EMOTIONAL REACTIONS TO THE CONCEPTS OF RACISM AND WHITE PRIVILEGE IN NON-ABORIGINAL HEALTH PROFESSIONALS WORKING IN REMOTE COMMUNITIES

A Thesis submitted by

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ABSTRACT

National standards require health professionals to address racism in health service delivery at individual and systemic levels. However, identifying racism elicits strong emotional reactions including denial, anger, guilt and shame, fear, loss of belonging and disgust. These emotional reactions shut down critical reflection on racism and thwart antiracist initiatives. These emotional reactions need to be better understood in order to successfully develop antiracist professional practice. This research examines how health professionals working in remote Aboriginal communities engage with antiracism in their professional practice, whether it elicits strong emotional reactions, and if so whether these emotional reactions impact on their health service delivery. Eleven non-Indigenous allied health professionals were interviewed in a semi-structured format. Interviews were transcribed and thematically analysed. Themes were compared against existing literature. Every professional interviewed identified overwhelming and difficult emotions in their work that they linked to racism, white privilege and colonisation. Professionals reported grappling with denial, anger, guilt, shame, fear, anxiety and perfectionism, loss of belonging, disgust, and care. They reported the emotions cause exhaustion, poor performance, tensions with colleagues and managers, burnout, leaving remote jobs and changing professions. Previously these emotional reactions and their impact on antiracism have only been described in the context of universities and by antiracist activists. This research identifies for the first time that these reactions also occur in health services working with remote Aboriginal communities in Australia. This indicates the need for wider research to understand how these emotional reactions impact health service delivery to Aboriginal communities. It also demonstrates the need to trial and evaluate ways to support staff constructively navigate these reactions and develop antiracist, decolonised professional practice.

CERTIFICATION OF THESIS

I, Caitlin Prince, declare this thesis entitled *Emotional reactions to white privilege and racism in non-Aboriginal health professionals working in remote Aboriginal communities* is not more than 40 000 words in length including quotes and exclusive of tables, figures, appendices, bibliography and references. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Date: 31 August 2022

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Student and supervisors signatures of endorsement are held at the University.

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CHAPTER 1: INTRODUCTION

The role of white Australians discussing race relations in Australia is contestable. As a white woman working in Aboriginal communities now completing research about that work, it is essential for me to unpack some of the dynamics that surround my position in this discussion.

I am descended from invaders and colonisers. My ancestors on my maternal side trace back to convicts and first settlers 'clearing out' Ballardong Noongar land for agriculture in the Wheatbelt of Western Australia. On my paternal side, my grandfather and grandmother immigrated from England after World War Two. My family has thrived on unceded land. We are beneficiaries of genocide.

Enabled by their wealth, education, and privilege, my parents decided to temporarily relocate to an expatriate life in Nepal, so my own childhood was spent as a privileged white minority in a Nepalese majority. I returned to Australia for my final years of primary school and, like my parents, I completed high school and graduated from university. As an occupational therapist, I have been paid well to work in rural and remote communities across Western Australia and the Northern Territory for the past fourteen years. I have the privilege and social mobility to alternate periods of working in these places with traveling internationally for extended periods. I am often complimented on being a 'good person' for working in Aboriginal communities. This is an incomplete summary of ways in which white privilege has shaped my life, what Land (2015, p. 159) calls accrued, unearned privilege resulting from prevailing social relations.

In outlining some aspect of my privilege, there is a risk I am attempting what Tuck and Yang (2012, p. 10) call a 'move to innocence', a demonstration of conscientiousness to relieve my guilt or avoid my responsibility towards more significant and uncomfortable tasks like giving up power, privilege or land. Historically, much harm has been caused by non-Aboriginal Australians writing about working in Aboriginal communities. Because I am white, there is an implicit limitation and bias to my perspective and much I'm blind to. It's also possible I am acting out the tendency white people have of assuming they may 'act and think as if

all spaces are or should be available to them to move in and out as they wish' (Curry, 2009, p. 30). There's a lot I should not write about and a lot to be gained from both the absence of my voice and the presence of other, First Nation, voices. There's also the chance my work here is a self-serving enactment of my white privilege, as I stand to benefit professionally from doing this research, especially as I complete it in service of a Master's degree and received a twelve month scholarship.

As Land (2015, p.239) points out, it is impossible for me to escape the 'oppressor camp.' I am a product of white privilege. However, Land also argues that if I identify and understand it, I can reject or redeploy this privilege. While still a debated assertion (Curry, 2009), some believe non-Aboriginal allies who engage in self-reflection to understand how whiteness and colonialism colour their motivations, actions, and impulses to 'help' Aboriginal people, can serve an important role in supporting Aboriginal causes (Boudreau Morris, 2017; Land, 2015; Maddison, 2019). In particular, many Aboriginal people, and people of colour, suggest white people should work with other white people to understand the ongoing mechanisms and impact of whiteness, racism, and colonialism (Land, 2015; Maddison, 2019; Menakem, 2017; Moreton-Robinson, 2004).

This research topic is a result of witnessing strong emotional reactions in myself, colleagues, and students, as they worked in Aboriginal communities. As an occupational therapist, I have been trained to analyse any breakdown in 'occupation' by examining the interplay of environment, occupation/task and the person—their physical, emotional and spiritual capacities. Occupational therapists are also specifically trained in applied neuroscience, to recognise when a nervous system is under stress and dropping into states of hypo or hyperarousal. We are taught to notice if someone is overwhelmed by either sensory input or their emotions and are unable to function with the full use of their cerebral cortex. What I have witnessed when working in remote Aboriginal communities, in myself and other health professionals over the past fourteen years, is that we are regularly challenged by strong emotional reactions that impact our ability to work at our best. This research seeks to understand these reactions; to explore whether they are a product, or performance, of whiteness, racism or colonialism. It is an attempt to take

responsibility for potential barriers in our helpfulness as allies, including our ability to get out of the way of Aboriginal people.

There is a risk of this research shifting focus back to white people (Land, 2015) and inappropriately recentering discussions of whiteness, race, and racism to feelings of white people (Zembylas, 2018a). It is important to ask whether this research really serves the Aboriginal communities these professionals work in, especially given it is still an unresolved question whether white people can ever be a reliable ally; perhaps we have too much lose (Land, 2015). As a progressive Australian, I identify with a desire to improve non-Aboriginal Australia's relationship with Aboriginal and Torres Strait Islanders, but my position, status, freedom and wealth, are a direct result of the colonial system that continues to oppress them (Land, 2015; Maddison, 2019). Some argue that the enlightened white ready to end racism is a naïve fantasy already disproven by history (Curry, 2009).

I am also warned by white people to not overinflate the impact of racism. I am told talking about racism deters well-intentioned white people from engaging in cultural awareness training and practice. I am told this topic will upset people, an assertion well supported by literature (Boler, 2003; Bullen & Flavell, 2017; Zembylas, 2018b). However, it is my opinion that the question remains relevant: if these topics evoke strong emotions that cause people to disengage from learning how to work better with Aboriginal people, isn't it necessary to understand why these reactions occur and how to work constructively with them?

This range of perspectives create a knife-edge on which to undertake this research. Sensitive to these risks and doing my best to straddle the conflicts and find balance, I enter into this inquiry as a result of my own experiences working in Aboriginal communities. It is research I wish I'd had; a better map to follow as a professional navigating the strong emotions experienced by myself and colleagues while working in Aboriginal communities.

As a non-Aboriginal professional working in Aboriginal communities, my starting point in some ways was atypical. Growing up in Nepal had normalised, and taught me to tune into, cultural difference. My own family's cultural norms were at odds with the majority culture surrounding us. At my international school, it was normal to discuss and navigate the differences in religion, first language, cultural practice, and lived experiences of my peers. When I returned to live in Perth, I was

confused by the attitudes of my almost entirely white school peers who criticised or ridiculed anything foreign or different. I quickly learned not to tell stories about my life in Nepal and to lose my strange accent. The experience led me to notice and be concerned about the way majority Australia treated anyone who was different—minorities, immigrants, people of colour and Aboriginal people.

It also meant that when I first arrived to work in an Aboriginal remote community, I understood how to watch for different social and cultural dynamics; how to sit with the discomfort of the cross-cultural interface (Nakata, 2007) and how to deconstruct my own culturally informed communication pragmatics and code-switch to match another. Remote Aboriginal communities felt more familiar to my cross-cultural childhood than the white Australian suburbs of Perth, so I did not experience the disorientation and dislocation colleagues have described. For many of my colleagues and students, working in a remote community is the first time they experience being the cultural minority: a white face in a black majority. Assumed norms, even as fundamental as making eye contact when speaking, or the cadence and emphasis used when discussing emotional content, no longer apply. The natural, unthought ways of connecting with another human are swept out from under them.

