

A Racist Attack

Managing Complex Relationships with Traumatized Service Users– A Psychodynamic Approach

The child trapped in an abusive environment is faced with formidable tasks of adaption. She finds a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness. Unable to care or protect herself she must compensate for the failures of adult care and protection with the only means at her disposal - an immature system of psychological defences. (Herman, 2015)

But race is the child of racism, not the father. And the process of naming “the people” has never been a matter of genealogy and physiognomy so much as one of hierarchy. Difference in hue and hair is old. But the belief in the pre-eminence of hue and hair, the notion that these factors can correctly organize a society and that they signify deeper attributes, which are indelible – this is the new idea at the heart of these new people who have been brought up hopelessly, tragically, deceitfully, to believe that they are white. (Coates, 2015)

Abstract

Notions of whiteness, white supremacy and racial hatred such as the recent multiple racist murders by a white supremacist in New Zealand are at the forefront of public consciousness. How does whiteness and racism play out in a clinical and social welfare context? This article illustrates the impact of trauma on a vulnerable young white woman who although was not the direct target of a racist assault was left traumatized by witnessing it. It discusses how initially she sought refuge in a racist solution synonymous with a psychic retreat to her own detriment. Working with such complex, unconscious and bewildering dynamics are extremely challenging for clinicians. It describes the impact of these dynamics on a clinician of colour who attempted to work with this young woman in a child and adolescent mental health service after the family were referred as a consequence of her assaulting her child shortly after witnessing the racist attack. The unconscious responses to trauma and challenges for clinicians and clinician of colour in particular when working with racism in the consulting room are also discussed.

Racism, Trauma, Violence, Assault, Psychic Retreat, Vicarious traumatization, Racist Solution, Witnessing.

Introduction

Mental health and social welfare professionals work with traumatised individuals and within traumatised organisations on an almost daily basis in a variety of agencies and contexts. Working at the coalface of such trauma has an impact on the practitioner due to the overwhelming and painful emotions and experiences that need to be managed. The management of difficult and painful knowledge and experience is one of the fundamental tasks of those working with traumatised people (Stevenson, 2017). Due to the pain of the work dysfunctional defences (Lyth, 1988) can be generated leading to a strong pressure to act in a way that is different from usual good practice and it is essential that those working with trauma understand its psycho-dynamics including its broader impact and how to manage it. This requires an ability to recognise when trauma is negatively affecting the work and is overwhelming for those working in this field. A failure to do so can lead to an excessive use of dysfunctional defences that increases risk to service users and to professionals in the field. The impact of trauma on those working in this field is considerable and there is a body of literature relating to this under the auspices of a ‘vicarious traumatising’ which outlines the impact on the clinician of working with traumatised service users. (Newell et al., 2016) This article extends

this discussion and considers the complex unconscious dynamics, which help explain why service users may take a racist position as a response to trauma when it is clearly against their own interests. I also consider the painful issue of working with racism for all practitioners and specifically the impact on a clinician of colour.

What is Trauma?

Trauma is a kind of psychic wound that ruptures expectations of self and others in a way that is extremely distressing for the person and often for those in the person's network. The word trauma extends from the Greek word relating to a piercing in the skin or a breaking of the bodily envelope. Psychoanalysts (Freud, 1920, Garland, 1982, Hopper, 2012) extended this definition further with the idea of trauma to the mind as a rupture or an injury that overwhelms the mind's usual capacity to manage difficult experiences. The mind is a highly sensitive and complex organism enveloped by a kind of psychic skin or protective shield that can also be pierced by overwhelming experiences. The function of the mind is to selectively filter out thoughts, feelings, images and experiences that are overwhelming and unmanageable. A trauma occurs when the mind is unable to manage this. A traumatic event is unique to each person. His or her own personality and disposition and the response of their network will react with the individual's early history, their relationship with their primary carer and the quality of the care which may or may not have been containing.

