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Feeling Seen: A Pathway to Transformation

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Chronic exposure to racial indignities can engender a subjective sense of invisibility, in which an individual feels that the dominant culture fails to recognize one's worth, abilities, and talents. The sense of feeling unseen can permeate myriad aspects of the lived experience and negatively impact well-being. Using the case of an African American male in therapy with an African American female psychotherapist, this article presents how implicit and explicit acts of recognition of the patient and acknowledgment of race, integrated into a change-oriented and experiential psychotherapeutic process can facilitate transformational experiences. This case study seeks to highlight the importance of therapeutic alliance and patient perception of therapist empathy, which may contribute to enhanced well-being of African American men seeking psychotherapy.

Keywords: *psychotherapy, African Americans, the nod, recognition, invisibility, transformation, AEDP*

> I am an invisible man. . . . I am a man of substance, of flesh and bone, fiber and liquids—and I might even be said to possess a mind. I am invisible, understand, simply because people refuse to see me. Like the bodiless heads you see sometimes in circus sideshows, it is as though I have been surrounded by mirrors of hard distorting glass. When they approach me they see only my surroundings, themselves, or figments of their imagination—indeed, everything and anything except me. (Ellison, 1947/1995, p. 3)

Human beings possess a deep-seated need to feel seen and acknowledged. Historically in the United States, African Americans have been subjected to slavery, racism, oppression, and discrimination, the effects of which have rendered them invisible to the dominant culture, stripping them of the felt sense of being seen and acknowledged through un-stigmatizing lenses. When this subjective sense of invisibility leads to low self-worth, Franklin (1999) referred to this state as the "invisibility syndrome." African American men in particular can be susceptible to the invisibility syndrome because paradoxically, they are highly visible and surveilled, often perceived as dangerous, violent, or a threat, while their abilities and quality of character can be summarily overlooked (Carr & West, 2013; Franklin & Boyd-Franklin, 2000). If left unresolved, the tension between these dichotomous states can lead to a sense of disillusionment, disappointment, and isolation.

This article aims to illustrate how implicit and explicit forms of recognition of the other and the self in a setting that acknowledged race and racism-related experiences catalyzed spontaneous experiences of transformation in an African American male in therapy with an African American female psychotherapist (the author). Principles of accelerated experiential dynamic psychotherapy (AEDP), a form of psychotherapy based on change rather than psychopathology (Fosha, 2008, 2005), influenced the psychotherapeutic approach. Case vignettes illustrate how therapeutic change can occur rapidly, and how emotions and the experience of profound recognition can play a pivotal role in the transformation process.

In this case, when the patient and therapist met face-to-face for the first time, an unplanned and unexpected moment of shared implicit recognition—"the nod," a non-verbal symbolic act of recognition and acknowledgment communicated between African Americans—occurred. This momentary and spontaneous gesture established a secure alliance between the patient and therapist that allowed the patient to quickly dive into unexplored and often painful emotional territory.

'The Nod" and Race: When the Implicit Becomes Explicit

A phenomenon known more through experience than through review of psychological literature, "the nod" describes the almost imperceptible downward movement of the head accompanied by direct eye contact that African American strangers give when passing one another on a sidewalk, in a crosswalk, in a corridor—generally any place where few African Americans can be spotted. In mere microseconds, the nod and shared gaze can communicate the felt sense of collective struggle across generations; understanding and freedom from having to justify emotional states that arise from racism-related experiences; recognition that the other and the self are unique individuals who are infinitely more than the dominant culture leads others to believe about them.

Aside from common parental instructions to look others in the eye as a sign of respect and acknowledgment, it seems at least anecdotally that African American children do not generally receive explicit instructions on how to execute the nod or how to convey and experience the profound felt sense of mutual recognition and acknowledgment that occurs when two African Americans engage in the nod. The nod seems to be learned implicitly and to manifest organically. Manning (2014), an African American physician and clinician-educator documented the phenomenon of the nod. During rounds, one of her medical interns, a self-described "regular white girl from the Midwest" (p. 133) noticed the subtle forms of acknowledgment between Manning and an assortment of African Americans throughout the hospital, and inquired whether Manning knew all of those people. Manning took the opportunity to explain the cultural gesture of acknowledgment, solidarity, understanding, and empathy shared between African Americans. In her article, Manning speculates that the nod arose out of necessity because in decades past it was safer for African Americans who were in public and surrounded by White individuals to communicate nonverbally with one another. The nod communicated that they were not alone and invisible, that they were in fact being seen.

What happened when the nod—with all its implicit messages—occurred between the patient and therapist during their first face-to-face meeting? On a mutual level, the invisible became visible; an inner knowing set in; a sense of trust took root; the armor could be laid down for the duration of the session; the implicit became explicit. In the first session the patient declared that he had never worked with an African American therapist and felt overjoyed to have one. He realized that he would not have to expend precious energy and time suppressing his rage or justifying his anger for fear that he would come across as an "angry Black man." He no longer worried that he would offend or scare his therapist. When in the presence of a White therapist, therapy for the patient had become more about ensuring that his therapist felt at ease than about revealing authentic facets of himself. Although the patient stated that he had benefitted from therapy with his former therapist, he had only revealed the parts that he perceived would be accepted and understood, and had withheld sharing particularly traumatic experiences that had their roots in racism, oppression, and the legacy of slavery.