As clinicians, much of what we have been taught in university or other jobs is ineffective in this context. Our training and professions, based on a white cultural norm, are not immediately transferable to the different family structures, languages and worldviews of Aboriginal communities. Standardised assessments are not validated for most remote Aboriginal populations, leaving clinicians feeling ill equipped. This can not only trigger feelings of inadequacy but can also set up tensions between the clinician and town-based employers and professional associations. Feelings of inadequacy can be so overwhelming that professionals withdraw from community, spending more time at home or locked away in offices instead of seeing clients.

In many other ways, I was like most non-Aboriginal Australians when I began working in Aboriginal communities. Woefully uninformed about the true history of our country; unaware of the ongoing impact of racism on the daily lives of Aboriginal people; blind to how whiteness had informed not only my life and perspective, but also my profession and the organisations I worked for.

I was unprepared for the flashpoint reality of race relations between Aboriginal people and white service providers in community. An example that made

state newspaper headlines (McNeill, 2017) was a report of children being 'publicly flogged' for breaking into the community shop. The reporting reflected the tone of the non-Aboriginal people working in the community—anger, outrage, fear. Emotion blazed ahead of facts or understanding. When reports like this breakout in community, it feels impossible to remain unaffected. My experience is that it can push a (white) button in me that suddenly amplifies every worst story I have heard about Aboriginal people. I experience confusion and disillusionment; I question my commitment to working in a community where something so terrible has occurred. Then, as I come to understand the situation has been misrepresented, I experience a deep shame at how internalised racism can creep in so quickly. Reports like this inevitably turn out to be a complicated interplay of cultural clash and racism. What is reported is rarely an accurate representation, misinterpreted, simplified and sensationalised through white filters. The original event is usually a complex mix of cultural practice, interrupted cultural power structures, stress, intergenerational trauma and, at times, alcohol and substance abuse. Events like this are emotionally draining to navigate. They are also very difficult to explain to town-based managers, which contributes to feeling isolated.

The experiences I observed evoking the strongest emotions in myself and my colleagues is seeing the clash of two very different cultural systems, and the inability of dominant Australian institutions to understand, recognise, or allow First Nation cultures to operate. Too many people I have worked with—children, middle aged, and elderly—have died as a direct consequence of these misunderstandings. Outside of Aboriginal communities, this can seem like strong aspersion to make, yet for those of us on ground it is an unavoidable daily reality. That this daily reality for Aboriginal families is something non-Aboriginal Australia still debates, despite multiple national investigations into deaths in custody, child removal and stolen wages finding substantiated evidence, is an example of how whiteness and racism continue to operate. People have died because health services don't understand how to listen to Aboriginal patients, nor how to explain things in a meaningful way to Aboriginal families. Legal and police systems respond with violence and imprisonment rather than understanding cultural collisions at play.

I find it increasingly difficult to stay calm in meetings where services are designed in boardrooms full of white people debating service models hypothetically, because the impact of those services is no longer hypothetical but deeply personal. I

have a huge respect for First Nation people who manage to retain some kind of equanimity so they may discuss and impact change at this level, while the decisions made correspond to the lives and deaths of their family members. They are not my family, and yet I struggle with intense frustration, anger, and grief arising during these meetings.

As I am gradually exposed to more First Nations' culture and knowledge, more anger and grief arises because it feels as though that knowledge is not being utilised, nor protected, by majority Australia. Thorpe (as cited in Land, 2015) articulates the peril of this for all Australians, Aboriginal and non-Aboriginal alike, with Western culture's disconnection from the land leading to exploitative and unsustainable practices that destroy the environment we all rely on. In the communities I work, it often feels like Australia is doing very little to protect the people and nations who hold this knowledge, and conversely, act out a colonisation process that threatens the survival of these cultures. In practice, it seems we continue to demand a 'sameness' from Aboriginal people, similar to the push for homogeneity I observed as a child returning from Nepal, with historical roots linked to justifying seizing land (Moodie, 2017) .

I am interested in why dominant culture Australia struggles to grapple with cultural difference. Why are so many individuals and organisations unable to significantly modify how they do things to permit a different cultural system to operate? First Nation writers, as well as other people of colour, implore us to consider the impact of power dynamics in this process, what Sakamoto describes as 'interrogating the power-laden contexts in which the process of othering occurs; towards naming and subverting the dynamics of power that allow for the culturally different to be deemed as "other"' (2018, p.106). These 'power-laden contexts' have also been called white privilege, whiteness, or racism.

The emotions arising in myself and my colleagues while working in remote Aboriginal communities are complex, layered, and difficult to attribute to any one cause. On top of the cultural and workload demands, we are all also living in communities far from our friends, family, and often our spouses. We are usually isolated from managers, colleagues and professional networks. Our work can entail a great deal of travel in rough conditions. Many of us are impacted by vicarious trauma. And, some of our emotions are elicited by the process of deconstructing our own

cultural practices and encountering our own whiteness, privilege, and the impact of racism on the communities we work in.

My hope, in undertaking this research, is to articulate the common emotional ground trodden by health professionals working in remote communities. Perhaps by mapping these out we can better understand the challenges staff face and the support they may need to manage and move through these feelings and develop into effective allies for Aboriginal people.

In this research, I interviewed eleven health professionals working in remote Aboriginal communities, about their experiences grappling with colonisation, racism, and white privilege. I focussed on the emotional experience, and how these emotions impacted their professional practice. I reviewed literature by academics, antiracist and decolonisation educators and activist, to draw out what is known about the emotional terrain of these topics: Why emotions come up when these topics are explored, the impact these emotions have, as well as productive ways of working through these responses towards antiracist, and decolonised, professional practice.

This thesis is arranged into four chapters. Chapter 1 reviews Australian and international interdisciplinary literature informing both professional health practice in remote Aboriginal communities, and this research. Chapter 2 presents the methodology used in this research. Chapter 3 discusses the results, comparing and contrasting it with existing literature. Chapter 4 concludes the thesis by summarising the key findings of this research, and its implications for professional practice and future research.

CHAPTER 2: LITERATURE REVIEW

2.0 Introduction

This chapter reviews interdisciplinary literature informing professional health practice in remote Australian Aboriginal communities. It explores both Australian and international literature written about working with Black, Indigenous and People of Colour and critiques its relevance to the specific context of remote Aboriginal communities Australia. Section 1.1 examines the current expectations around cultural competency, antiracism and decolonisation in professional health practice. Section 1.2 reviews literature describing the strong emotional reactions white people have in response to discussions of racism and colonisation, such as denial, anger, guilt and shame, fear, loss of belonging and disgust, and the ways this functions to uphold racial inequality. While national standards and practice frameworks call upon health professionals to implement antiracist and decolonising approaches to service delivery, there is an absence of literature discussing the impact of the associated emotions in the workplace. Therefore, Section 1.3 draws upon the research from educators in schools and universities, as well as the experiences reported by antiracist activists, that describe emotions elicited by antiracist and decolonising pedagogies: their causes, presentations and impact, as well as effective ways of working with them. Section 1.4 contextualises these emotional experiences with other stressors and emotions arising from living and working in remote Aboriginal communities. Section 1.5 highlights the implications of this literature for the research project.

2.1 Professional practice: what is required of health professionals in Aboriginal communities?

At all Australian state and national levels, practice guidelines agree that health professionals working with Aboriginal and Torres Strait Islander people require specific cultural competencies (*Aboriginal and Torres Strait Islander health curriculum framework*, 2014; *National Aboriginal and Torres Strait Islander health plan 2013-2023*, 2013; *The national scheme's Aboriginal and Torres Strait Islander health and cultural safety strategy 2020-2025*, 2020; *Northern Territory Health Aboriginal cultural security policy*, 2016; *WA Country Health Service Aboriginal*

health strategy 2019-24, 2019). There are numerous frameworks that all use different terms, however, they all agree on the basic tenets that

1) Non-Aboriginal professionals need to recognise and understand Aboriginal and Torres Strait Islander ways of knowing, being and doing including history, cultural, worldview and diversity (*Aboriginal and Torres Strait Islander health curriculum framework*, 2014);
2) Professionals need to identify their own culture and one's organisation's culture (*Aboriginal and Torres Strait Islander health curriculum framework*, 2014);
3) Aboriginal people and cultural practices should be empowered to guide service delivery (*Mia Mia Aboriginal community development: fostering cultural security*, 2017; *The national scheme's Aboriginal and Torres Strait Islander health and cultural safety strategy 2020-2025*, 2020).