Trauma overwhelms the mind's protective capacity challenging the ideas the individual has about the world and their relationships. The individual will find himself or herself in a highly distressed state, disconnected, unable to think and vulnerable to resorting to dysfunction and unhelpful defence mechanisms. Trauma, therefore, breaks through what is expected, what is predicted and what is usually manageable leaving the individual feeling powerless, alone, unable to cope and in something of an infantile state without their usual adult capacities. This can have profound and permanent implications for a person depending on the frequency and severity of the trauma and their developmental stage at the time of the trauma. *"Repeated Trauma in adult life erodes the structure of the personality already formed, but repeated trauma in childhood forms and deforms the personality"*(Herman, 2015).

Early Infancy: Containment and Holding

The role of the early caregiver, when managing the emotional needs of the infant, is complex yet essential and success or failure to do this has reverberations throughout the life of the individual. The task is to enable the infant to engage with the world, monitoring the level of stimulation in predictable, manageable proportions. This requires attunement to the infant (Stern, 1985). Over time the infant will internalise the 'holding and containing' (Bion, 2013, Winnicott, 1960) function of the mother as part of its core self which enables the child to manage its environment increasingly independently as its mind matures.

A person's ability to manage trauma will be influenced by the earliest relationship during their infancy, which is usually with their mother. Underpinning the experience of trauma and how this is managed is the early care giving and how the anxieties connected with the building blocks of personality have been managed. The early mirroring the infant receives is the basis of 'witnessing' and, is essential when working with trauma. 'Witnessing' is an extension of this mirroring and is vital to the mature development in the individual and society that binds humans into moral community (Berger, 2012). Witnessing is being there in a mindful way and this creates bonds of concern and mutuality and challenges loneliness, isolation and the suffering caused by trauma and abuse (Stern,

1985). Witnessing, therefore, is the antidote to trauma and an understanding of witnessing should form the basis of working with traumatized individuals.

Case Vignette

Corbett (2016) describes trauma *as a bomb that detonates nearest to the survivor, which also explodes into those around him*. The following vignette illustrates the complex impact of trauma that in line with this quote demonstrates that trauma goes beyond but includes the person who was the primary target of a racist attack.

An Asian woman in her 70s had been standing at a bus stop. A young white woman in her early 20's was also at the bus stop with her three year old child at her side. The Asian woman was set upon by a group of white male youths. She was verbally and racially abused, spat at, punched in the stomach and head and kicked in the genital area before they ran off laughing. At this time the young woman and her child were stood frozen. The child did not make a sound during the attack, which lasted less than a minute.

The young woman and her child were referred by her GP to a service where I was working as a clinical social worker. She lived in a block of flats and was isolated with a limited amount of community and family support. The child had regressed since the incident; soiling and wetting. His sleep had become very disturbed and he would wake up in the middle of the night seeming to have night terrors. This was unbearable to the mother who was unable to contain him. Due to her anger and frustration she had begun to withdraw from him, leaving him in his bedroom at night to cry on his own in great distress whilst she sat in another room full of anguish. There had been a referral to social services after it was discovered that the child had bruising on his arm and torso, which was considered consistent with hard gripping. The mother admitted grabbing and yanking him in a fit of rage. She had a history of being in the care system herself due to abuse during her own childhood, which included sexual abuse and witnessing domestic violence between her mother and her mother's various partners. More recently she had suffered domestic violence from her child's father who was currently in prison for knife crime.

I was immediately affected by the mother. The first few sentences that she uttered gave me a strong indication of what was to come and how I was likely to be affected by her in relation to her trauma. When I collected her from the reception, she immediately made reference to my 'race', and said, *"You're half caste aren't you? My ex-boyfriend is half caste"*. I did not think it was appropriate to challenge such terminology at this moment as I wished to focus on the possibility of building a relationship with her and not risk persecuting her. The young woman seemed frightened, dishevelled and was looking wildly round the consulting room. Both mother and child looked exhausted with dark shadows around their eyes. When the mother sat down, I asked about what had happened more recently. I was aware of a spate of racist incidents in the area and that she had indeed witnessed such an incident. Incredibly she began a racist vitriol, aiming the blame for the incident at the Asian woman and the number of Asians living in the community and complaining just how hard it was to be white in the UK at this time with all the f...ing Muslims. She said explicitly, *"If it wasn't for these f...ing Pakis this incident would not have happened"*. She attributed the blame for what she and her child had experienced entirely to the woman's race and not to these youths for their violence. This was very shocking and I recognised just how complex service users can be to social workers and other clinicians. Social workers often can feel very bewildered by the responses of their clients and this was such an example. I had a very negative personal response to her as a clinician of colour recalling my own experiences of racism including incidents of racist and homophobic assault to family and friends.

