertransferences) need to be carefully attended to, and that they often must be addressed before noncultural transferences, especially if these cultural transferences are negative. We suspect that a significant proportion of the drop-out rate that has been pointed to repeatedly in cross-cultural therapy dyads occurs because cultural transference is ignored or simply not noticed (see the discussion by LaRoche, 1999).

Helms and Cook (1999) were addressing a specific version of cultural transference when they saw the therapist as symbolizing past traumatic experiences or socialization that the client or the client's identity group had encountered with the therapist's identity group. What they pointed out is a negative transference that specifically derives from the patient's expectations of the therapist, based on the therapist's cultural group. The experience of oppression seems key in their definition (e.g., their focus on cultural traumatization). Similarly, transference for LaRoche (1999) is not simply a repetition of the patient's relationship with parental figures; transference reactions are also about "the various sociocultural meanings regarding therapist's authority and assumed group membership" (p. 391). However, cultural transferences may be negative or positive, and although they may reflect traumatization by the therapist's identity group, they may also

represent a wide range of projections onto the therapist. For example, as LaRoche noted, "Latinos have favorable opinions of Americans and expect much from psychotherapy. These cultural expectations need to be explored and addressed as soon as possible in order to prevent disappointment" (p. 391).

It is important to recognize that cultural transferences also occur when the patient is a member of the majority group and the therapist is a member of a minority group. Cultural transferential experiences of fear, disdain, superiority, and comfort may occur when the patient is White and the therapist is Black. Thompson (July 2000, personal communication), for example, notes that some White patients of Black therapists persist in treatment because these patient's feel like they are the "colored person" in their families of origin. Thus, they identify with the therapist's outsider status and feel as though they are with a therapist who can understand them. The Black therapist may be experienced as safe and caring as part of such a transference, but they may also be experienced as the devalued "servant." When gender is added to the racial/ethnic mix, complex gender × race interactions are likely. For example, the White male patient may project racial aggression onto the Black male therapist, but may transferentially experience the Black female therapist as a nurturing "nanny."

The examples provided by Thompson lead to the second conception of transference and countertransference that appears central when RSM members are involved in treatment. This second conception is referred to as culturally reinforced transference and countertransference. These transferences are similar to cultural transferences, but they have a deeply significant additional feature: they are rooted in early childhood experience. We define these transferences as culture-related distortions of or rigid interpersonal behaviors in response to the therapist that are connected to and partly stemming from unresolved conflicts early in the patient's life with significant others. (The definition of countertransference is parallel to this, with the only difference being that it is a feature of the therapist rather than the patient.) In such transferences, the cultural component is fueled partly by the earlier roots and partly by cultural phenomena. In this way, the culturally reinforced transference is a combination of cultural and noncultural transference. An example of culturally reinforced transference would be the Black male patient who fears that his White male therapist will try to make him subservient in their relationship, as White people historically have done with Black people; this patient projects these impulses onto his therapist. The tendency to experience the therapist as diminishing (the cultural aspect of the transference) is fueled by the patient's early and ongoing experience with his father, an anxious man who, out of his own insecurity, diminished each of his four children, fearing that they would surpass him in their achievements. Another example is the following case treated by the first author.

> The client was a 28-year-old gay male who happened to come from the same small town as the therapist, a town whose inhabitants tended to have very conservative attitudes toward sexuality and most other political issues. The therapist was an experienced psychodynamically oriented practitioner who was male and heterosexual. The patient harbored a fear that the therapist, as a heterosexual male, was contemptuous of the patient, partly for his sexual orientation (cultural transference). As part of this projection, the patient feared and felt that the therapist was critical of him for not being effective at mechanical things (e.g., repairing his car, fixing broken faucets). In fact, the therapist himself was not mechanical and was comfortable with this fact. The patient's father, however, was a plumber by trade and was abusively critical of his children for all of their "shortcomings" including their not being handy around the house (noncultural transference). Thus, the cultural transference around conventional masculinity was fueled by more primitive issues revolving around the patient's relationship with an abusive father.