The criticism of the 'cultural competency' model is that it positions the Aboriginal and Torres Strait Islander community as a marginalised 'other'(Fredericks & Bargallie, 2020, p. 297) and essentialises culture as a 'series of knowable characteristics to be studied, known and managed' (Razack, 1998, p. 10) while Anglo-Australian culture and whiteness are positioned as the invisible norm (Moreton-Robinson, 2000). This masks the control and dominance of the colonising culture as well as the complicity of health professionals in maintaining that dominance. It positions Aboriginal and Torres Strait Islander people and culture, rather than white people and culture, as the object and focus of training (Fredericks & Bargallie, 2020). It fails to critique the impact of racism on Aboriginal and Torres Strait Islander communities and the perpetuation of whiteness and colonial culture in health service delivery.

Now, all national and state bodies that govern health services within Australia identify the need to address racism in health service delivery. This includes the current *National Aboriginal and Torres Strait Islander Health Plan 2013,* state and territory health service strategies and cultural security policies, and the Australian Health Practitioner Regulation Agency's (APHRA) *Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy.* This nationally agreed-upon benchmark requires health professionals to both identify their individual racism and 'provide care that is free of bias and racism' (*The national scheme's Aboriginal and Torres Strait Islander health and cultural safety strategy 2020-2025*, 2020, p. 9),

as well as 'identify, promote and build on good practice initiatives to prevent and reduce systemic racism' (*National Aboriginal and Torres Strait Islander health plan 2013-2023*, 2013, p. 15).

As antiracist and decolonising frameworks rest upon decades of work theorising concepts of racism, whiteness and colonialism, it is worth briefly unpacking these theories here, and exploring their application in Australia.

2.1.1 What is whiteness?

Whiteness is not used in reference to skin colour (though skin colour can increase an individual's access to white spaces and power), but to the governing structures and their related worldview that currently hold power within Australia, and much of the world (Hage, 1998; Moreton-Robinson, 2015). White 'privilege' comes from being classified as belonging to these dominant white spaces and all the benefits that flow from that classification (Land, 2015). Research shows the term 'whiteness' is unfamiliar and uncomfortable for many white people (Vanidestine & Aparicio, 2019). Whiteness gains its power through this near invisibility (Moreton-Robinson, 2000). White cultural ways of knowing and doing are taken for granted, and because they are considered the established norm, whiteness is rarely examined or critiqued. It is omitted from discussions about race amongst white people because race is reserved for the 'other' (Moreton-Robinson, 2004). Whiteness 'is what allows us to see the deficient and the abnormal without itself being seen' (Montag as cited in Moreton-Robinson, 2004, p. 75). In Australian cultural competency literature, words like 'dominant culture', 'Western culture', 'colonial/postcolonial Australia', 'Anglo', 'mainstream' may all be used to describe this same phenomenon (*Aboriginal and Torres Strait Islander health curriculum framework*, 2014; Hage, 1998; Johnson, 2011; Trudgen, 2000), the assumed cultural norm that is invisible and rarely examined, shaping societal structures, including health services.

As Castle et al. (2019, p. 28) observe, 'Policy-makers are majority white. Public health decision-makers are majority white. Whether consciously or not, most have likely been socialized into a white racial frame that is invisible to them yet shapes their world view.' Anderson (2003) traces how whiteness has been constructed within Australian medical practice from the beginning of colonisation. He describes how the fear held by newly arrived British doctors about this unfamiliar continent, coloured their perspective: could British bodies be healthy in this

challenging environment, or would subsequent generations born in Australia be sick, stunted or infertile? Anderson argues that whiteness became associated not only with skin colour and European descent but with geographic location, following colonisation's path across the continent. The more temperate, first settled, parts of Australia became associated with whiteness and 'civilisation', and the tropical, later settled territories were considered 'wild' and 'coloured'. Medical practice contributed to the concepts of white superiority and white purity, by pushing ideas that illness came from transgressing into the wrong type of climate and 'contact with the wrong kind of person—a coloured person' (p.17), a perspective still echoed in the phrase 'gone troppo'. In positioning the European white male as superior and 'fully human', Indigenous people were positioned as 'subhuman', facilitating the 'appropriation of Indigenous lands in the name of patriarchal white sovereignty' (Moreton-Robinson, 2015, p. 139).

Since its beginnings, Australian health practice has not been culturally or racially neutral. Denying whiteness limits scope of reflection and the development of antiracist practice (Moreton-Robinson, 2000). In a health professional charged with providing care, it is crucial that whiteness is made visible, and examined for how it guides service delivery towards an assumed white norm whilst disregarding 'inferior' Indigeneity.

2.1.2 What is racism?

Given its everyday usage and its prevalence in health governance literature, the term 'racism' is a surprisingly 'contested concept' (Winston, 2004). The understanding of the term 'racism' differs greatly between white and Black, Indigenous, and People of Colour communities (Trepagnier, 2010; Unzueta & Lowery, 2008) in terms of a) whether racism is an individual or systemic/societal phenomenon and b) whether racism requires conscious intent. Racism and white supremacy are also framed in some literature as an intergenerational, collective trauma deeply embedded in bodies, neurobiology, behaviour and culture (Kendi, 2020; Menakem, 2017; Ogden, 2021; Ricketts, 2021).

Is racism individual or systemic?

White people are more likely to define racism in individualist terms, and Black, Indigenous, and People of Colour are more likely to define it in systemic,

societal, institutional terms (Trepagnier, 2010; Unzueta & Lowery, 2008). Aboriginal academic, Aileen Moreton-Robinson for example, defines racism as

> the process by which whiteness operates possessively to define and construct itself as the pinnacle of its own racial hierarchy…instrumental in the assertion and assumption of patriarchal white sovereignty and its manifestation in this place as the Australian nation-state. (Moreton-Robinson, 2015, p. 138).

Racism began purposely, to enable subjugation of a group of people for labour, and in colonising countries like Australia, to steal land and territory (Curry, 2009). Subsequent generations of white people inherit a cultural legacy in the form of internalised superiority, the right to rule, and antiblack sentiment (Grosland, 2019), justified through stories and explanations that rationalise and maintain this world order(Ladson-Billings, 1998). Racism is woven into the fabric of society (Trepagnier, 2010) with prejudice embedded into societal laws, institutions, and media representations that disadvantage some groups while privileging others (Bourke et al., 2019). Some literature calls this 'institutionalised' or 'systemic racism' to differentiate it from an individualist phenomenon; Kendi (2020) uses the term 'racist policies' to more immediately draw attention to the mechanisms of racial oppression.

Many authors and activists warn that 'limiting definitions of racism' (Ioanide, 2019, p. 22) to 'an individual evil, rather than the political and organisational problem' (Srivastava, 2005, p. 46) functions to perpetuate racism, diverting antiracist efforts towards 'deciphering who is a racist and who is not' (Ionanide, p. 23) rather than the critical examination and dismantling of systemic racial domination (Vanidestine & Aparicio, 2019). The individualist framing of racism also triggers defensive reactivity in white people that derails examination of racial inequality: 'The possibility of being touched by the "evil" associated with some imagined racist identity calls up deep emotions—fear, anger, despair.' (Srivastava, 2005, p. 46).

Ricketts (2021) incorporates both the individual and systemic issues in her framing of racism, emphasising the importance of the individual, inner work specifically because the 'broader social system' have ensured that 'white supremacy is taught, learned and absorbed from birth' and is therefore inherently imbedded in the 'hearts and minds' of individuals (2021, p. 38).

Does racism require intent?

A fundamental question asked in attempts to define racism is whether an individual or institution must have deliberate racist 'intent' for racism to exist (Bourke et al., 2019; Moreton-Robinson, 2000). Hage (1998) argued the term 'racism' should be reserved for racially targeted subjugation, intimidation and harassment, to give these acts the negative stigma they deserve. He argued racism should not be defined merely by holding a prejudiced fantasy about an 'other', nor having the power to do something with that prejudice but rather, that racism lies in what one does with that power. This definition suggests racism is limited to a handful of individuals and that the majority of whites are only implicated if they personally harbour and act on prejudiced views (Unzueta & Lowery, 2008).

The issue with this limited definition, however, is it ignores the way whiteness operates. The invisible norm of whiteness in governing laws and institutions such as schools and health services implicitly disadvantages non-white groups. The embedded, systemic operation of whiteness impacts and implicates all individuals, regardless of the racial group membership, by the way whiteness either unjustly advantages (whites) or disadvantages (Black, Indigenous, and People of Colour) everybody based on race (Unzueta & Lowery). This invisibility of whiteness and racism means even well-meaning white people can contribute to racial inequality without intending to or knowing that they do so (Trepagnier, 2010). Several terms have been used to describe the racism that occurs without conscious intent including unconscious racism, dysconscious racism, silent racism, everyday racism and internalised racism.