Harrell (2000) cautioned therapists to be aware that clients of color can be sensitive to the slightest of cues (e.g., tone of voice, eye gaze, positioning of the body) that would possibly indicate that the therapist was uncomfortable or disapproving when it came to discussing racism. Moreover, she advised that "clinicians should avoid any tendency to turn the therapy session into a courtroom by requiring proof that a client's experience of racism really is racism" (p. 52). In agreement with Harrell, the author further contends that at the core, African Americans desire to be seen, heard, and understood regardless of the color or ethnoracial background of the therapist. Once trust has been established, the work addressing internal and external realities, whether related to race or not, can commence.

In their study of African American men and the invisibility syndrome, Tovar-Murray and Tovar-Murray (2012) found that the men they studied expressed preferences for counselors who were accepting, validated their experiences, acknowledged racism, and were genuine, regardless of the counselor's race. One study participant stated:

> Any counselor must be interested in me as a Black person and show me that he or she cares about my issues. He or she needs to accept me for who I am and validate how I feel. Of course, he or she needs to know that racism exists. (p. 33)

Extant literature on whether African American patients benefit more from having African American therapists as opposed to White therapists is inconclusive (Liggan & Kay, 1999). Some reviewers have averred that ethnoracially similar dyads are not more effective (e.g., Atkinson, 1983; Hall & Malony, 1983), whereas others hold otherwise (e.g., Butler, 1975; Parham & Helms, 1985). Still other investigators claim that White therapists working with African American patients is iatrogenic (e.g., Thomas, 1970), while some contend that despite African American patients' preference for African American therapists, they do not have better outcomes when paired with African American therapists (e.g., Pena & Koss-Chioino, 1992). In contrast, Cabral and Smith (2011) in their meta-analytic review of the literature on ethnoracial matching found that some of the literature indicates that not only do African American patients prefer to work with therapists who have the same ethnoracial background, they also have slightly better outcomes when matched with African American therapists. Nonetheless, Cabral and Smith contended that if a therapist has a worldview congruent with a patient's worldview, the match in worldview would very likely influence therapy outcomes more directly than a match based on ethnoracial similarity.

Comas-Diaz and Jacobsen (1991) cautioned that therapists who are ethnoracially similar to their patients might overidentify with their patients to their patients' detriment, while Priest (1991) encouraged therapists to be culturally aware if their patients come from cultural backgrounds different from the therapist's. A phenomenological study that investigated the experiences of African American therapists working with African American patients addressed similar themes (Goode-Cross & Grim, 2016). Goode-Cross and Grim documented African American therapists' accounts of overidentification, the consequences of which led to enmeshment and the lack of appropriate boundaries with their African American patients. The authors also explicated that although a therapist and patient could both be African American, they could have widely divergent backgrounds and experiences (e.g., level of educational attainment, socioeconomic status, sexual identity, racial identity) that could impede or prolong the development of a therapeutic alliance. Despite these caveats, Goode-Cross and Grim found that the African American therapists interviewed for the study tended to develop therapeutic bonds with their African American patients rapidly and with ease, in part due to a felt sense of familiarity and solidarity, as well as a deep understanding of what it means to be African American in the United States.

On the larger scale of therapy outcome studies, definitive conclusions regarding the efficacy of ethnoracial matching in therapy have yet to be drawn (e.g., Cabral & Smith, 2011). The author contends that a more realistic, relevant, and useful variable to explore in context to the therapeutic relationship is the interpersonal domain, which encompasses factors such as the therapeutic alliance and patient perception of therapist empathy. The author would further argue that the nod, a form of non-verbal communication, is also an interpersonal variable that can highly influence therapy outcomes. It is a variable difficult to capture, let alone quantify because it occurs spontaneously and organically between some—not all—African Americans. Nevertheless, within the scope of this particular clinical case study, the phenomenon of the nod and the pivotal role it played in creating space for transformation by allowing the implicit acknowledgment of race and of racism-related experiences to become explicit on the patient's terms—not the therapist's—was not only observed, but also experienced. It laid the foundation for deeper work and accelerated change. As Harrell (2000) asserted: "Indeed, when racial and cultural issues are mutually understood and appreciated early in therapy, the door may be opened wider for the exploration of other problems and concerns" (p. 52).

The remainder of this article describes the clinical case, including the principles of AEDP, which informed the psychotherapeutic approach. Case vignettes illustrate how moment-to-moment tracking of negative and positive emotions and how moments of profound recognition led to sudden and spontaneous experiences of transformation.

Principles of AEDP

An integrative mode of therapy that draws from a number of approaches including emotion-focused, attachment, psychodynamic, experiential, somatic, and short-term psychotherapy, AEDP is particularly focused on the transformational processes that take place within an emotionally regulated therapeutic dyad (Fosha, 2000; Fosha, 2004). Serving as a secure attachment figure, the therapist endeavors to create positive new experiences with the patient by engaging in moment-to-

moment tracking of the patient's somatic and emotional experience and by helping process the patient's emotions to completion. This process has seven components: four states and three state transformations (Fosha, 2009).

State One is the domain of defenses (e.g., fear, shame), which impedes the patient's ability to access core affect or categorical emotions (e.g., joy, grief). In the first state transformation, the pathway from State One to State Two, the therapist creates a safe environment in which glimmers of core affect can emerge, defenses can dissipate, and the patient can come into contact with the somatic experience of the emotion (e.g., feeling the senses, the muscles, the skin, the breath). All the while, the therapist is aiding in the patient's emotion regulation through eye contact, position of the body, tone of voice, and rhythm of speech.