Because culturally reinforced transference is rooted in the patient's direct and vicarious cultural experience as well as in unresolved issues (e.g., with primary caretakers), we believe them to be among the most complex and difficult transferences for the patient to understand and work through. The basis for the projections may be seen as double-barreled.

We have been discussing three kinds of transference: cultural, culturally reinforced, and noncultural. A word should be added about so-called noncultural transferences. Surely cultural factors enter into all transferences and countertransferences. From our perspective, cultural factors cannot *not* come into play. And yet cultural factors revolving around race/ethnicity and sexual orientation are not fundamentally important in all transferences, even though all humans are partly cultural beings. From our perspective, noncultural transferences are fueled mostly by individuals' unique histories of interactions with significant others rather than by their contact with shared cultural realities.

It should also be noted that there is a fourth category with respect to the therapeutic relationship and the participants' reactions to one another: nontransference. Not all client perceptions, to say nothing about therapist perceptions, are transferential. Using the patient as an example, much of the patient's experience and perceptions of the therapist are rooted in reality, and it is important that this be understood and acknowledged. Furthermore, even transferential reactions nearly always have a realistic element and in this sense are coconstructed by therapist and client. Because of this coconstruction, it is helpful for the therapist to consider his or her contribution to the transference. Doing so provides the patient with validation, while at the same time fostering the discovery of how the patient reenacts his or her issues in the transference. In any event, it is especially important that the therapist maintain a high level of self-awareness during cross-cultural therapy. As therapists, we are surely not immune to culturally based distortions (cultural countertransferences); in fact, we suspect that the intimacy and intensity

Table 1. *A 2 × 2 Categorization of Transferences Based on Cultural and Familial Causal Factors*

	Familial factors	
	Present	Absent
Cultural Factors		
Present	Culturally Reinforced Transference	Cultural Transference
Absent	Noncultural Transference	Nontransference

of the therapeutic relationship pulls for cultural countertransferences. So it behooves the culturally sensitive therapist to stay open and curious about whether his or her patient's reactions represent cultural or culturally reinforced transference projections or whether they are realistic and accurate perceptions of the therapist, picking up on subtle aspects of the therapist's unconscious cultural prejudices, idealizations, and other unresolved issues.

Table 1 presents the transferences we have been discussing. As can be seen, a 2 × 2 categorization is possible based on the presence or absence of cultural or familial factors as fundamental causal agents. The result is the four clusters we have explored: cultural transference, culturally reinforced transference, noncultural transference, and nontransference.

We have discussed the four clusters as if they represented nominal categories. This has been for the sake of convenience and communication. From a scientific perspective, however, it may be more useful to think of two dimensions: a cultural and a noncultural dimension. Thus, to one degree or another, transference and countertransference may be seen as residing on these two dimensions. Such an ordinal system permits scientific measurement and analysis and may better represent the "true" state of the world as regards these phenomena.

Let us now explore working alliance, transference, and countertransference in psychotherapy dyads in which one or more participant is a member of an RSM group. We begin by examining the working alliance and how it is affected by RSM factors. Note that in the following discussion we incorporate the comments of the experts we interviewed. When we do so, their comments are cited as personal communications.

The Working Alliance, Race/Ethnicity, and Sexual Orientation

Based on clinical experience as well as research findings over many years about how racial pairings influence therapy process and outcomes (see, e.g., reviews by Coleman, Wampold, & Casili, 1995; Sue, Zane, & Young, 1994), one can readily offer the following general proposition.

Proposition 5: Perceived RSM similarity aids the initial formation of a strong working alliance, whereas RSM dissimilarity makes initial alliance development more complex and difficult. Note that the focus here is on perceived rather than actual similarity. It should also be noted that there are many instances in which actual or perceived similarity is either irrelevant or even detrimental to the formation of working alliance. We have more to say about these situations subsequently.

