Christine Schmidt, LCSW, CGP
Cschmidt535@gmail.com
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Why Racial Affinity Groups - introduction

Affinity groups are developed in corporate and non-profit organizations to strengthen diversity and inclusivity efforts. They are homogenous support groups composed of people who share common interests or experiences (Indeed, n.d.).

In clinical and community settings, homogeneous affinity groups are similarly designed to offer a safe space for people to support each other in learning and healing situations. They foster interpersonal connections in pursuit of a broader unifying vision. While affinity groups may form around common needs or behaviors (e.g., single parenting, substance abuse, survivors of domestic violence), they also form around key identities (gender, sexual orientation, race) and offer a safe space for members to examine the elevation or subjugation associated with the social locations of their identities (Watt-Jones, 2010).

This writing focuses on the value of racial affinity groups as a component of psychosocial clinical training and delivery of clinical services. The rationale for this approach to racial learning and racial healing will be discussed. Resistance to affinity group work often comes from white-identified people who maintain that such groupings are discriminatory rather than educational and healing. These arguments will be critically examined.

The author is a white-identified group psychotherapist who, in consultation with therapists of color, facilitates whiteness affinity groups. This writing was developed in consultation with therapists of color.

Clinical social work confronts racial trauma and fosters resilience

Much clinical work focuses on the impact of trauma and the development of resilience for an individual, family or community. The New York State Society for Clinical Social Work identifies the impact of trauma on an individual as “bio-psychosocial-spiritual dysfunction....” that considers “the influence and impact...of pain and suffering, race, religion, sexual orientation, stress and spirituality on human development and functioning” (NYSSCSW, n.d.). Clinical social workers are tasked with helping clients understand and cope with trauma that impacts their lives.

Many people accept that societal and interpersonal racism is traumatic for both victims and perpetrators. Clinical social worker Dr. Joy DeGruy Leary (2005) diagnoses Post Traumatic Slave Syndrome as a legacy of slavery and educator Dr. Robin DiAngelo (2018) attributes white fragility as the psychological defense against acknowledging racism. Both phenomena are manifestations of trauma. Racism is woven into the fabric of social structures that have evolved and endured since the founding of the country. Racial violence and inequities remain pervasive in the social environment erupting from racist policies and practices. Racist policies and practices are reciprocally buttressed by racist beliefs that are often unconscious and therefore

not easily confronted. The ecological approach for social work practice purports that an individual's social functioning is both shaped by and influences the social environment (Smith College School for Social Work, n.d.). Therefore, racial trauma that pervades the social environment is present in the clinical setting and addressing it in a manner that fosters resilience is in the purview of clinical work.

Resilience is the capacity to recover from trauma. Traumatologist Judith Herman (1997) contends that "helplessness and isolation are the core experiences of psychological trauma. Empowerment and reconnection are the core experiences of recovery (p 197)." Building resilience requires psychological safety. Psychological safety isn't a condition that can be simply declared; it has to be developed through trusting relationships over time. Building racial resilience in a clinical situation requires measures of risk-taking, vulnerability, and honest self-reflection that will promote healing and will not retraumatize. While there is no prescribed path, the connections and validations offered by racial affinity groups may offer a foundation of psychological safety.

Clinical value of racial affinity groups

Racial affinity groups build resilience while minimizing the risk of racial re-traumatization. Because the racializing experience is different for Black-identified people, non-Black people of color, and white-identified people, the focus of respective racial affinity groups will be different. As previously stated, racial attitudes largely reside in the unconscious as internalized racial oppression. For Black-identified people, being in an affinity group means gathering outside of the white gaze, being relieved of unintended microaggressions, being released from the expectation to emotionally protect white people from anger, being free to be vulnerable, and being able to grieve and heal together. Somatic coach Kelsey Blackwell (2018) writes, "People of color need their own spaces. Black people need their own spaces. We need places in which we can gather and be free from the mainstream stereotypes and marginalization that permeate every other societal space we occupy. We need spaces where we can be our authentic selves without white people's judgment and insecurity muzzling that expression. We need spaces where we can simply be—where we can get off the treadmill of making white people comfortable and finally realize just how tired we are."

For non-Black people of color (e.g., people of Asian ancestry, indigenous ancestry, people of mixed-race ancestry), being in an affinity group means, in addition to gathering outside of the white gaze, being in community with others to disentangle the racist experience of being tagged 'model minority', 'almost-white', and to examine the resultant anti-Black racism internalized from being immersed in dominant white culture. In their seminal article on racial melancholia, humanities professor Dr. David Eng and clinical social worker Dr. Shinhee Han (2000) ask, "How might psychoanalytic theory and clinical practice be leveraged to think about not only sexual but also racial identifications? How might we focus on these crossings in psychoanalysis to discuss, in particular, processes of immigration, assimilation, and racialization underpinning the formation of Asian American subjectivity? (p. 670)" They regard racial melancholia as psychic splitting that simultaneously draws the subject towards idealized whiteness and rejects it. "Whiteness" writes mixed-race feminist scholar Sara Ahmed (2007), "is

an orientation that puts certain things within reach. By objects, we would not include just physical objects, but also styles, capacities, aspirations, techniques, habits (p. 154)." The intrusion of whiteness into the psyches of people of color is pervasive and the accumulation of biased stereotypes, microaggressions is depleting. Being in a people of color affinity group validates these depleting experiences and, through connecting with others, enables recovery to begin.