In State Two, the patient with the therapist can deepen into and process core affect somatically and emotionally. In the second state transformation, the pathway from State Two to State Three, in the wake of processing core affect (e.g., anger) that arose out of loss, trauma, or other dysregulating events, the patient feels relieved, energized, and empowered, enabled to act in new and adaptive ways.

State Three, the processing of transformational experiences, involves metatherapeutic processing or metaprocessing, which invites the patient not only to experience the transformational process, but also to reflect on the process. Four specific types of affect, transformational affects (Fosha, 2009), arise out of metaprocessing: (1) Mastery affects capture the feelings of joy and pride that occur in therapy when defenses (e.g., shame, fear) no longer hold power; (2) Emotional pain characterizes the feeling of grief for oneself over what one had to endure, but it is accompanied by a sense of liberation; (3) Tremulous affects characterize feelings of fear and excitement, curiosity and interest that emerge as one integrates the transformational process in relationship with the therapist; (4) Healing affects symbolize the feeling of gratitude toward the other (i.e., True Other; Fosha, 2000, 2005) and feeling moved within the self upon deep recognition, affirmation, and acknowledgment of the self. In sum, the processing of transformational experiences serves to solidify the transformational experience and the attachment bond between patient and therapist.

In the wake of high intensity emotions, the third state transformation, the pathway from State Three to State Four, gives way to feelings of calm and ease, setting the tone for State Four, the core state. The core state encompasses a sense of peace, clarity, equilibrium, and truth, of deep inner knowing, often activated by the True Other (i.e., the therapist), who recognizes and validates the true essence of the patient. When both patient and therapist are in the core state, they are engaging in True Self/True Other relating (Fosha, 2005). In this state of relating, the patient can fully experience the True Self (Fosha, 2000, 2005) and embrace the self he knows he has always been. The patient senses that he is on the right track, self-directed and self-attuned, operating from a place that feels embodied, empowered, and alive, resourced by adaptive qualities such as wisdom, compassion, and receptivity to new experiences. From this state, the patient is able to create a coherent narrative of his life (Fosha, 2009).

The Case Example

The following case example illustrates the relational dynamic between patient and therapist, transformational processes, and the power of recognition.

The patient is an unmarried, tall, broad-shouldered, dark-complected African American male with a sonorous voice in his sixties seeking treatment because he feels "stuck" and would like to confide in someone. Whenever he feels stuck, he ruminates on how he ended up in dire financial straits. These thought processes lead to feelings of anger for not being acknowledged and financially compensated for his work as a performing artist, and to excessive alcohol consumption and drug use. The alcohol and illicit drug use serve to suppress the patient's depression and anxiety, for which he also takes prescribed medication. He does express the desire to reduce his alcohol consumption and to stop his drug use. He states that he needs "to let anger out" and that he is committed to revealing parts of himself that only few people have witnessed in order to support his mental health and overall well-being.

Coming of age in the 1950s and 1960s in a conservative, predominantly White town, county, and state, the patient grew up in abject poverty with his mother and four siblings. Starting at the age of five, he took on odd jobs to earn money for the family to supplement their meager food budget. As a result of his determination and commitment to keep the family afloat, his mother frequently kept him home from school

so that he could earn money and tend to the household. Excessive absences from school did not serve the patient who already struggled with reading comprehension, spelling, sustaining attention, and sitting still. (He was informally assessed for learning disorders and Attention-Deficit/Hyperactivity Disorder (ADHD, predominantly inattentive type) while in treatment; both assessments indicated a high likelihood of a learning disorder and ADHD.) Neither his parents, who were divorced, nor his teachers addressed his learning and attention difficulties. Instead, he was labeled a problem child in elementary school and relegated to classes for recalcitrant children—most of whom were African American males.

This stigmatizing label followed him through high school, disincentivizing him to apply to college and earn a degree, a feat his siblings achieved. Teachers, neighbors, and family members continually told him throughout his childhood and adolescence that he would never amount to anything. Coming into manhood in the late 1960s in the United States, he felt like a "victim" living in a region where African Americans were "not considered citizens." Salvation came in the form of music. As a young adult, he and his friends formed a band. He quickly learned how to play various instruments then launched his career as a musician and performing artist. Despite his achievements as a performing artist, profound feelings of shame for not having achieved academically plague him to this day. Nonetheless, his success as a performing artist and the joy he derived from making people move, dance, and feel good, bolstered his sense of self-worth.

At the height of his career as a performing artist, the patient felt the most acknowledged, seen, and respected. He especially treasures the times he toured in Europe because his audiences deeply appreciated his talent, his expertise, his knowledge, and his commitment to his art. In a perfect world, he would go back to Europe where he toured as a musician. "They loved Black people." In Europe he felt appreciated. He felt like he could open up and be who he was. He didn't have to be "Mr. Black Man." In the twilight years of his music career, the patient has been struggling with feelings of frustration, resentment, and anger at a population in the United States that does not know, let alone appreciate, its musical history (and the social conditions that contributed to its creation) and the individuals who carry on the legacy of these musical traditions.

The patient came in for twenty-two 50-minute sessions spanning a 14-month period. Approximately half of the sessions were videotaped.

In his first session, the patient declared that he has ignored his "inner spirit," which he experiences somatically as an inner pressure that makes him want to sit up and look at what he is doing. "It's like feeling a stirring, like when you feel happy inside." This stirring is a glimmer of his vitality, his life force. This is who he is at his core. In this particular instance, the patient started in State One: defense (i.e., shame), then moved into the first state transformation as he opened up a pathway to core affect (i.e., happiness).