I knew that this would need to be managed and I needed to be mindful of just how vulnerable this young woman was.

Common responses to trauma are denial, encapsulation, repetition compulsion, an identification with the aggressor, dissociation and in more extreme cases psychosis (Garland, 2002). Four of these were apparent very quickly in this first assessment session with this young woman and her child. The child seemed cut-off in the sessions and sat playing with toys and did not seem to take any notice in an obvious way of the adult conversation. At no stage did he make any eye contact.

The core experience of trauma is disempowerment and disconnection. It is, by its nature, a very lonely experience. Therefore, recovery is based on empowerment and reconnection. I was struck by just how isolated this young woman was. She had no support in her network. Why would she identify with these white youths more than with this vulnerable Asian woman when it seemed, at least on the surface, that she had more in common with the Asian woman in terms of gender and vulnerability?

Retrospectively, I felt concerned about her in the local community, which was highly multiracial. If she were to make such comments and express such views, she would risk alienating the right people and instead attract the wrong people. This potential to alienate people who may be able to help her included myself as a clinician of colour was a serious concern. I did feel alienated from her in that moment when she attributed blame to the Asian woman, due to my own experience of racism. I felt a powerful wish to withdraw from her and to act punitively, losing my connection with her vulnerability.

Psychodynamic Formulation

A psychodynamic formulation has the potential to enable a better understanding of the mother's needs and how they were re-enacted and is likely to lead to a more rounded response from the clinician, avoiding retaliation or punitive reactions. According to psychodynamic principles, past trauma often repeats itself in the present. This helps us understand how the service user may fear making progress and letting go of bad internalised objects and representations of previous caregivers and relationships. Although these dysfunctional defences and internal objects proffer a sense of psychological balance on one level, they come at great psychic cost.

In 'Hate in the Counter-Transference', Winnicott (1947) discusses the essential need for the clinician to manage their more negative feelings towards their service users to provide the necessary 'holding and containment' that they need. Recovery from trauma can only take place within the context of relationship, it cannot occur in isolation. It was, therefore, essential to form a relationship with this young woman and for me to manage my negative feelings towards her based on her expressed racism. This requires management of the negative effect. Indeed, the emotions it elicited in the countertransference can also give clues into the nature of what may be transmitted of the trauma into the child / mother dynamic. The mother in this instance was unable to provide 'a protective shield' for her child from the trauma. This related to her own experience of trauma that she had not been protected from. This parental dissociation and inability to connect with the child during a traumatic event, and shortly after, has implications for how the child will manage the trauma. It reinforces negative behavioural and parenting patterns because the parent/child relationship is imbued with intolerable anxiety and emotional affect that cannot be contained or given a voice. Indeed, the child's distress served in this instance to reactivate traumatic experiences in the mother,

leading to a vicious cycle that had dangerous implications for both and the eventual assault to the child. Emotions had simply become too intolerable for this mother and were enacted in her violence to her child.

This is a highly vulnerable young woman who had very little in her life. She had suffered extreme trauma and abuse throughout her life. There had been repeated traumas at each stage of her development. She did not have any psychiatric diagnosis; however, it seems that she was unable to manage herself and her child during this recent trauma. Her depression was affecting her ability to provide the environmental essentials for her child. Thus, both mother and child were unable to process this new trauma and she had become overwhelmed.

What is Race?

The concept of 'race' and the rationale for such a categorization is often challenged (Lewontin et al., 1984) Alternatively, it is better understood as a socially constructed concept (Blackwell, 2014) that does not relate to biology and exists, instead, in our minds and social structures. None the less, race is most commonly perceived as synonymous with the colour of a person's skin and applies to people who have physical characteristics, which identify origins in Africa, the Middle East and Asia, and in my experience usually relates to those who are not considered to be white as 'Whiteness' exists outside of this pernicious categorisation or racialization (Dalal, 2002) due to the privilege that 'Whiteness' is afforded. I shall return to this difference shortly.