Regarding the benefits of similarity, Cook (personal communication, June 2000) cites a Black blues saxophonist who commented to his appreciative Black listeners that he experienced an "abundance of understanding" from them. To Cook, this is an apt metaphor for working alliance formation when participants from the same RSM group form the therapeutic dyad. In other words, an immediate alliance may be formed in which the client expects to be understood, and the therapist is especially ready to understand. We suspect that this early alliance formation (or this expectation and readiness for an abundance of understanding) occurs more broadly when members of sociocultural groups that have been the recipients of severe societal oppression form the therapeutic dyad.

On the other side of the ledger, when the members of the dyad are of different races or sexual orientations, the working alliance may take special efforts to cultivate. This is especially the case when one participant is a majority group member and the other is a minority group member (for both race/ethnicity and sexual orientation). This is so because the initial cultural and culturally reinforced transferences are likely to be negative, revolving around fear and an expectation of nonunderstanding. We have more to say about such transferences in the text that follows, but suffice it to say that such transferences create an initial stumbling block for healthy alliance formation. It should be noted that initial cultural and culturally reinforced countertransferences are often also at work and serve as impediments to sound alliance formation. The possibility (perhaps likelihood) of cultural countertransferences points to the fact that not all cultural expectations are transferential. At times (some would say usually), the client's negative expectations of the therapist is on target. The therapist does, in fact, harbor conscious or unconscious conflicts around race and/or sexual orientation.

Although the initial alliance formation is likely to be positive when therapy participants are of the same race or sexual orientation, a word of caution is in order. Rios (personal communication, July 2000) suggests that a superficial alliance based on race/ethnicity similarity can jeopardize the working through of transference issues. This superficial alliance may also be thought of as a premature alliance or even a pseudo-alliance. In such cases, the therapist seeks to cultivate an alliance too quickly based on race/ethnicity (or sexual orientation, we would add). Rios provides a case example that clearly illuminates this issue.

> The client was a adolescent Black male. The therapist was Latina who appeared White. The client presented himself as very angry and was quite challenging and questioning of the therapist in their initial meeting. Thus, he entered

therapy with a psychological base of anger that likely had components related to race and gender. The therapist "corrected" the client's assumption that the therapist couldn't understand his experience as a person of color by telling him that she herself was a Person of Color. She did this because of her countertransference-based need to diffuse the client's anger; but, in doing so, she lost an opportunity to explore affectively his fears about surviving in a White world. Rather than acting out her countertransference in this way, the therapist wished she had built an alliance with the client to the point where he could have really dealt in a deep way with his racial issues. Instead she went for a "quick fix" for the strain in the alliance by "coming out" as Latina.

Rios also notes that, had the therapist been White, her defensive reaction to the client's challenge may have been on the order of "Yes, I could never really understand your experience because People of Color have such a hard time of it." In other words, the therapist's cultural countertransference would likely have been around racial guilt. In these examples, the therapist's fear of potentially alliance-damaging transference created a countertransference reaction that, in turn, sought to create a quick alliance. Such premature alliances, in keeping with Rios' observations, are unlikely to be sound and stable.

Within-Group Factors in Alliance Formation

The hypothesis offered in the last section may be termed the demographic similarity hypothesis. To our mind, both clinical experience and empirical evidence support this hypothesis. However, we do not believe this main effect hypothesis goes far enough, and in certain instances it may, in fact, be misleading. There are two reasons for our belief in the insufficiency of the demographic similarity hypothesis. First, in its focus on demographics, the hypothesis does not address the underlying psychological factors that more directly affect alliance. For example, in cross-racial therapy dyads, within-client and within-therapist constructs, such as racial trust–mistrust (Terrell & Terrell, 1984; Thompson, Worthington, & Atkinson, 1994) and perceived attitude and value similarity (Atkinson & Lowe, 1995), have been empirically demonstrated to affect preferences for therapist. In fact, in a series of laboratory analogues, Atkinson and his collaborators (see Atkinson & Lowe, 1995) demonstrated that most racial/ethnic minority participants rank factors such as attitude, value, and personality similarity as more important in determining their preferences for a counselor than they do racial similarity.