For white-identified people, being in an affinity group means examining the traumatic impact of un-named, non-confronted whiteness that has insidiously woven into white subjectivity. Clinical psychologist of color Dr. Lara Sheehi (2020) defines whiteness as, "the ideology, then, that has the potential to collapse clinically analyzable space, allowing us at once to disavow historical realities and displace them into the past, far from their present iterations. In this way, ideology becomes the apparition, ever present, but unseen, especially when the limitations of a prevailing ideological framework instigate anxiety within an intersubjective, relational space. It is particularly important to attend to the accompanying anxiety, in the context of clinical practice and process p. 327)." A white affinity group benefits white people who are beginning to consider racial identity for the first time and how it has been regarded as invisible and normal. The affinity group affords relief from fear of being exposed as racist by Black, indigenous and people of color. White group members can experience shame, guilt, and confusion about owning and navigating white privilege, and, at the same time, not place additional burden on BIPOC while unpacking these emerging realizations. Within the safety of an affinity group, members can contradict and edit their verbalizations without fear of committing more racial harm to people of color. White-identified educators Dr. Ali Michael and Dr. Dr. Mary Conger (2009) emphasize the value of safe space for white-identified people "who have anger and confusion about institutional racism, who have guilt and hope about internalized racism, and who have questions about race that they are afraid to ask (p. 56)." White people can begin to grieve the loss of culture and ancestry that was traded in for white racial identity and begin to examine how whiteness is expressed in attitudes, expectations, and beliefs in the clinical space with clients of all racial identities. Within the safety of the group, white people examine how the transgenerational trauma of whiteness resides in white bodies. As clinical social worker Resmaa Menakem (2017) writes, "On the surface, white-body supremacy looks like a highly favorable arrangement for white people. They get to reap a wide range of benefits, while forcing other, darker bodies to bear all the costs. This does not tell the whole story, however, which is that white-body supremacy comes at a great cost to white people. There is the moral injury, which creates shame and ever more trauma in white bodies p. 105)." Affinity group offers a pathway to resilience against toxic whiteness.

Understanding white resistance to racial affinity groups

Frequently, the loudest objections to racial affinity groups in clinical training and services come from white people. This author suggests that white people who have not yet examined their own social locations are attempting to maintain the status quo of an organization that from inception has been white-centered. They haven't grasped the dynamic place affinity groups

occupy in healing processes that could lead to more robust cross-racial dialogues, embrace of a racial equity vision by the organization, and an authentic embrace of the core values of clinical social work (NASW, n.d., NYSSCSW, n.d.).

This author responds to some resistances about formation of racial affinity groups:

Why are we meeting separately by race?

Members of different racial groups have different internalized experiences of whiteness. In an effort to create maximum psychological safety, affinity groups may reduce the emotional triggers encountered during exploring conscious and unconscious experiences of race.

Isn't this a step backwards?

It is a step forward towards healing. It offers a safe space to bear what has been unbearable and to examine what was unexaminable. This will hopefully lead to more productive mixed-race work in the future.

Aren't affinity groups exclusive and discriminatory?

White-identified people have discriminated against people of color for centuries and are reluctant to acknowledge this violence. White people are more likely to be honestly introspective in a space composed of white-identified people. View this as an essential step in a psychosocial and psycho-historical healing process.

How can a white person learn about racism without hearing from Black people about their experience?

White people know a lot about racism. In fact, white people invented it. Diverting attention towards people of color is a defense against facing the unvarnished truth about white racism.

Why is this relevant to a clinical organization?

Clinical work is concerned with the psychological impact of trauma on individuals, families and communities and supports the development of resilience. Racism is a traumatic experience and developing resilience against trauma is an aim of clinical work. Affinity groups are relevant to the clinical mission.

What if affinity groups aren't allowed?

The prohibition of affinity groups and insistence on mixed race gatherings is a declaration to people of color that their needs aren't valued. It risks emotional shutdown and, at worst, re-traumatization. Queer, Black-identified clinical psychiatrist Dr. Kali Cyrus (2020) writes, "For me, when white people drift in and out of the fragile state, the best means of protection against the introjection of those paranoid anxieties is to dissociate…. For these reasons, in mixed racial groups, race dialogue is almost never for the people of color (p. 599)."

Conclusion

Clinical training programs and organizations have an opportunity to address the racialized trauma that has impacted individuals, families, and communities in this country. Honest examination and reckoning with the violence of racism begins by creating emotionally safe spaces within professional programs and organizations. Sanctioning racial affinity groups within professional spaces is an affirmation of the organization's commitment to racial equity and healing from historical trauma. It is the foundation from which resilience and emotional honesty will grow and support healthy cross-racial work. This process will benefit clinical service providers and clients now and in the future.

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