The five vignettes that follow originate from sessions two, six, eight, sixteen, and seventeen. They have the general themes of negative affect transforming into positive affect (e.g., shameful feelings transforming into pride, wonder and amazement). What is striking is the swiftness with which the patient begins to undergo transformative experiences, the stability in themes over time, the further deepening into each experience as therapy progresses, and the depth with which the patient feels seen and acknowledged, rendered visible, worthy, and deeply human in relationship with the therapist.

Vignette 1 is taken from the second session, in which the patient declares his commitment to disclose personal information to the therapist; information that he has never disclosed to anyone else. This act serves to strengthen the attachment relationship.

Note that text in italics enclosed in parentheses signifies nonverbal forms of communication between patient and therapist. Text enclosed in brackets signifies comments on the process.

Vignette #1: Establishing Trust, Experiencing Anger (Session 2)

The beginning of the session . . .

PATIENT (P): I went back and thought, "Am I going to do this, come here, talk to you, and talk straight up, or am I just going to talk halfway and not get anything out of it?" So I came to the conclusion I have to let some of this stuff out; stuff that I've never told anybody about and that's you know, 'cause if I couldn't do it, I wouldn't come back. I wanted to tell you a little bit about the drug use. [patient self-discloses, reaches out to therapist to establish trust]

THERAPIST (T): Yeah? (encouragingly, leaning

forward slowly, making direct eye contact)

(The patient revealed that he used drugs as a way to help him focus and to cope with his anger and rage. Later in the session, patient recounted acts of injustice perpetrated against him in the 1960s and 1970s).

T: You've had this life where you've seen so much history [acknowledging patient's place in history and its long-lasting effects on him]. The anger and the rage: How does that flow through your body? (bringing attention to the body)

P: I have to control it. It has to be controlled because sometimes I just get angry at stuff. When I see stuff today and I see these young kids, and I just go, "You don't know what's happening to you. You don't know because you look at all this stuff and you don't know what I went through. You see me everyday, but you don't know. You don't know." [patient verbalizes previously expressed anguish over young African Americans' lack of comprehension and respect for what African Americans of the patient's generation endured, and the younger generation's seeming lack of organized resolve to effect change in race relations in the United States]

A few minutes later . . .

T: So you find ways to channel the anger, the rage. Where does it want to go? There's one thing about controlling it, but . . .

P: It wants to go to change, you know. It wants to go to a place where it wakes somebody up, you know, and tell 'em, you know. . . [expressing a desire to transform anger into something productive and catalytic]. You see these things and you don't want to come off, making people feel you know, you're out of control or some kind of militant or racist. [with frustration and resignation, patient had expressed his vigilance in projecting a non-threatening image to others]

Because he does not wish to be labeled an "angry" man or a "racist" (by expressing thoughts that might make White people feel uncomfortable, defensive, or angry), the patient uses drugs and alcohol to suppress his anger and rage stemming from among other things, racial indignities endured, the status of race relations in the United States, the appropriation of his intellectual property by companies run by White people that in turn negatively affect his sense of self-worth, sense of agency, and sense of accomplishment. Conversely, the patient has found adaptive ways to channel his anger through regulating his emotions, playing his instruments and writing music. In the face of struggles that could seem insurmountable, the patient expresses glimmers of hope and the desire to transform powerful emotions (i.e., rage and anger) that could consume him into a force that awakens.

In the first session, patient and therapist had established a clear sense of recognition, trust, and safety that emboldened the patient to disclose more of his thoughts, feelings, and experiences in this second session. In this session, the patient chooses to reveal parts of himself that in the past he did not sense were safe to reveal. He feared rejection and being perceived as angry. He feared that he would not be understood. He feared that he would lose the connection and goodwill he did have with his therapist. Through it all, the therapist remained present, empathetic, responsive, and aware of the cultural and historical contexts contributing to the patient's reality, thus strengthening the therapeutic alliance and attachment bond.

The patient's interactions with the therapist very likely contributed to a growing trust within the patient that he could confide in friends without experiencing irreparable ruptures in his relationships with them. In the following vignette, the patient relays a situation in which he experiences a major transformation by revealing his vulnerability to trusted others. In the process, he asks for emotional support, receives it, and is able to avoid engaging in addictive behaviors.

Vignette #2: New Behavior Patterns Replacing the Old (Session 6)

The patient reported that he fell into a deep depression over the weekend. The trigger: He wanted to buy something for his computer, and he realized that he had no money to do so. This led him to contemplate why he had no money. Not wanting to drink, although he felt compelled to do so, he bought some ice cream and ate it. With his body craving cocaine, he fought the impulse because he had been feeling better talking to his therapist. He knew that drugs and alcohol made him feel worse, and he did not want to fall into that hole of substance use yet again. Therefore, he attempted something new: He reached out to his friends. Talking to his friends took his mind off of his depression. He

also took a steam at the gym and even turned off his phone so his dealers could not reach him and tempt him with drugs. He did everything he could to distract himself from getting high.

Ten minutes into the session . . .

P: I feel better. I feel like I've gained a little bit on how to fight back, and I didn't have that at first. I was scared to fight back.

T: Scared to fight back. And what was . . .