The empirically supported importance of internal, psychological processes (e.g., racial attitudes and values) within the client and therapist in RSM dyads hints at the second reason why the demographic similarity hypothesis does not go far enough. That is, these within-group factors are likely to moderate the effects of RSM pairings on the formation of working alliance. Whereas the demographic similarity hypothesis is a main effect hypothesis, the within-group moderating hypothesis is an interaction hypothesis in the statistical sense. And, as is the case with interaction effects generally, they qualify main effects. In other words, interactions ordinarily inform us about the conditions under which main effects may and may not be operative. In terms of working alliance formation in the RSM pairings of interest, we suggest the following hypothesis: *In therapy dyads in which one or more participant is a racial or sexual orientation minority, within-therapist and within-patient factors will significantly influence or moderate the effect of perceived race and sexual orientation similarity on working alliance formation.*

Innumerable examples may be provided of the within-group moderating hypothesis in the area of RSM pairings and the working alliance. For example, White therapists may have difficulty establishing a productive alliance with Black patients who have high levels of cultural or racial mistrust, regardless of the therapists' level of self-awareness, knowledge, and experience concerning race. On the other hand, knowledgeable and self-aware White therapists may have a relatively easy time forming an alliance with Black patients who have a lower level of cultural or racial mistrust. Drescher (May 2000, personal communication) offers an illuminating example of when similarity impedes rather than fosters the alliance.

A patient who was confused about his sexual orientation chose a gay therapist with the unconscious aim of (a) externalizing his internalized homophobia by denigrating the therapist and (b) colluding with the denigrated therapist in maintaining an antigay stance. The formation of a strong working alliance was a delicate, arduous, and complex matter in this case. The countertransference difficulties that such a case inevitably creates further complicated the development of a sound alliance.

Examples such as these may be usefully conceptualized from the perspective of the culturally based identity theories that have emerged into prominence in recent years. Such theories have been developed in the areas of race/ethnicity (e.g., Helms, 1995; Rowe, Behrens, & Leach, 1995) and sexual orientation (e.g., Fassinger & Miller, 1996; McCarn & Fassinger, 1996). In discussing racial identity models, Helms and Cook (1999) stated that:

In actuality, racial (in fact, "socioracial") identity models are psychological models because they intend to explain individuals' intrapsychic and interpersonal reactions to societal racism in its various manifestations. That is, they are descriptions of hypothetical intrapsychic pathways for overcoming internalized racism and achieving a healthy socioracial self-conception under varying conditions of racial oppression. We find these models useful for assess-

> ing the influence of racial factors on the client's concerns as well as the reactions of the client and therapist to one another. (p. 81).

Perhaps the most comprehensive, integrative, and heuristic identity theory is the racial identity theory of Helms (1984, 1990, 1995; Helms & Cook, 1999). Because this theory has considerable value for understanding therapeutic alliance formation and subsumes many of the specifics we have noted here, we provide a brief summary. In its most recent rendition, Helms' racial identity theory conceptualizes racial identity development in terms of ego identity statuses, which in turn are defined as "cognitive-affective-conative intrapsychic principles for responding to racial stimuli in one's internal and external environments" (Helms & Cook, p. 84). Models are offered by Helms for People of Color (i.e., Asian, African, Latino/Latina, and Native Americans living in the United States) and for White people. In the model for people of color, there are six ego identity statuses, and these range from the Conformity status to the Integrative Awareness status. At the lowest level (Conformity), the person devalues his or her own race and is oblivious to social racial concerns. At the highest level (Integrative Awareness), the person values his or her own collective identity and empathizes with members of other oppressed groups. Life decisions are motivated by globally humanistic self-expression. In the four statuses in between the highest and lowest, individuals range from being ambivalent and confused about their socioracial group commitment, to idealizing their own racial group while denigrating the majority group, to being deeply immersed in one's own group, to moving toward acceptance of one's group and an ability to respond objectively to members of the dominant group.