Race is, therefore, a powerful signifier that points to a whole social system and its history, and has significant implications for those perceived as 'other' due in this instance to belonging to a particular race (Wilson, 1997) Although people who do not fit in to this particular construction of racial othering, such as travellers, Jewish people, Irish and Eastern Europeans, also suffer discrimination, the first level of race and vulnerability to racism is "colour coded" (Dalal, 2002) or better still 'visually coded' in that the racial otherness of the individual is there to see in that they cannot be classified as being white. Race in this sense is a set of visible markers and is more likely to result in a how a person is categorised and subjected to racist responses in society.

'Racism' has become a generic term by which physical markers, most often relating to people of colour, and many of their cultural concomitants, are used to 'other' people of colour with prejudicial consequences against their inclusion or acceptance in society on equal terms to white people. Othering can be seen as an unconscious projective process of attributing things that a person does not like about themselves to others, to avoid having to manage the painful realisation of what they do not like or most fear in themselves. The 'other' in this context is used as a verb, and 'other-ing' is used as a projective term of denigration. (Wilson, 1997)

Turning to the issue of 'Whiteness'. According to DiAngelo (2011), (DiAngelo, 2011) *"Whiteness is thus conceptualized as a constellation of processes and practices rather than as a discrete entity (i.e. skin color alone)"*. There is a great deal taken for granted in Whiteness as Whiteness assumes that we all share the same rights and privileges, but which are actually only consistently afforded to white people. White people do not often experience themselves as racialized and more usually see only others, that is people of colour, as being raced, meaning that they do not see the need to build *"the cognitive or affective skills or develop the stamina that would allow for constructive engagement across racial divides"*. There is, therefore, no perceived need to think about Whiteness as an identity, or as I would see it as a vulnerability to being perceived as 'other' that would negatively impact lives. Therefore, white people are simply just people, unnamed, un-raced and un-located. This is the basis of what has been termed *"White Privilege"* (McIntosh, 2010). This is, indeed, at odds with the experience of people of colour who would be unwise to move through the world in such a 'race blind way'.

Race and Defence Mechanisms

Group analytic principals challenge the notion of the mind as an isolate, centring the group as the most powerful agent in terms of relationships operating in the interactions between people. From the perspective of group analysis with its focus on the group, the social and the external, the individual mind consists of internalised forces operating in the group to which he or she belongs. Inner processes are considered to be internalisations of group dynamics. The direction, therefore, is from outside to inside (Dalal, 1998)(Foulkes, 1953). This differs from psychoanalytical notions of the mind, which have been criticised for failing to recognise the mind as essentially relational and permeated by the social (Foulkes, 1953). There is a clear divide between such psychoanalytic theories and radical group analysis. They propose different models of the mind and view the issue of race in different ways. Some modern contemporary psychoanalysts such as Davids (2011)(Davids, 2011) describe an internalised racial object as part of a normal human psyche. This view is strongly rejected by group analysts such as Dalal (2006)(Dalal, 2006) and Blackwell (2014) for viewing the mind as primarily the domain of the individual, as an inner world in its own right, with a limited consideration of the impact of the social. Instead, they maintain strongly that racism exists in interaction and the relationship between people in the overall matrix, including the social unconscious.

According to Blackwell (2014), race is most certainly not a specific component of the mind but is instead is the target of a universal human tendency to 'other', much in the same way as they do with difference in general. It is, therefore, the visibility of race that makes it more available for projective processes. Blackwell explicitly challenges the notion that there is an internal racist residing within the normal psyche and questions why this should be so, as this seems to support race as a positivist phenomenon rather than a social construction. This is could lead to racist ideology in the wrong hands.

All of us, therefore, project 'otherness' on to so-called out groups that extends beyond race. I am, nonetheless, often concerned and perplexed about the way in which race seems to illicit such extreme and powerful reactions and consequent defences. Although I also question the notion of race holding some specific place in the mind and I do share the view of race as a social construction there is, nonetheless, something about race that in my experience leads to extreme and perhaps psychotic responses that requires further understanding. This may be related to "White Privilege" and what DiAngelo (2011) calls "White Fragility". If being white comes with assumed privilege there is inevitability a wish to maintain such privilege and increased anxiety if this privilege is experienced as fragile. I would add 'Whiteness' can offer a sense of safety and protection at time of great anxiety as has been illustrated in the case study, which I return to below.