P: Well, I was scared to fight back because I didn't want people to know. I didn't want people to think that I wasn't you know, a strong mountain of a man that I could solve my own problems. [alludes to gender identity issues and cultural concepts of masculinity] And once I got past that point, you know, I needed to say something to somebody. Then I could feel this wall a little bit starting to crumble, so it's good. I really feel a little better about myself, that I can fight, you know, when I get the urge to get high or something. I can go, "Nah, maybe I'll call so and so." [utilized his resources, chose adaptive action rather than maladaptive action]

T: Right! (verbalizing enthusiastically, leaning forward, and smiling)

P: Yeah! (slight smile)

T: Yeah, call somebody: call friends, call me, reach out. (gestures with palms open)

P: Yeah, but I've never done that before. This is the first time this stuff has ever happened. (slight smile, downward gaze, shaking his head)

T: Huh! (conveys amazement)

P: Because I always went to the same program . . .

T: Uh-huh . . . (encouraging tone of voice)

P: . . . the quick fix. Actually, what I noticed is that when I get high, it isn't just the next day. It lingers on for 2 to 3 days afterwards, you know. But after talking and not getting high, the next day I had my senses around me. [indicates his somatic awareness; he has developed a clear sense of how he feels in his body when he uses substances and when he does not]

T: Uh-huh . . . (encouraging tone of voice)

P: Staying clear. (looking directly at therapist)

T: So you had this experience where you realized the world didn't end and you actually weren't worse off?

P: Right. Yeah. (slight smile, nodding)

T: Yeah, you actually felt that. (nodding in agreement)

P: I woke up with a few dollars in my pocket.

T: Yeah! (smiling, then chuckling, delighted by patient's use of language)

P: (Chuckles)

T: Wow! (beaming) [indicating acknowledgment of patient's significant accomplishment while also conveying admiration and joy]

P: Yep, to me, I was just kind of happy, you know, I kind of was shocked and happy, all joyful feeling inside . . . (smiling) [patient coming into contact with core affect on a somatic level]

T: Mmmm-hmmm.

P: . . . then I finally could fight back and say, "No, I'm not doing this," you know? I moved to a place where I've never been. I could feel it. I could feel my soul one step from the edge because I kept thinking about the same stuff over and over and over again. [patient expressing a felt sense of what was right for him in the moment]

T: So when you say that, I'm getting this image of those thoughts you had, those self-defeating thoughts . . .

P: Thoughts of being poor, being you know, you know, having all this music and not being recognized, you know, anger came up. I was mad and disappointed. I'm just going to lay here for as long as I can you know, until you know, my thought patterns change or something. [instead of resorting to old and familiar maladaptive behavior, patient engaged in new behavior that supported his well-being]

T: And it did, I mean something triggered. You were so low.

P: Yeah, well I think it came to a point where I didn't want to be here anymore. I didn't want to be there and do the same things because I know the results of what's going to happen. And the results of that just would lead to another round of me being depressed. [patient realized he no longer wanted to engage in a negative feedback loop and created new behavior patterns]

T: Mmmm-hmmm, so it was really that? You're like: "I have to do something."

P: And you know, I also had you. Coming to see

you was another factor, another part in this that I knew I could come and just be relaxed and just tell you exactly what is going on, you know. [statement of attachment and trust]

T: Well I'm really glad to hear that you feel comfortable here (laughs gleefully) because I love having you here. It's a real honor to be here and to sit with you, to witness . . . [therapist accepts patient's compliment and expresses pleasure]

P: Yeah, yeah. Witness is a first. (joint laughter) It's a first. (still smiling)

T: Yeah, and it's huge. And how does it feel to tell me about all of this? [invitation to metaprocess]

P: It feels good. It feels, I feel comfortable. You know, I don't feel like I have to squeeze it out of myself, you know. And when I get to that point, then that means that I start feeling like I can open up to other things in my life. (excitement and anticipation in his voice) [emergence of tremulous and mastery transformational affects] But talking to you is really easy. (chuckles)

T: Mmmm . . . [contemplating how to respond to the compliment] And so bit by bit, you were able to come out of this? [deflecting patient's compliment out of therapist's own discomfort with receiving praise; therapist shifted focus from emotion to behavior]

P: (nods) Slowly, slowly . . .

In this deeply transformative session, the patient relayed how he leapt out of his comfort zone, adopting new behaviors despite the pull of depression and addiction. By engaging in new behavior, he was able to develop and integrate a new experience that far exceeded that of a substance-induced state. The patient found alternate strategies—adaptive strategies—to self-regulate, which helped him become more familiar with another way of knowing. It is the place within him that seeks growth, health, and well-being. In the process, the patient transitioned from a severely depressed state to an empowered and awake state—to the core state.

Through it all, the therapist remained present with the patient, acknowledging, validating, and praising his success in breaking the cycle of addictive behavior and making choices in support of his well-being. The patient also affirmed that he felt relaxed and able to confide in the therapist, further strengthening the bond between the two. Through the development of a secure attachment with his therapist, the patient realized that he could rely on close friends and ask for emotional and moral support when he was in need.

As the number of sessions attended increased, the patient began to share more memories; memories that had left emotional scars.

Vignette #3: Connection to Joy, Spirit (Session 8)

Patient and therapist continued the discussion about the patient's unexpected and uncharted journey from a childhood in which those around him expected him to fail, to the height of his career as a performing artist in which he defied the odds stacked against him. Well into the session, the therapist began to discuss the many forms of intelligence that exist, and the ways in which the therapist experienced the patient's intelligence.

More than halfway into the session . . .

T: These many parts of you that are so intelligent and you know, we have many forms of intelligence. And also you said you want to listen to that space inside . . .