White people are taught not to see race or racism (DiAngelo, 2018; Dyer, 1997; Ladson-Billings, 1998). Not seeing race is instrumental in perpetuating racism.

> 'A central feature of white settler colonial subjectivity is forgetting; we live whiteness in part as active ignorance and forgetting. In situations where facts of the matter are routinely brought to our attention, forgetting must be an active and ongoing thing' (Shotwell, 2015, p. 58).

One way to obscure racism is to use coded language which avoids racial language, but effectively perpetuates racial control (Castle et al., 2019; DiAngelo, 2018; S. Schulz, 2017). Words such as 'ethnic', 'diverse', 'multicultural', 'underprivileged', 'disadvantaged', 'remote', 'culture', allow race to be discussed

without ever being mentioned. These words encode naturalised whiteness worldviews; 'remote', for example, positions predominantly white Australian cities as the normalised centre (S. Schulz, 2017). Hage argues that the language of 'multiculturalism' and 'tolerance' holds an implicit assumption that White Australians have the power to choose to tolerate (or not), and to control who and what behaviour can be tolerated in the national space. Importantly, the language of 'not seeing colour', also known as 'colourblind racism', is also considered covert racism as asserting racism is not occurring prevents any action to address it (Bonilla-Silva, 2003; Burke, 2012; Castle et al., 2019; DiAngelo, 2018).

Is racism intergenerational trauma?

In trying to understand the intractable nature of racism perpetuating through generations, some researchers have turned to neurobiology and psychology, framing racism and white supremacy as an intergenerational collective social trauma. 'Oppression is a social trauma that traumatizes—although in very different ways—both the targets and the agents of oppression' (Tarakali, 2010). It's theorised that white people carry intergenerational racial trauma as a result of what they and their ancestors have done and continue to do to Black, Indigenous, and People of Colour; of how they have witnessed subjugation and brutalisation of others; how they have failed to oppose this subjugation of others and the unbearable knowledge that their gains come through the subjugation of others (Britzman, 1998; DiAngelo, 2018; Menakem, 2017; Zembylas, 2018b)

Tarakali and Ricketts argue that white supremacy requires white people to continue to 'internalise dominance, to 'deny, disassociate and defend' (Ricketts, 2021, p. 49) and that it disrupts the essential human need of connection—both with those they oppress and their own community should they fail to maintain white solidarity (DiAngelo, 2018). Tarakali outlines that 'internalised dominance' in white people requires from the individual:

> Denial; dissociation; numbness; obliviousness to oppression and to target group members in general; defensiveness; attacking and blaming target group members'; refusal to take responsibility for oppression; self-absorption; avoidance of target group members; paralysis. (Tarakali, 2010).

Whether or not ‘trauma’ is the correct term, it is helpful to examine racism and white supremacy with an understanding of the neurophysiology and psychology, and how ‘bodies inherit not merely genes but power relationships, legacies of discrimination, the ideological effects of past social policy, and generational systems of belief.’ (Bridges et al., 2017, p. 181)**.**

There are a number of ways in which these legacies can be passed through the generations, often without an explicit story or verbal understanding as to why (Ogden, 2021). Physical and emotional responses to black bodies can be taught in infancy, with the learning stored in procedural parts of the brain that respond automatically without conscious decisions being made (outlined in detail in Section 1.2.2). The impact of trauma, such as a dissociative or shame response to having murdered an Aboriginal person, could also be passed down through subsequent mistreatment of family members, either in a disassociated, numb parent, a conspicuous silence in the family story or out of place rage issues within the home (Menakem, 2017). Cultural norms, institutions and systems are another way in which internalised dominance, dehumanisation of racial others, or denial and disassociation are passed down through generations. Finally, there is some research human genetics suggesting that trauma is passed on through DNA expression and activation, as well as the biochemistry of the womb (Menakem, 2017).

Understanding white supremacy as a collective trauma is significant because of the approach it could offer for dismantling racism. The psychobiology of trauma understands that deep emotion and traumatic responses emerge from deep brain and body structures (particularly the brain stem, limbic system and vagus nerve), rather than the cortex or rational mind. ‘A traumatic response usually sets in quickly—too quickly to involve the rational brain. Indeed, a traumatic response temporarily overrides the rational brain’ (Menakem, 2017, p. 8). Understanding white supremacy through the lens of trauma neurobiology gives alternative ways to deal with the seemingly intractable emotional responses of white people, such as the irrational, but very real fear white people feel, when confronted about racism. ‘Our ego tries to convince us that we are in “life-and-death” situations—that a change in our world view of self-identification is the same as facing a lion in the jungle. We get mired in flight, fight, freeze, or fawn’ (Ricketts, 2021, p. 45). ‘Your body doesn't give a rat's ass what your cognitive brain thinks or believes. Your [vagus] nerve and lizard brain either feel safe, or they feel threatened’ (Menakem, 2017, p. 206).

Psychotherapists such as Menakem and Ogden, have begun to apply their somatic and sensorimotor therapies to racial trauma, teaching white people how to calm their nervous systems, grow their resilience to emotional discomfort, and turn to face the difficult knowledge of how they and their ancestors have harmed others. This work illuminates the unconscious patterns of behaviour that perpetuate oppression and upskills individuals with alternative, more helpful responses. These approaches help deal with the emotional reactivity surrounding antiracism, regardless of whether white supremacy can accurately be framed as intergenerational trauma.

2.1.3 What is antiracism?

Antiracism requires individuals as well as organisations to critically examine their privileged position and engage in practices that challenge racism and create racial justice (Davis & Gentlewarrior, 2015). Antiracism emphasises the need to actively work to dismantle racial inequality, rather than perpetuate it by denying or minimising its existence. 'The opposite of "racist" isn't "not racist." It is antiracist' (Kendi, p. 9).

The current antiracism movement is underpinned by understandings of racism (and its remedy) derived from Critical Race Theory (CRT), originating in the 1970s by African-American writers such as Derrick Bell, Richard Delgado, and Alan Freeman. CRT established racism as an ordinary, common everyday experience of most people of colour; the normal organisation of society, rather than the aberrant behaviour of evil individuals (Bell, 1980; Delgado et al., 2017). Applied to health, CRT would consider racialized power relationships as the norm in health service delivery, 'as opposed to a "sporadic aberration: in an otherwise beneficent system'(Bridges et al., 2017, p. 180).

CRT posits that 'interest of blacks in achieving racial equality' have historically 'only been accommodated only when it has converged with the interests of whites' (Bell, 1980). Bell argued that while some white Americans could support black causes based on the morality of racial equality, change has only ever occurred in history when it was in the interest of white Americans. CRT outlined the difficulty of disrupting racism, given that it benefitted white people and therefore 'large segments of society have little incentive to eradicate it' (Delgado et al., 2017, p. 34). This scepticism of white people as allies in the struggle for racial justice is reflected

by Aboriginal writers and activists, who note that 'rarely do the interests of Indigenous peoples align with those of the settler state' (Moodie, 2017, p. 36), that non-Indigenous people have 'too much to lose to be reliable allies of Indigenous people' (Land, 2015). Kowal observed how this message had been internalised in 'white antiracists' working with Aboriginal people in the Northern Territory (NT). She described how white health professionals and researchers wrestled with self-doubt, unsure whether there was an ethical, non-harmful way for a white person to help Aboriginal people that didn't ultimately serve white interest or repeat assimilation. This appeared to be a core fear, Kowal argued, that made white people limit their work, causing Kowal to wonder whether white anti-racism was 'based in the negation of its own possibility' (p.148).

Another legacy of CRT present in current antiracism movements is the positioning of people of colour story-telling experiences of racism, as valid, authoritative forms of knowledge (Delgado et al., 2017; Ladson-Billings, 1998) 'minority status, in other words, brings with it presumed competence to speak about race and racism' (Delgado et al., 2017, p. 36). This is an important challenge for health professions that 'fetishize' quantitative measures in medical and scientific research, pointing to the need to be inclusive of other research methods including qualitative and narrative approaches (Bridges et al., 2017, p. 181). Kowal noted the prioritising of Aboriginal voices at the Indigenous health research institute as defining characteristic of its antiracist culture.