For the White racial identity model, there are seven ego identity statuses. At the least developed status (Contact), the person is satisfied with the racial status quo and, in fact, is oblivious to racism and to his/her participation in it. At the most developed status (Autonomy), the person evidences "informed positive socioracial-group commitment, use of internal standards for self-definition, capacity to relinquish the privileges of racism" (Helms & Cook, 1999, p. 91). In the five statuses in between, the person may range from great ambivalence and anxiety about racial dilemmas, to idealization of Whiteness and denigration of other groups, to intellectualized racial openness and subtle White superiority, to a search for the personal meaning of whiteness and racism.

As can be seen from this brief glimpse of Helms' racial identity theory for both White people and People of Color, the racial identity status of both client and therapist has major implications for the quality of working alliance that is formed. Certain combinations would make for a ready alliance formation, whereas others would make it nearly impossible for a White person and a Person of Color (whomever is in the therapist or client role) to form a workable alliance (e.g., see Helms & Cook, 1999). These types of dynamics are also relevant for ethnic identity (as differentiated from racial identity), where alliance formation may be significantly affected by the similarities and differences in clients' and therapists' culture-based values, worldviews, and communication styles (Chin et al., 1993; La Roche, 1999).

The emerging gay and lesbian identity theories have a similar thrust to racial identity theories in the focus on awareness of and response to societal oppression, and these theories also have similar implications for alliance formation. One point of divergence from racial identity theories, however, is related to a fundamental difference between sexual orientation and race/ethnicity. Whereas racial/ethnic categories are largely based on one's visible characteristics (e.g., skin color) and characteristics of one's family of origin (e.g., language, religion), sexual orientation categories are largely based on a factor that is both invisible and open to change: romantic and sexual attractions. Thus, a unique task of sexual orientation identity development is discovering (or perhaps rediscovering) who one is in terms of one's attractions. Because of this component of identity development, Fassinger and her colleagues proposed that lesbian and gay identity formation consists of two interrelated processes (Fassinger & Miller, 1996; McCarn & Fassinger, 1996). One process involves individual sexual awareness and identification, and the other process involves reference group identification. Although few parallels to White racial identity theory have been offered in the sexual orientation literature, models of heterosexual identity have been proposed recently (Worthington & Mohr, in press).

Many specific hypotheses are possible for working alliance formation with RSM pairings based on racial and sexual orientation identity theories. Although the statement of such hypotheses is beyond the scope of the present article, this is a highly fruitful line of inquiry for future theoretical and empirical work.

In the sections that follow, we discuss transference, countertransference, and the relation of these to working alliance in RSM pairings. As we examine these constructs, our discussion of the within-group moderating hypothesis and of racial and sexual orientation identity as moderating variables should be kept in mind.

Transference and RSM Pairings

Issues of authority are inherent in the client–therapist relationship as well as in relationships between members of minority and majority cultures. Thus, as Drescher (personal communication, May 2000) points out, transferential issues related to authority are especially likely to occur when the client is a minority culture member and perceives the therapist to be a majority culture member. In such cases, the client is likely to believe that the therapist holds majority views (e.g., is homophobic, is ignorant regarding gay and lesbian issues). Although these beliefs reflect cultural transferences, they also likely reflect some degree of reality. To be effective, the therapist must be comfortable exploring and possibly acknowledging his or her own issues related to the client's pro-

jection or perception. Once again, we point to the issue of cultural countertransference and its importance when working with members of racial or sexual orientation groups that are different from the therapist's.

As a case example of these issues, Drescher describes a gay patient who led a very active sexual life and was convinced that the therapist disapproved. The patient may be on target in that there may be a realistic basis to his beliefs about the therapist's disapproval, and the therapist may be out of touch with his or her own disapproval (as well as the value and countertransference material that may be associated with this disapproval). On the other hand, the client's belief may reflect transferential distortions related to the client's gay identity. Such forms of cultural and culturally reinforced transference may be most common in clients who are in the earlier stages of identity formation, wherein negative views are held either of their own sexual orientation or of heterosexuality. Thus, the therapist may represent an amalgam of roles, such as parent and representative and enforcer of oppressive social norms.