P: Yeah.

T: . . . that guides you and that joy. All these different levels, I mean I'm just seeing such an intelligent being.

P: Yeah . . . you know? (surprised)

T: How does it feel for you to hear me say this? [metaprocessing]

P: It feels kind of weird to hear . . . because I don't, I don't think of myself like that. (slight smile) I think of myself as a wise person that you know, through the years and all the stuff that I've done, I think I can, you know, talk and listen to people's problems and, but I've never thought myself of being somebody other than that, just, just a normal person. I think I can get through stuff, you know, and I'm a survivor. That's basically who I think I am . . .

T: Mmmm-hmmm . . . (encouragingly)

P: . . . just a person who can survive in this world, you know, and dodge the potholes. (laughs)

T: Yeah, that takes a lot of intelligence, you know. (smiling)

P: Yeah. (smiling timidly)

T: It takes a lot of fortitude, a lot of intelligence. Maybe that's one of the reasons why you made it and some of your partners didn't. [patient had

reported that a number of his compatriots from his younger days are either incarcerated or dead]

P: Yeah, they didn't dodge the potholes. They fell in.

One of the people who did not dodge the potholes was the patient's older brother, who was academically brilliant, but had an addiction problem that eventually killed him at a relatively young age.

P: What happened to me? (in wonderment, laughs)

T: As you know, just because one is book-smart, doesn't mean you're smarter in other areas. Knowing that you got to bypass all of that. And then also, I'm still touched by that image of the joy, that interconnectedness, whatever that is.

P: Yes. It's Spirit. People don't know it's right there. (points to heart)

T: Mmmm-hmmm . . . (nodding)

P: You probably have felt it so many times. You kind of feel this happiness inside. (fluttered his fingers around his solar plexus). You look around, it's like why am I feeling this joy inside? It's because your spirit is telling you, you have to have faith in whatever you do. That's what it tells me. You know, you got faith, just stay on this path. Whatever it is, change what you're doing; things become better. [patient is accessing the core state of knowing, of trust and truth]

(A few minutes later . . .)

T: What is it that you ask for?

P: I ask for strength. I ask for a lot of things. I ask for gigs. . . . I'm stuck in this place; I need to get out. I need to not be afraid to take another step. Some of the steps that we should take may be a right step into a right direction, but we're so scared, we don't take it. So that's what I ask. You got to clean up your soul in order for it to move on because that's the blockade that's holding you from where you got to go. And that's one of the reasons I decided to clean myself up. It's all here and here. (pointing to his heart then his head) When I decided to stop, everything I did drug-wise came to the surface . . . increased cocaine, increased drinking. It wore out its welcome. Talking to you, taking medication . . . I don't need it anymore.

T: Yay! (applauding) Wow! What an amazing journey! (broad smile)

P: It's amazing! (shared joy) [patient takes pride in his accomplishment; expression of mastery affects: pride and joy]

T: I'm just really in awe of you and really commend you for having the courage to make a change. To listen, to ask, to listen, and to make those changes. [acknowledging and praising patient for his resilience and ability to create new behavior patterns]

P: You have to ask.

T: You have to ask. (nodding)

P: If you don't ask, you won't get anywhere.

End of session.

This session ended on a very hopeful note, but before the therapist was able to metaprocess with the patient. The patient seemed to be embodying his new behaviors, experiences, and transformations more deeply each week. He had gone from theorizing what it would be like to stop drinking, taking drugs, and holding all of his emotions inside to choosing healthier lifestyle habits that enhanced his well-being. Through it all, he was able to access the joy and the spirit that reside within him. Feeling witnessed by the therapist and regulated by his prescribed medications, the patient realized that excessive alcohol consumption and illicit drug use no longer served him; securely attached relationships served him.

In the following vignette, the patient struggles with taking in the witnessing of the True Other.

Vignette #4: Transformation, New Experiences (Session 16)

Well into the therapeutic relationship, the therapist comments on the patient's lyrical use of language . . .

T: The themes that are running through, and just again the languaging that you use. If you weren't already a musician (laughs), or I guess even a poet. . . . What you speak of and just the metaphors and how you tie them together. You're talking about "being fueled constantly" from these interactions [patient started volunteering at a food bank where he feels appreciated and acknowledged] and before

you were "running on empty." [quoting patient from therapist's notes]

P: Mmmm-hmmm.

T: You have this beautiful imagery of talking about the anger that you've had for years and it's like: "This door cracked and this other part of me started showing."

P: Mmmm-hmmm.

T: There's such beauty in the way that you speak and that I'm sure in what translates into your writing. I don't know if anybody's said this to you, but it's very poetic and eloquent . . .

P: Really? (smiling)

T: . . . how you speak. Yeah. It's very inspiring and it's very imagistic, and like I said, embodied because you talk about a crack showing and being fueled. It's like you bring the body into it. It's like I can really feel you when you speak. [witnessing of the True Other; recognizing and validating patient's unique talents]

P: Well thank you! (chuckles)

T: I'd like to acknowledge that. I'm sure when you're interacting with people, they feel that as well.

After directing the patient back to the therapist's observation of and comments on the patient's intelligence, the therapist began to metaprocess with the patient . . .

P: Now when you say that, I don't know how to take it because I always felt like my education level wasn't the highest, and I was just never at that level.