It's worth noting that CRT, which underpins antiracism, originated in the United States examining the roots of how racism functioned to support slavery—arguably, overlooking therefore North America's own Indigenous history (Moreton-Robinson, 2015). In Australia, racism functioned to justify colonisation: the seizing of land, the positioning of Aboriginal people 'as a raced subject, rather than a sovereign subject' (Moodie, 2017, p. 38), and all the practices that then flowed from this positioning: displacement, massacres, child removal, and slavery. In contrast to CRT, decolonisation theory, originating from colonised nations, centralises the issue of sovereignty (Watego et al., 2021) as well as unceded land and territory (Tuck & Yang, 2012). Emerging bodies of scholarship in Australia are seeking to connect critical race theory with Indigenous studies scholarship (Watego et al., 2021)and decolonisation theory (Moreton-Robinson, 2015). This is not dissimilar to scholarship from other minority groups such as Asian-Americans, Latinx, First

Nation and LGBTQI, who have critiqued and added to CRT, utilising it to conceptualise the unique barriers to equality they face (Delgado et al., 2017).

2.1.4 What is decolonisation?

Where Critical Race Theory and antiracism focus on race, decolonisation addresses the denial and denigration of Indigenous sovereignty; in particular, the seizing of land and the displacement and marginalisation of First Nations within their own homelands (Tuck & Yang, 2012). Decolonisation is about coming to understand how realities and identities of both colonizer and colonized have been mispresented, along with a willingness and commitment to disrupting this process (Dudgeon & Walker, 2015; Land, 2015). Decolonisation is about unsettling the dominant narrative of a settler state (Boudreau Morris, 2017), illuminating the assumptions and beliefs that lie within the colonial lens, a process inextricably linked to, but distinct from, understanding whiteness and white privilege.

There is some debate as to whether decolonisation should focus entirely on Indigenous sovereignty and land rights, or more widely address the inclusion of Indigenous perspectives in things like curriculum, or methodological approaches to research conducted by or with Indigenous peoples (Moodie, 2017; Moreton-Robinson, 2004; Tuck & Yang, 2012). Tuck and Yang (2012) argue that the term 'decolonisation' is being increasingly used as a metaphor to describe a myriad of other social justice causes and attempts to de-centre whiteness, to fight off other oppressions, failing to acknowledge its roots in a very non-metaphorical reality of Indigenous people struggle for sovereignty and land rights.

For Australians, decolonisation lies in challenging the fantasy that colonialism is already over (Maddison, 2019). Non-Aboriginal Australians must understand they live on unceded land (Land, 2015). Maddison (2019, p.34) states that 'the majority of Australians resist the idea that their country is a contemporary coloniser, despite the evident fact that there has been no structural decolonisation and little restitution of the majority of stolen land.' According to Maddison, 'While the British colonies ended at Federation, colonialism has continued in a relationship that many Aboriginal and Torres Strait Islander peoples still experience as an occupying power living on their lands' (p. 20).

Non-Aboriginal Australians who want to see reform for Aboriginal people face the uncomfortable tension of wanting their position as an occupying power to be

resolved (Maddison, 2019) but are perhaps not reconciled to the loss of privilege this might entail (Land, 2015). An insidious hold of colonisation occurs because of the fundamental clash of Aboriginal and Torres Strait Islander interest with non-Aboriginal interest. There is conflict inherent in the desire for the relationship with Aboriginal and Torres Strait Islanders to improve, with the often-unconscious level of investment in colonialism that oppresses them (Land, Maddison).

Decolonisation is not a term used consistently in the policies and practice frameworks guiding Australian health practice like racism and antiracism are. It appears in university cultural competency frameworks for health graduates (*Aboriginal and Torres Strait Islander health curriculum framework*, 2014; *National best practice framework for Indigenous cultural competency*, 2011) and health textbooks and journal articles (Dudgeon & Walker, 2015), but not in Health department policies or Australian Health Practitioner Regulation Agency's (APHRA) position paper. Arguably, this is a significant omission when critiquing the impact of whiteness and racism in Australia. Whiteness and racism were utilised to justify the seizing of Aboriginal land and ignoring Aboriginal sovereignty (Moreton-Robinson, 2015) and is inextricably intertwined with colonialism.

2.1.5 What is intersectionality?

The term 'intersectionality' was originally coined by Crenshaw (Carbado et al., 2013) and is now widely used in literature to describe the way multiple types of disadvantage and marginalisation compound one another to increase oppression. For example, how Black women experience oppression because of both their race and their gender. Intersectionality provides a framework to thoroughly analyse how power and oppression operate in any given individual or social group. An individual may receive privilege for being white, but experience oppression for being female and/or queer or disabled. Intersectionality brings much-needed nuance to discussions around oppression, in order to understand how an individual can simultaneously be both a victim of oppression and a beneficiary of other oppressive systems.

2.1.6 Implications for professional practice

Both antiracism and decolonisation approaches centralise power dynamics and place the impetus on members of the privileged group to dismantle oppression in their communities. Some argue this addresses poor health outcomes of Aboriginal

people from the ‘right end’ (Green & Bennett, 2018) as the impact of racism and colonialism ‘disables virtually all Indigenous Australians, regardless of any specific impairment’ (Hollinsworth, 2013a, p. 607). These approaches also place a spotlight on examining the white health professionals and their service delivery, rather than the ‘Aboriginal problem’ or ‘non-compliance’ of Aboriginal clients (Fredericks, 2008). On the other hand, Kowal (2015) argues that an antiracist approach can minimise Aboriginal agency, limit the scope of non-Indigenous staff in Aboriginal communities, and reduce the confidence of non-Indigenous people to the point it makes them ineffective. There’s also a school of thought that focussing on past and present oppression limits the identity of the oppressed and does not provide a clear enough vision for an alternative, emancipated future (Gilroy, 2000), but it’s worth noting this is idea is rejected by many Black, Indigenous, and People of Colour academics and activists (Asante, 2001; Chrisman, 2011).

Others argue that focussing on racism and white privilege reinforces a ‘them and us’ split between service providers and Aboriginal communities. For example Shepherd (2019, p. 4) states that ‘far-reaching social statements such as ‘workplaces are institutionally racist or extensions of colonisation’ or ‘majority-culture clinicians are innately privileged and have racial blind-spots’ create a ‘shame and blame’ approach that induces resentment and backlash from non-Aboriginal professionals. Section three of this literature review explores the arguments about why triggering these emotions can be a useful and productive stage of developing antiracist professionals.

It is also significant that the word ‘racism’ has no agreed-upon definition, and that this one word is used to describe a multitude of different social phenomena. When health professionals are instructed within practice guidelines to evaluate racism and develop antiracist practices, what is really being asked? To examine their individual racism or the institutionalised racism of the health services they work for? Can these processes even be separated? As health professionals begin to see their whiteness and confront their complicity in racial equality, aren’t they as likely to see and critique the whiteness and inequality in the health services they work? What power do they have to develop antiracist professional practice within their employing organisations, or the state and national service policies that inform their design? Are antiracism obligations met once overt discriminatory language is not in use within the workplace, or are health professionals obligated to address examine

how whiteness is operating to exclude Aboriginal people? If a white person is upset at being asked to examine their racism, is it because they feel unfairly accused of personally, intentionally, harassing a person of colour, when in fact they're being asked to examine their unconscious participation in a white norm? If white supremacy is a deeply embedded, intergenerational trauma, do health professionals have the tools to deal with the big emotions and 'flight, fight, freeze, fawn' responses that emerge from the body and deep brain structures beyond their immediate, rational control?

Section 2.2: Do emotions matter?

> We need to respond to injustice in a way that shows rather than erases the complexity of relation between violence, power and emotion.(Ahmed, 2015, p. 196)

> White victimization follows an affective logic where feelings trump facts. That is, people rarely shift their emotional realities and beliefs because they are exposed to corrective facts and evidence. Understanding this affective logic is critical for anyone who wants to create effective racial justice strategies. (Ioanide, 2019, p. 87)

As discussed above, there is a school of thought that antiracism education that triggers feelings of guilt, shame and resentment is counterproductive to its aim because it causes white people to withdraw and disengage (Shepherd, 2019). The counter-argument to this is that these feelings are not only inevitable but are a necessary part of engaging with antiracist and decolonising content (Boler, 1999; Bullen & Flavell, 2017; Saad, 2020b). Many, such as Ioanide and Ahmed above, argue that racial and colonial systems of power are upheld by emotions, and any deconstruction of this power requires understanding emotion. They argue that reason and factual learning alone cannot counter the strong emotional reactions that uphold racism.