A Racist Organisation or 'Whiteness' as a Psychic Retreat

'Whiteness, as a set of normative cultural practices, is visible most clearly to those it definitely excludes and those to whom it does violence. Those who are housed securely within its borders usually do not examine it.' (Frankenberg, 1993)

Questions about the meaning of whiteness and why and how it used in terms of its social construction and psychic organisation require robust scrutiny. An analysis of the unconscious dynamics of a racist solution and how to manage it can offer important insights into such a phenomena. Turning then to why the mother's identification with the racist youths and not the Asian woman. This young woman had always been relatively powerless. By identifying with these white youths and not with the Asian woman she aligned herself with the aggressors. Being a victim was now unbearable for her. She sought a Psychic Retreat(Steiner, 2003) in a racist organisation that superficially gave her a sense of safety but prevented her from processing her own trauma and from managing her child's trauma. This type of scenario contributes to a cycle of intergenerational transmission of trauma and abuse.

The racist retreat to whiteness offered the mother in this case something of a haven, some protection from the re-traumatisation she had suffered. However, this comes at great cost as such retreats prevent connection and meaningful contact. The person denies his/her own vulnerability and identifies with aggressors. In this instance, the pathological organisation was racist. The mother identified with the racism of these adolescent boys who attacked the Asian woman. The retreat's main purpose is to avoid intolerable anxiety and fear, especially the fear of death. The retreat afforded an illusion of immortality whereas the attack could have easily been fatal for the Asian woman. Further, the retreat is an encapsulation of the original and later trauma. It is considered preferable to facing the horror of what this woman had witnessed -an attack that had re-traumatised her and her child, although they were not directly attacked.

The horror and the trauma of witnessing this attack had fuelled this retreat, which was already an established part of her personality due to her previous trauma and abuse. My role was to enable this young woman to emerge from this retreat which would mean putting her in touch with more depressive anxieties (Klein, 1959), a sense of empathy and connection with the Asian woman, and less of a denial of what this Asian woman symbolised to her, that is a hated and abused part of herself, which she could not tolerate due to her own experience of being having hated and abused. It therefore felt safer to make an identification with these abusive white boys. Loosening the grip of this defensive structure is painful and diligent work. The clinician is never an uninvolved observer, a clinician of colour will almost invariably have had to manage his/her own traumas relating directly to race and racism.

The management of the transference and the provision of a facilitating and holding environment is particularly challenging in this regard, as was my experience working with this young woman. The internalising of violent and disturbed objects is due to previous experiences of trauma and neglect. The retreat acts to bind these destructive impulses and traumas and they are brought into play when the anxiety caused by the new trauma is beyond what the individual can manage. Such a retreat can last various lengths of time and have different levels of intensity and they are fundamentally defensive in nature.

In this instance the mother lost contact with an abused part of herself and she could not, therefore, empathise with the Asian woman. Instead, she identified with the aggressors – the racist white youths. This was a racist retreat. My role was not to persecute this woman with accusations of her racism but to help her reconnect with her trauma and her feelings about what had happened to her child, so that she could move on. If the mother has a sense that the clinician can understand, contain and connect with these terrible anxieties and can support her to make steps, this will enable her to emerge from the racist retreat. However, one would need to be very cautious. Making contact with such anxiety can be terrifying and during the work the emergence from the retreat will not be a linear process. The work, therefore, is back and forth between emergence and retreat. It is potentially slow and painful and must be done at the right pace to help her connect with such vulnerable aspects of herself.

The Impact of Trauma on the Clinician

What history of trauma does the therapist take into the situation with the client and to what extent does this inflect on the work? How robust is the clinician? Is his/her relational field supportive? These are complex and subtle fluctuations that are very difficult to measure, but no doubt have a powerful impact on the success of the work. Vicarious trauma is the consequence of long-term exposure of working with traumatised individuals. The personality of the clinician is affected by exposure to such trauma. This may lead to a cynicism and a detachment in the clinician who may begin to work in a distanced way with their clients. Although, it is important to have the necessary professional defences in order to work in such a challenging environment, these defences can become excessive and can run counter to work task. Indeed, research has suggested that therapists who have their own personal history of trauma are more susceptible to vicarious traumatisation (Pearlman and Mac Ian, 1995).