T: You are so at that level. I mean, you can speak. This is this gift that transcends education and like I said to you when I first met you, I never would have guessed that you only had a high school education. You are extremely articulate. I mean, I don't think it crosses anybody's mind when they meet with you, not to negate your experience, but just from somebody on the outside, I never would have guessed . . .

A few minutes later, after directing patient back to the observation that he is intelligent and articulate . ..

T: And again, to have that skill and ability. We've talked about all these different types of intelligence and they're many different types of intelligence. Just this ability to weave words, concepts and thoughts: "weaving fantasies and dreams together"—storytelling. [patient's words when therapist commented on his eloquence: "I'm just storytelling: weaving fantasies and dreams together . . ." as if his eloquence were not something remarkable] This ability, someone can be highly educated and not have that ability. This is very high-order functioning of the brain. I just want you to take this in: This is high-order functioning of the brain . . .

P: (chuckles timidly)

T: . . . for you to be able to do that because not everybody can do that.

P: Hmmm. I didn't know that. (smiling shyly, occasionally casting his gaze upward to the therapist)

T: Yeah, yeah, it is. So let's just acknowledge all of you including that beautiful brain of yours.

P: Wow. (eyes widening) That's really interesting. I never knew that. . . . I shut down. [realization of past behavior] That's kind of interesting. I didn't know that. [digesting new information; on the path to creating a more coherent narrative of his life story]

In the last ten minutes of the session after directing the patient back to how he feels when the therapist acknowledges his intelligence . . .

T: How is it for you to hear me say this? [metaprocessing]

P: I'm flattered. I am. It is kind of hard to take this in because I never thought that was me.

T: Take it in you know, because it's there. Yeah. Thank you for sharing yourself with me. (leaning forward, looking patient directly in the eyes) [therapist conveying gratitude and compassion]

P: Wow, my first session [after a 5-month hiatus] and I get my mind blown! (joint laughter)

End of session.

This session illustrates the patient's initial discomfort and unfamiliarity with taking in the concept that not only does someone (i.e., the True Other) consider him articulate and intelligent, he is articulate and intelligent. The therapist had to continually and persistently bring the patient back to the topic of his

intelligence because he would deflect the therapist's observations by telling tangentially related stories from his past. Throughout the session, the therapist consistently affirmed the patient's abilities and talents. By the end of the session, the patient began to gradually entertain the concept, however incredulously, that he is intelligent and has a remarkable brain, which led to transformational experiences in the following session.

The following and final vignette details the transformational process, the patient stepping into and acknowledging his True Self, and True Self/True Other relating.

Vignette #5: Working Emotions Through to Completion (Session 17)

(Halfway into the session . . .)

T: I wanted to check in with you about last week. So how was it when you said your mind was blown when hearing me say that you are such a poet and you've got a powerful brain in there. [metaprocessing]

P: First thing, I thought about that all week and I had never thought about it. The second thing was, I've never had a Black woman tell me that. [from early childhood, the African American women in the patient's life did not expect him to amount to anything, and told him as much; his siblings, especially his sisters, were considered the smart ones in the family]

T: Really? (incredulous)

P: Unh-unh.

T: Really?

P: Never in my life.

T: Geez!

P: You're the first. (laughs)

T: Oh my goodness!

P: Yeah, that's right. And that was kind of like a first. I've never had a Black woman tell me that my brain was you know—no, never . . . (shaking his head, eyes bright)

T: I'm so sorry to hear that. [therapist focused attention on the emotional pain]

P: Yeah, but it was uplifting to me because you know how I am. [feeling seen by the True Other, acknowledging the True Other; display of healing affects] I don't go around trying to be some great poet. I kind of just look at life as one big story, chapter after chapter. So when you told me, I was like, I'm putting this in the chapter of life. This woman just told me I was brilliant! I ain't never had no one tell me that; not a Black woman at least! (laughing) [patient turned toward the healing process, toward change]

T: Are you able to integrate that?

P: I put it all in the bank. It's a very good feeling, the feeling of knowing [indicator of the core state] that that's what I am and other people like yourself acknowledge that, you know, because I never did. I just thought I was going along playing music and writing songs. [patient recognizing his True Self while relating to the True Other]

(A little later . . .)

T: So how's that part of you that believed for so many years that you weren't smart enough?

P: It just kind of blew my mind that you would say that. And hard to accept it for a minute because I didn't think that that's how I was. But it was a great feeling. It was a great feeling to have you acknowledge that and tell me because I didn't know. I just kind of thought well this a blessing I have, it's the blessing I was given and that's it.

T: You are quite exceptional, you know.

P: (smiles, giggles, then laughs) It's hard for me to take it. Yeah, sometimes I don't know how to take these things. I swear, I don't know how to take it because I'm not a school musician. I'm just a musician that was blessed to play music, you know.

T: Which is exceptional in and of itself!

P: (laughs)

T: Oh my goodness! Wow! Wow! Even more so, wow! (broad smile)

P: (laughing with glee) I didn't even look at it that way. That's what I do and I went on about my business.

T: So few people can do that. I mean to have that blessing wherever it comes from, to flow through you and for you to produce that?

P: Yeah.

T: Wow! (laughing in unison)

A little later, the topic of resilience comes up . . .