2.2.1 Learning is emotional

Those advocating for a 'pedagogy of discomfort' (Boler, 1999) challenge the notion that learning should be an emotionally neutral or altogether positive

experience. They argue learning is ‘an emotional as well as an intellectual or cognitive encounter’, charged with ‘resistance to knowledge’ (Britzman, 1998, p. 118). Specifically, when learning about racism and colonisation, unearthing emotion is considered essential:

> Challenging emotions like shame, anger, grief, rage, apathy, anxiety and confusion will come up for you if you are doing this work deeply. Don’t run away from those feelings. Feeling the feelings—which are appropriate emotions to racism and oppression—is an important part of the process. When you allow yourself to feel those feelings, you wake up. You rehumanize yourself. You start to realise that you weren’t feeling these feelings before because you had shut down a part of your humanity in order to participate in white supremacy. White supremacy purposely numbs you to the pain that your racism causes. Doing this work brings back the real feelings of pain of what committing racism actually feels like physically, mentally, emotionally and spiritually. (Saad, 2020b, p. 25).

2.2.2 Emotions are produced by white supremacy and perform white supremacy

Emotions themselves are an important focus of decolonisation and antiracism because they are a product of, and performance of, white supremacy. Ahmed (2015, p. 196) explains that emotional responses ‘work as a form of judgment’ and ‘involve different movements towards and away from others, such that they shape the contours of social as well as bodily space’ (p.209). Emotions, and their corresponding movements, expressions, micro-expressions and sensations are shaped, and deeply invested in social norms (Ahmed, 2015; Ogden, 2021). Sensorimotor psychotherapist, Pat Ogden, outlines how infants are sensitively attuned to the emotional state of their caregivers while developing their bodies and nervous systems. Infants learn whether it is safe to reach out or to withdraw, whether it’s safe to yield their body weight to someone or whether to tense up, by the reaction of their caregivers. In this way, movement and the emotions associated with those movements, are learned relationally, in a social context. This learning then gets moved into the procedural part of the brain, meaning it does not require constant conscious review but can happen quickly and automatically. We do not need to think about withdrawing from a hot stove, nor do we need to think about reaching out to

hug a loved one. In the same way, a white child learns whether to seek proximity to certain (white) bodies and distance with other (black) bodies (Menakem, 2017). A white infant learns to tense their body around people of colour, their heart rate may speed up, their palms may become sweaty (Ogden, 2021). Because children learn these quick emotional judgements and associated expressions and movements from the adults around them, they are an effective vehicle for passing down of implicit bias (Ogden, 2021), emotional trauma (Menakem, 2017), and oppressive behaviours (Ricketts, 2021).

Some antiracism educators assert that the avoidance of feeling the emotions evoked by discussions of oppression is another exertion of white privilege:

> …wanting to be in the work [of antiracism] but in the back of their mind are trying to figure out, "How can I be in the work and still stay safe, and still stay who I am?" And you can't. You actually have to unravel everything that you thought you believed was reality. Everything that you thought was correct or right or normal. You have to actually unravel that and come apart and have your heart broken open so you can see how other people who don't have white privilege are being experienced in the world, and are experiencing the world so that you can then really change your behaviours to make it clear that Black lives do matter to me. (Saad, 2020a, 18:20)

Antiracism and decolonization education are viewed as necessarily, and fundamentally, destabilizing to the 'self', because that identity is underpinned by racial and colonial narratives. Doyle (2020) reflects that as a white woman, to be an antiracist, 'one of the privileges she's letting burn is her emotional comfort' (p. 192).

2.2.3 Emotions block antiracism

> White fragility functions as a form of bullying; I am going to make it so miserable for you to confront me—no matter how diplomatically you try to do so—so that you will simply back off, give up, and never raise the issue again. (DiAngelo, 2018, p. 112).

It is important for white people to understand and successfully navigate their emotional responses because of how they 'block, diffuse and distract' from tackling

racism (Srivastava, 2005, p. 29). As discussed in depth in the following sections of this literature review, certain emotional reactions cause white people to disengage from discussions of race, deny or minimise the impact of racism, and further perpetuate oppression (Saad, 2020b). Ogden and Menakem point to the neurophysiology of this fragility, how discussions of oppression trigger nervous system dysregulation in white people. Their emotional reactions arise from deep structures of the brain like the amygdala and brainstem, poorly controlled by the intellect. Menakem and Ogden advocate for strategically targeting these deep brain processes by increasing awareness of these reactions—made up of physical sensation, emotions, and thoughts—and widening an individual's 'window of tolerance' to feel these emotions. Effectively regulating these emotions will increase an individual's capacity to then engage the rational mind, challenge assumptions, navigate conflict and engage with difference.

2.2.4 Implications for professional practice

It's clear, from the experience of Black, Indigenous, and People of Colour and antiracism educators, that strong emotions are evoked by these topics. Some argue that's a reason to avoid these topics(Shepherd, 2019). Others argue, rather than shy away from it, these emotions are a necessary, implicit part of the terrain (Boler, 1999; Ricketts, 2021; Saad, 2020b). They argue it's important to examine the emotions firstly because it's part of truly understanding our collective history and the ongoing injustice(Saad, 2020b); and secondly, because these emotions, and the behaviours that stem from them, continue to uphold that injustice (DiAngelo, 2018). If this kind of education was widely recognised as an emotional labour, proactive supports and strategies could be put in place to safeguard mental health, and build 'racial resilience' to move through these challenging emotions and engage with antiracism content (Ogden, 2021; Saad, 2020a; Zembylas, 2018b).

Section 2.3: What emotions are elicited in antiracism and decolonisation work?

2.3.1 Denial

Kendi (2020) calls denial 'the heartbeat of racism', arguing that denial is essential for the continual reproducing of racial inequality. DiAngelo asks white people (in Saad 2020b, p. xii), 'How have you managed not to know [about racism]? Then posits that the answer is some combination of: '1) Because its overwhelming to

face, 2) because we have a vested interest in not facing and dismantling racism and 3) because we're educated *not* to see it.'

Like racism, it's helpful to understand denial as a systemic, rather than a purely individual issue. Denial has a been necessary component of colonisation and whiteness for hundreds of years. It was woven into Australia's earliest laws to justify 'the violent control of racialised subjects' (Giannacopoulos, 2011, p. 8), recasting 'dispossession, colonial violence and the denial of Indigenous sovereignty,' as practices of 'peace, order and good government', a 'necessary sacrifice to make way for the British legislative… purportedly founding a "peaceful" Australian state'.

Some psychotherapists frame denial of racism as 'affective numbness' and 'the inability to feel', a freeze, or dissociative trauma response within settlers and white people resulting from witnessing, perpetrating, or failing to prevent historical and ongoing harm to Indigenous and Black people (Ioanide, 2019; Menakem, 2017). Boler describes this phenomenon vividly:

> Denial is the psyches odd twilight zone. Satre's "bad faith"; Rich's "lying"; Nietzsche's "forgetfulness". Denial can only be the product of human subjectivity, a unique feature of our species consciousness; the space of neither knowing nor ignorance, awareness nor misinformation…An excavation of this phenomenon in relation to emotion reveals that the twilight zone syndrome feeds on our lack of awareness of how powerlessness functions, effect, feeds on, and drains our sense of agency and power as active creators of self and world-representations. By powerlessness I mean a state that is usually silent and mutates into guilt and denial that gnaw at us… (p.143).

Boler links denial to feelings of overwhelm and helplessness, congruent with the understanding of freeze and dissociative trauma responses that arises when an individual feels overwhelmed in a situation (Menakem, 2017). DiAngelo describes a similar phenomenon she calls 'poor racial stamina', observing that white people appear unable to tolerate discussions about race without feeling overwhelmed (2018, p. 2).

Another expression of white denial is 'colourblind racism' (Bonilla-Silva, 2003; Burke, 2012), where white people deny, or minimize issues of race and profess to 'not see colour'. When white people profess that they 'don't see race,' it denies the presence and impact of racism. We cannot examine or change something

that we deny exists. A similar denial occurs when non-Aboriginal health professionals minimise the impact cultural difference has on their service delivery (Shepherd, 2019). Denying difference cuts off further analysis. As Boudreau-Morris (2017, p. 466) writes, 'the enemy of solidarity is not difference but the lack of engagement with difference.' Observers of cross-cultural work also note that some professionals feel so overwhelmed by the complexity and adaptation required in cross-cultural practice that they retreat back into ethnocentric practice (Ward et al., 2001).