Cultural and culturally reinforced transferences also figure prominently into the relationship when the therapist is from a minority culture. Thompson (personal communication, July 2000) notes that being a Black therapist is a lightening rod for transference issues. We would broaden the conception and add that, when one or more participant in the dyad is a member of a historically and/or currently oppressed group, the therapist's race or sexual orientation is a lightening rod for transference. Sometimes these transferences are subtle, at times becoming manifest in the form of dreams. Thompson, for example, describes a patient whose dreams are related to what we are calling cultural and culturally reinforced transference:

> In one client's dream, the White client showed the therapist a house the therapist clearly could not afford. This tapped into a real issue for the therapist, but it also reflected a transferential one involving the assertion of societal norms around race and class. In another dream, the client was on a sinking boat. The client shared that the therapist was the captain, but then showed some uncertainty about this: "Well, maybe it was you, but it definitely was a Black person." The therapist's countertransference reaction to this was shame—shame that was based on societal oppression (i.e., the therapist as herself or as any other Black person was not good enough to keep the boat afloat). Analysis of the dream with the client also suggested that the therapist was indistinguishable from other Black people, that all Black people are alike.

As Thompson notes, White clients are often anxious about sharing race-related transference material due to fears of being seen as racist and jeopardizing the working alliance with racial minority therapists. In such cases, the working alliance itself can serve as a buffer against such anxieties and allow for a relationship in which it feels safe to explore cultural and culturally reinforced transferences.

As is its nature, transference reactions may be highly complex; thus complexity is magnified when therapist and client are from different RSM groups. Drescher (personal communication, May 2000) describes a case in which a man who was confused about his sexual orientation chose a gay therapist. This choice appeared to be aimed at the client's unconsciously externalizing his homophobia by denigrating the therapist and colluding with the denigrated therapist in maintaining an antigay stance. These unconscious maneuvers were also viewed by the therapist as a "transference test" or a "transference learning experience" in that the patient wanted to see how the therapist would deal with homophobia. Would the therapist accept the antigay stance? Would the therapist reject himself and the client? How would the therapist withstand homophobic assaults?

Although we believe that awareness of cultural and culturally reinforced transference enriches therapists' work with clients, it is critical to attend to alternative interpretations of client behavior that may initially appear transferential. Therapists who are unfamiliar with the normative behaviors of certain cultural groups may mistakenly believe that clients are engaging in transference when they are actually acting in accord with culturally prescribed roles. For example, clients from cultures that emphasize deference for medical professionals may exhibit behavior that appears unusually passive or submissive to some therapists. Such therapists may automatically interpret this behavior as a sign of distortion or pathology rather than an expression of social norms.

Countertransference Management as a Necessary Ingredient

Earlier in this article, we addressed the critical importance of therapists coming to grips with their countertransference reactions. We noted that such reactions are inevitable, and that they could be for better or worse, depending on how they are dealt with or managed. Based on the burgeoning literature on multicultural therapy, our own personal experiences as therapists, and the four interviews we have reported, it seems inarguable that the management of cultural and culturally reinforced countertransference is also a key ingredient of successful treatment when one or more participant in the dyad is members of a RSM group. In fact, we would suggest that it is the most potent ingredient. This is because in our society race, ethnicity, and sexual orientation are such emotionally provocative factors and because long-standing issues of oppression inevitably enter into the therapeutic relationship. The therapist cannot be immune to these issues, and they must affect his or her emotional reactions in a range of ways. Ongoing self-monitoring and the willingness to face one's fears, conflicts, and idealizations about race and sexual orientation are of fundamental significance for therapists.

Within psychoanalysis, the topic of countertransference had the features of a taboo for many years; it is only recent-

ly that anything like an open discussion of the topic has occurred. Few personal examples are offered in the literature. When race and sexual orientation are part of treatment, even fewer examples are provided. Rios (personal communication, July 2000) sidesteps such prohibition and provides the following case vignette from her work.