T: I know it was hard for you last week, but just sit with me for like 10 seconds. Say: I have an amazing brain. Alright?
P: (laughs)
T: Let's just sit with that
P: (laughs)
T: I know it's hard. (empathizing)
P: Yeah, it is hard. (quietly, head bowed)
T: Do you have any feeling that I'm bullshitting you?
P: No, I think that you're right on target with what you're saying. (looks therapist in the eye) [patient understands that the therapist sees his essential self and understands that it is who he has always been; no one had affirmed that with him up until now] You're an honest person and it's not too many people that I do open up to, and I think that you understand my story and where I come from. And a lot of people don't know about my disability, either. So in that case I can tell you the hard part of what I went through. And one of the parts is that I was never told I was a smart person. I've always asked, "What's wrong with me?" Never got an answer. [experience of emotional pain, a transformational affect]
T: You were left in the dark.
P: I was left in the dark for years.
T: Yeah.
P: In that case, whatever is in the dark will come to the light. [creating a coherent narrative of his life story; an indicator of the core state]
T: It'll come to the light!
P: These things started to come to the light. And when the light opened up it was music! . . . I've become the person I used to admire. I am now that person. [patient is experiencing his True Self in the core state]
T: Ah! Ah! (enthusiastic, clapping hands together)
P: (laughs) It's weird. I am older and I used to see all these cats play. They were older than me now. They're gone, I'm now that person . . .
T: Yes you are.
P: . . . and I have to be and acknowledge to be that person [stepping into a new way of being and knowing]
T: Amen! You do.
P: Yeah.
T: Yes! To fill that role, to step into that? Yes . . .
P: I cannot B.S. that role because they just handed me the torch although I didn't know it, but they did. [realization of the weight and import of the legacy he is carrying]
T: . . . that is you now. Yeah. (smiling)
(shared laughter)
T: So we're going to have to break. But before we do, I want to read this to you. This is a very powerful poem written by Marianne Williamson. Just reflect on this.
The therapist read the poem. It begins: "Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure." It ends with, "As we're liberated from our own fear, our presence automatically liberates others" (Williamson, 1992, pp. 190-191).
P: Wow!
T: Yeah, I just want to give this to you to . . . (hands a copy of the poem to the patient)
P: Yeah, that's great. I'm going to read it again tonight.
T: . . . yeah, read it again, and just know by you showing up for who you are, being that person you admire, owning that and knowing that is who you are, also as a Black man, stepping into that, of how that can liberate others . . .
P: Yeah.
T: . . . for me to witness you is very liberating for me.
P: Yeah. (nodding, eyes wide)
T: It's very special for me to have an African American client and to just witness this . . . [expressing appreciation and recognition of the rare honor of having an African American patient]
P: I think this is one of the reasons why I wanted to be here with you because I don't think a lot of African American men open up that much. And I knew at some point in my life before I leave this world I'm going to just tell what I am to somebody. And when I started to open up and tell you, I'd leave out of here a little bit more lighter. [experiencing the True Other]
T: Mmmm, yeah.

P: I walked a little bit more straighter than I did. Now we're at this point where I can just say what I feel inside, you know. That's how I express the things that happened to me.

T: Yeah. Thank you. I mean thank you for showing up. I know that takes a lot. Seeing you shine more and more . . .

P: (laughs) Yeah, it's good. You know it's good to leave out of here knowing, yeah well, maybe I'll have something else next week! [conveying a hopeful outlook]

This final vignette illustrates the patient's instinct and motivation to move toward light (e.g., "whatever is in the dark will come to the light"), healing, transformation, and "the feeling of knowing" who he truly is and has always been when he is in the core state. This vignette also illustrates moments of True Self/True Other relating between patient and therapist, in which the therapist as the True Other in the core state witnesses and recognizes the essential self of the patient, and the patient experiences and recognizes his True Self within his core and in relation to the True Other.

Conclusion

> Even though a client may feel as if he has hit rock bottom, the treatment, whether short or long-term, has the potential to change the course of his life because for the first time someone acknowledged and validated the darkness of being invisible. (Carr & West, 2013, p. 122)

These vignettes are but a few of many interactions with the patient whether tackling historical, racial, and social injustice, the pains of growing up in poverty, the struggle of being an African American man living in the United States, self-doubt, self-contempt, addictive behaviors, or feeling the sensation of inner joy in one's solar plexus. Throughout the sessions, the patient maintained his connection to that joyful happiness inside, that spirit, to the extent that even the most intensely negative emotions transformed into something positive. In those moments, the patient could drop into the core state, experience his True Self in relation to the True Other, and undergo transformative experiences.

The author contends that the mutual initial "nod" (a beautiful example of spontaneous and reciprocal True Self/True Other relating) allowed the patient and therapist to dive as deeply and swiftly as they did into complex and multi-layered territory because the patient opened up at the very first session and even more with each successive session. With that initial nanosecond of a sign of implicit recognition and acknowledgment, patient and therapist became more visible to one another. As the implicit became explicit and the patient understood that he could speak freely and openly about race and racism-related experiences without fear of rejection, he could disclose more about his internal and external realities and process his emotions through to completion. In the process, the therapist witnessed and validated the patient's essential self, the patient experienced his True Self, and the patient felt seen on multiple levels. He became visible to the True Other and to himself..

This clinical case study offers therapists working with African American men and members from historically marginalized groups the invitation to employ therapeutic approaches that allow room for the patient's cultural and historical realities, the therapist's implicit and explicit recognition and acknowledgment of the patient's essential self, and the patient's recognition and acknowledgment of the patient's True Self. These approaches can ultimately lead to the development of secure attachment bonds and increased patient well-being. The powerful act of recognition alone can lift the cloak of invisibility that can shroud an individual's true essence. From a place of visibility and clarity, healing pathways can emerge.

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