Educators call for care, empathy and sensitivity when approaching white people exhibiting denial, particularly because of the feelings of overwhelm and helplessness denial often stems from. Matias and Zembylas (2014) call for 'reconciliatory empathy,' a willingness to empathise even with views one finds offensive and difficult in order to be emotionally present and supportive to students as they explore and understand their troubled racial knowledge. Menakem (2017) suggests white people need mindfulness and body focussed techniques to settle their nervous systems to build resilience, to confront racism and white supremacy. Ogden et al. (2021) recommends white people gradually learn to inhibit automatic denial responses through self-compassion towards one's 'learning edge', as well as meeting with other like-minded people in a supportive community.

2.3.2 Anger

Literature reports that a common white emotional response to discussions about race or colonialism is anger. White people report 'feeling attacked', largely because they understand racism to be an issue of individual morality and goodness rather than a systemic and political one (Srivastava, 2005, p. 46). The emotional outburst derails the conversation from analysis and deconstruction of systemic racism. In interviews of Black women working in antiracism, Srivastava (2005, p. 42) found a common 'angry and indignant reaction' from white women was 'how can you call me a racist' and 'rage turns into tears, the foot stomping, temper tantrums, which are very typical responses.' Fellows and Razack (1994) describe white women leaving the room when confronted with discussions of racism. This response of white people is so familiar and well understood by Black, Indigenous, and People of Colour that Saad (2020b, p. 19) opens her book by writing 'You will want to close the book, run away, and pretend you never heard of me. You will want

to blame me, rage at me, discredit me, and list all the reasons why you are a good person and why you don't need to do this work. That is a normal, expected response'. DiAngelo (2018) summarises defensive behaviours of white people as arguing, denying, emotionally withdrawing, physically leaving, or seeking absolution. These responses function to silence discussion, hijack the conversation, make the white person the victim, trivialise racism, and protect a limited worldview.

Boler (2003) emphasises the defensive nature of anger, observing it serves as a protection not only of one's beliefs but one's identity and one's investment in the values of dominant (white) culture. Boler suggests that angry responses from white students are a complex cry for recognition and care as their resistance is in response to a perceived threat. Saad (2020a) point outs though, that while white perceive discussions of racism as a threat, their lives are not actually threatened; they are not really in harm's way, unlike 'black indigenous people of colour across the world and how they have been impacted by white supremacy, the real trauma, the real violence—death, rape, murder right?'

2.3.3 Guilt, shame and responsibility

White guilt and shame are often described as both getting in the way of antiracism, and as an awakening force that can develop into social responsibility and antiracist action.

Guilt that inhibits antiracism is described as the kind that is 'self-focused'(Zembylas, 2018b) and 'self-flagellating'(Spanierman & Cabrera, 2014). Guilt can express as collapsing into overwhelm, despair and inaction (DiAngelo, 2018; Land, 2015; Zembylas, 2018b); defensive responses of 'proclaiming that they cannot be held responsible for actions that they have not committed themselves' (Todd, 2003; Zembylas, 2018b, p. 3) and individualistic responses that focus on one's own relationship to privilege and racism to the detriment of action against systemic racism (Srivastava, 2005; Todd, 2003).

According to shame researcher, Brené Brown, these unhelpful responses are perhaps more accurately attributed to shame rather than guilt. The key difference being 'guilt is *I did something bad*, shame is *I am bad*' (Brown, 2015). In antiracism work, a white person may respond with shame because of what DiAngelo (2018) calls the 'racist = bad person, not racist = good person' binary. White people respond to racism as an issue of individual moral character: 'How can you call *me* racist?'

Here *racist* is seen as an attack on goodness—a framing that is supported by a liberal, nonracist discourse that sees racism as bad acts done by individuals rather than as systemic" (Srivastava, 2005, p. 46).

However, some argue white guilt can be conducive to antiracism if it leads to a sense of responsibility, accountability and social action. Guilt and shame can move white people out of the denial, disassociation and numbness that helps keep white supremacy in place (DiAngelo, 2018; Todd, 2003)**.** As one recognises another's suffering, guilt can be an awakening force: **'**Guilt and innocence emerge precisely at the point of new awareness, where the stories of suffering become too difficult to hear, to bear, and to integrate into one's sense of self and one's worldview' (Todd, 2003, p. 98).

Guilt, in contrast to shame, 'assumes social responsibility' (Todd, 2003, p. 94), and it is this type of guilt that may be supportive of antiracist practice. Spanierman & Cambrera (2014) define white guilt as 'as remorse, self-reproach, or sense of responsibility for individual or collective wrongdoing with regard to racism' that 'motivates some people to take self-correcting action to alleviate negative feelings'(p. 16). Guilt can fuel a desire to 'unlearn' one's privilege and to make reparations to relieve the suffering of others (Todd) and has been linked by empirical research to increased cultural competence and some types of social action (Iyer et al., 2003; Spanierman & Cabrera, 2014).

Literature suggests strategies for white people to more productively manage feelings of guilt include realising everybody is implicated in racism, that responsibility and culpability exist on a spectrum (Zembylas, 2018b), thereby deconstructing the binary thinking that contributes to shame (DiAngelo, 2018). Thompson (1998, p. 524) writes 'There is no such thing as racial innocence; there is only racial responsibility or irresponsibility,' offering 'responsibility' as a moral lifeline for white people out of shame. Menakem (2017) frames white guilt as another expression of a trauma 'flight/fight/freeze' response and argues that healing does not occur through argument and logic. Menakem instead outlines mindfulness and body focussed therapy that develop an individual's ability to tolerate the discomfort of these emotions long enough to understand and transform them.

2.3.4 Fear, anxiety and perfectionism

Fear and anxiety are common responses when white people confront issues of race (Ogden et al., 2021; Spanierman & Cabrera, 2014). There are two key reasons for this listed in the literature. Firstly, a fear of Black, Indigenous, and People of Colour that is instilled by colonisation and racism. Secondly, as white people begin to address racism, there can be a 'fear of appearing racist' or 'getting it wrong'.

Fear of the racial other

Fear of the racial other is a strong emotional response passed down through generations, expressed in movements towards and away from others (Ahmed, 2015), as well as our posture, muscle tension, expression and micro expressions (Ogden et al., 2021). These cues, that communicate judgements of safety versus fear (Ahmed, 2015), are learned by infants from their caregivers, and moved into the procedural parts of the brain, forming an unconscious, implicit bias that is carried into adulthood (Ogden et al., 2021). These fear messages are also encoded on a collective, cultural level, reinforced socially through narratives such as those we explored in earlier sections of this literature review, fear of violence or disease in black bodies, the dangerous 'tropics' compared to the 'settled' coastal cities (Anderson, 2003). Giannacopoulos (2011) argues these 'fear' narratives within Australia actually function to obscure 'colonisation' from view. She argues that the colonial state does not protect itself because it is frightened, but rather requires violent force to establish itself. Fear, she argues, is 'given as an explanation for racial relations of inequality in lieu of naming colonisation' (p.2).

Ahmed (2015, p.74) also articulates how fear of the 'other' ironically functions to increase not only safety but also belonging to one's own group. 'The turning away from the object of fear involves turning towards home, as a fellow feeling…Fear may even allow some bodies to occupy more space through the identification with the collective body' (p.74).

Noticing and becoming aware of fear and anxiety can help develop antiracist and decolonised practice. Ogden et al. (2021, p.25) suggest that 'general discomfort or feelings of anxiety and uneasiness towards people of a different group' can be an early warning sign—the canary in the coalmine—that implicit bias is in action. Ogden et al. list physical symptoms one can look for in the body—'sweaty palms,

longer or shorter eye contact, more blinking, frozen smiles, or unconscious efforts to bypass difference through denial, fixation or overcompensation' (p.25). These feelings and physical signs can be a 'vital teacher' in helping one become aware of unconscious racism, which can then be examined reflectively. The use of mindfulness and body-calming techniques can help increase white people's ability to tolerate the discomfort of fear long enough to engage in reflection (Menakem, 2017; Ogden et al., 2021).

Fear of getting antiracism wrong

Another kind of fear described by antiracist educators is fear white people have of being 'found out' as having wronged others (Srivastava, 2005, p. 43) and fear of facing one's own racism (Spanierman & Cabrera, 2014). Race is an area of new learning for many white people, and they can feel that they 'don't know the rules' or 'don't know how to get it right' (Frankenberg, 1993, p. 3) and are afraid they may offend someone (Derman-Sparks & Brunson Phillips, 1997; McKinney, 2005).

Perfectionism, the fear of making mistakes along the way and what others may think of us, can heighten this fear. In a patriarchal society, women especially experience pressure to always be perceived as good and pure, to avoid conflict and people-please (Ricketts, 2021). For women, antiracism requires breaking not only from white solidarity (DiAngelo, 2018) but patriarchal expectations of femininity. 'You cannot be committed to being good and right and an anti-racist. It just ain't gonna work, honey. We need to be open to humility, to fucking up, to getting it wrong. To receiving and learning things that rock us to our core'(Ricketts, 2021, p. 23).