However, working with traumatised people within a good therapeutic frame provides growth for both therapist and client. During the process of the work there is an inter-subjective, reciprocal set of interactions between the practitioner and the client that can bring about positive changes in both. When the issue of racism, domestic violence and trauma is part of the situation there is a hotbed of very complex social and psychological phenomena which to work through. Can a clinician and practitioner of colour manage racist dynamics in the context of racist violence? I would assert that most clinicians of colour will have experienced racist trauma in their own lives. Although the service user is not directly responsible for the racist violence in this instance, she seems to condone it. This has the potential to obstruct the necessary witnessing that is required when working with traumatised individuals. The interpersonal tools that a psychodynamic understanding provides are essential if this work is to be fruitful and not be hampered by raw emotional affects that the clinician is unable to contain. In order to manage to work within this field will require a reliable supervisory frame for the clinical to consider the impact of the work and to monitor the progress of the relationship with the client through the clinical process..

Discussion

Complex affects require skilled holding and containment. The clinician needs to create the necessary 'environmental essentials' that allow the management and expression of painful affect. The vicarious traumatisation is likely to be more prominent in the mind of a therapist or clinician of colour when hearing accounts of racist trauma. It is very likely that the therapist of colour would have a particular relationship with racist trauma which makes hearing accounts of racist trauma more challenging, particularly when presented in such an unashamed and even cruel way by the service user and within an organisation where the clinician may experience racism or a lack of support. The challenge is the client's need for affect regulation to be provided by the therapist, to help them tolerate the intense emotional pain around the traumatic experience. This can make the clinical engagement particularly challenging, given that all therapeutic engagement is inter-subjective. The core experience of trauma is disempowerment and disconnection. As I have said, recovery is based on empowerment and re-connection and can take place only within the context of relationship, not in isolation.

One of the more negative aspects of vicarious traumatisation is that the clinician is less available, less attuned and less able to immerse themselves in the patient's experience and emotional world. Within an inter-subjective context what the clinician brings to the relationship has a powerful impact, which has significant implications if the clinician is suffering from such vicarious traumatisation. They will be less available and less able to manage intense effect and they are likely to mirror back to the patient earlier experiences of environmental failure where there has been a breakdown in the

caregiver's ability to provide a system of effective attunement. Therefore, this frightens the child/adult who is left with a sense that painful effect cannot be managed or contained. This drives dysfunctional defence mechanisms in order to manage such painful effect as a consequence of the trauma.

The psychoanalyst Dr Alice Miller's work on *"The Essential Role of the Enlightened Witness in Society"* (Miller, 1997) convincingly claims that if trauma is witnessed then the most damaging effects of such trauma can be mitigated. This concerns the witnessing of...

..people who have understood and recognized the consequences of child abuse. They can learn to verbalize their truth and to discover themselves in their own story. They will not need to avenge themselves violently for their wounds, or to poison their systems with drugs, if they have the luck to talk to others about their early experiences, and succeed in grasping the naked truth of their own tragedy. To do this, they need assistance from persons aware of the dynamics of child abuse, who can help them address their feelings seriously, understand them and integrate them, as part of their own story, instead of avenging themselves on the innocent.

Miller, 1997

To witness in an inter-subjective relational field provides holding and a validation of the traumatic experience. This mitigates previous unacknowledged experiences by the primary care givers, often in earlier childhood that led to complex emotions being repressed in order to maintain ties with these caregivers. A lack of attunement and mirroring in early infancy, which is the root of failing to bear witness, forms the basis of a mismanagement of trauma. It reinforces negative defences against further trauma when it is experienced later in life. This is one of the key features of the intergenerational transmission of trauma and defences such as "identification of the aggressor", where the trauma is located in somebody else whilst the person views him/herself as a non-victim. There is a need to understand the more complex and wide ranging impact of racist trauma and for on-going reflective supervision for all those working in this field.

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