> The client was a Colombian woman who suffered from panic attacks, and the therapist's ethnic background was also Colombian. Racially, both were White. The client clearly could have benefitted from desensitization therapy, and the therapist ordinarily referred to other therapists for such work. In this case, however, the therapist conducted the treatment herself. On reflection after termination, the therapist believed that she treated the case because of her identification with the client as a Colombian. The therapist also believed she may not have been doing enough analytic work (her preferred orientation) about how the panic came to be. She felt this avoidance of analytic work was due to the fact that the panic likely was rooted in the widespread violence and terror in Colombia, and this would be painful for both client and therapist to explore. Thus, the focus on behavioral work may have reflected a posttraumatic avoidance on the part of both therapist and client.

In this case, it is clear that countertransference can be positive as well as negative in valence, and that positive countertransference can work against constructive change, just as negative countertransference can if it is not understood and managed in one way or another. Helping clients avoid painful issues around culture, we would add, may be as harmful as therapists acting out of negative countertransference feelings.

Interplay of Alliance and Transference/Countertransference in RSM Pairings

We have offered a number of suggestions about the reciprocal impact of working alliance and transference/countertransference in general. These hypothesized relationships, as noted earlier, were expected to be maintained in RSM pairings. Naturally, though, the content (i.e., the participants' feelings, attitudes, expectations, and reactions) of the alliance and transference/countertransference would be different and would reflect cultural issues the a greater extent. We provide a few examples of these interrelationships.

As an example of how an initial negative cultural transference (or perhaps culturally reinforced transference) may preclude the development of a sound working alliance, Cook (personal communication, June 2000) describes a White client being in an intake interview with a Black therapist. The client explored his issues deeply during the session and shared a great deal of feelings. This included emotion-laden discussion of earlier suicide attempts. By the end of the intake interview, a sense of closeness had been established in the therapist's opinion. However, the client revealed that she could not imagine being seen by a Black therapist. In this case, the cultural transference issues were simply too strong and negative, and they poisoned the emerging relationship. In such a case, the therapist was helpless to deal with the transference in a way that allowed therapy to continue.

When the alliance does develop, it can facilitate the emergence and resolution of transference and can helpfully affect countertransference. This facilitating effect is exemplified by Cook in the following vignette.

> A White male client was in therapy for 3 months with a very light-skinned Black therapist. A relatively strong alliance had developed over this period. In a particular session during the fourth month the client noticed for the first time that most of the therapist's photos were of Black friends and family. The client was surprised by this and subsequently discovered that his therapist was Black. This discovery led to a more complex transference than had been the case. The client retained the eroticized transference that had developed prior to his discovery, but could no longer maintain the positive transference based on the assumed Whiteness of the therapist. Instead, he developed a negative cultural transference around his beliefs that a Black person cannot be a doctor. Furthermore, he had to struggle with the realization that his erotic reactions were now directed toward a Black person. The previously established working alliance was important in negotiating this change in the relationship, although the negative cultural transference, at the same time, did adversely affect the alliance, creating a rupture of sorts. Importantly, the positive working alliance also seemed to help the therapist avoid negative countertransference related to the client initially viewing her as White, given her own issues around appearing too White.

When cultural and culturally reinforced transference issues invade the working alliance and pose a threat to the overall therapeutic relationship, it is important that therapists bring these into the open and help clients explore them. Just as in therapy in general, the need for exploration is especially great when transferences are negative.

Concluding Comment

In this article we have explored the interrelations of working alliance, on the one hand, and both transference and countertransference, on the other. We extended our theoretical discussion of these interrelations to the psychotherapy situation in which at least one member of the treatment dyad is a member of a racial/ethnic or sexual orientation minority.

Although the empirical and theoretical literature on diversity topics in therapy has burgeoned in recent years, writing on psychoanalytic constructs has trailed behind. Yet there is a nascent body of literature on race/ethnicity and sexual orientation factors in the therapy relationship from psychodynamic and psychoanalytic perspectives (Drescher, 1998; Jack-

son & Greene, 2000; Leary, 1995; Roland, 1996; Thompson, 1995), and our conceptions are best viewed as part of these developments. Our hope is that the theoretical and clinical reflections that we have made will help generate further empirical inquiry and theory development on the topic of working alliance, transference, and countertransference in psychotherapy (psychoanalytic or otherwise) in which factors related to race and sexual orientation are central.

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