Saad suggests another way perfectionism can express is in a sense of urgency to rush to fix racism. 'You got to slow down so that you can actually take all of this information in and not be trying to prove as quickly as possible that you are the "wokest" most consciously aware person because it's not like an Olympic award, it's not for showing to other people.' (Saad, 2020b). Yancy (2015) describes how white people 'fail to linger', 'fail to tarry' 'fail to remain' with the painful truth of whiteness. The rush to solutions can function as an avoidance of the discomfort of confronting racism.

This is a specific skill required in antiracism work—relaxing into the discomfort (Boudreau Morris, 2017), 'lingering' (Yancy, 2015) in the 'space of uncertainty'(Aanerud, 2015, p. 106). As a result of interviewing non-Indigenous 'allies' in New Zealand, Australia, Canada and North America, Margaret (2010), concluded that some personal attributes required of a valuable ally were endurance, long term commitment and a willingness to make mistakes, mess up, hear and learn from criticism, and a willingness to not know the answers or 'get it right'. One of the positions white people let go off in antiracism work is the 'fixer', the 'knower', instead adopting a receptive new stance of not knowing and learning.

2.3.5 Destabilisation, loss of belonging and expanded world view

'Disagreeable mirrors'

Another form of anxiety that occur in white people is the result of destabilising the sense of self that can occur when white people confront previously denied white and settler privilege (Boudreau Morris, 2017; Bullen & Flavell, 2017; DiAngelo, 2018; Gair, 2016). Learning about colonisation and racism can shatter the worldview that structures an individual's world and identity (Boler, 2003; Boudreau Morris, 2017; Bullen & Flavell, 2017). Yancy frames this as a healthy crisis, a process of white people 'losing their footing', a process of disorientation as white people experience 'dispossession' of fictive self-identities (2015, p. xiv). Antiracism education holds up 'disagreeable mirrors' showing white people 'as no other mirror can' (Bailey, 2015, p. 46). It exposes white people to the idea 'that they don't know who are they are' (Yancy, 2015, p. xv). Britzman (1998) warns that the dissonance of this learning can be 'in the order of trauma' (p.118), because of how it challenges ones understanding not only of oneself but one's entire world. This raises the question—what kind of care is needed through this process? If an individual has a very fragile sense of self or self-worth, can they tolerate the deconstruction of self this crisis sparks? Can they expand from a 'single-pointed focus on goodness' and the need to be 'wholly good', into seeing one's plurality (Bailey, 2015)?

Culture shock

For professionals working in remote Aboriginal communities, the destabilisation is amplified by immersion in the 'stranger culture,' where all familiar social cues and structures are removed. 'Culture shock is the loss of emotional

balance, disorientation, or confusion that a person feels when moving from a familiar environment to an unfamiliar environment….The basic cause of culture shock is the abrupt loss of all that is familiar, leading to a sense of isolation.' (Trudgen, 2000, p. 177). The unfamiliar context undermines professional competence which can further threaten identity and self-worth (Trudgen, 2000). This is described well in the following first-hand account by a Health educator in Arnhem Land:

> I found myself getting off a plane in Nhulumbuy, a small town on the North East corner of the NT. It was the start of the wet season, and the air was thick from the humidity. It felt as if an enormous weight was tearing me apart. I felt extremely vulnerable. This was to be a metaphor for my experiences over the next 10 years as all my comfortable assumptions about what was teaching and what was healing were to be continually challenged. I felt like an earthquake victim must feel when their very foundations are thrown about like a cork in a bathtub. I did not know what I was letting myself in for, I thought I knew how to teach. If only I knew then how much there was to learn. Even though several other people had worked as the Aboriginal Health Worker educator there was very little documented that could be used to give me direction. I felt extremely isolated. I had a lot of ideas about what teaching was and how best to do it, but after a very short time I came to realise how limited my prior experience was in this new, and to me, totally alien environment. (Grootjans, 1999, p. 1)

Students and professionals living in foreign cultures commonly respond in one of four ways: 1) Remaining staunchly monocultural to their origin culture, and even becoming more ethnocentric; 2) Assimilating and identifying to the host culture and becoming monocultural within it; 3) Becoming bicultural: synthesising the best elements of both cultures and mediating between the two or 4) Vacillating between both cultures but identifying with neither and not being accepted by either (Ward et al., 2001).

Breaking white solidarity

Developing antiracism practice also entails breaking with white solidarity, the collective pressure to deny white supremacy (Boudreau Morris, 2017; DiAngelo,

2018), to not discuss racism and white privilege or cause racial discomfort for white people. There are real-world consequences for breaking with white solidarity; one risks being accused by colleagues and managers of 'going native,' being politically correct, over-sensitive, angry, combative, humourless, or unsuited for higher positions in the organisation (DiAngelo, 2018; Trudgen, 2000). Conversely, one is rewarded socially and professionally for not breaking white solidarity, and being perceived as a 'fun, cooperative and a team player' (DiAngelo, 2018, p. 58). Practising antiracism can cost white people their membership and status within white communities.

A new belonging in an expanded world

Literature talks about ways antiracist work can increase a sense for belonging for white people, albeit a new and different belonging. Firstly, antiracism work increases a sense of engagement with a more complex, expanded view of the word. Secondly, it can decrease the sense of separation from others that whiteness and racism enforce.

> I gain truth when I expand my constricted eye, an eye that has only let in what I have been taught to see. But there have been other constructions: the clutch of fear around my heart…kin to a terror that has been in my birth culture for years, for centuries: the terror of a people who have set themselves apart and above, who have wronged others, and feel they are about to be found out and punished.(Pratt, 1984, p. 17)

Boler (1999) quotes Pratt as an example of how antiracism allows one to experience and engage with a more complex and full world. Pratt also identifies the relief one can feel, decreasing the separation from others that whiteness and racism enforce. This is congruent with Tarakali's (2010) framing that white supremacy interrupts the human need for connection (although it's also been argued the process of othering can increase belonging to your group). Smith and Redington (2010) likewise identified in their small qualitative study of eighteen white antiracists, a benefit for antiracism work was a 'joyful feeling of connection to humanity', as well as a 'sense of integrity' and 'moral fulfillment'. Kowall (2015) reported Australian white antiracists in Darwin expressed the rewards of antiracism were engagement in the real complexity of being a settler-Australian, and the friendships they had with Aboriginal people.

Taken together, seeing oneself through the 'disagreeable mirrors' held up by Aboriginal perspectives, the disorientation of culture shock, and the new tensions that can arise with one's own culture and institutions, it's possible to see how working in remote Aboriginal communities can shake up a professional's sense of identity, competency and belonging. If supports for professionals are equally shaped by whiteness and not attuned to Indigenous voices and antiracism, where can professionals working in remote communities turn to for support as they navigate these challenges? Will a speech pathologist working in a desert community find understanding if she seeks clinical supervision? Will an occupational therapist searching literature for 'evidence-based practice' find the advice she needs to rebuild her sense of competency working in this context? How do we hold professionals during the inherent deconstructive process of antiracism, so they can make it through to a new sense of belonging with a shared understanding with Aboriginal people about colonisation?

2.3.6 Disgust and care

Disgust

Biologically, disgust is thought to perform a function of recoiling away from something perceived as unusual or toxic, to protect from contamination (Walker, 2016). Disgust responses have been consistently observed in interpersonal interactions with 'out groups'; people withdraw, physically distancing from the racial 'other' (Faulkner et al., 2004; Koller et al., 2021). It's been theorised disgust in response of people is a combination of the instinct to avoid pathogens—avoiding unfamiliar people arising from fear of infection—and the avoidance of 'animal-reminders'—recoiling from reminders of illness and death (Rozin & Haidt, 2013). Disgust plays a powerful role in establishing 'them' and 'us' groups because of how

> it organizes the social and bodily space, creating powerful boundaries between 'us' and 'them' (e.g., whites and non-whites); thus, disgust comes to signify the danger of proximity with them (non-whites), because they threaten to violate our space and our purity. Disgust, in other words, is not simply a means by which the subjectivation of the white individual and the white community is established; disgust also works to transform the bodies of others into 'the disgusted' through a

> discourse that assumes injury to the white subject and its privilege. (Matias & Zembylas, 2014, p. 321)

As racial disgust is no longer widely socially accepted, its overt expression is often repressed. Instead, it can be disguised as more acceptable emotions, such as superficial performances of 'care', and sentimentalising the other (Matias & Zembylas, 2014). Close examinations of 'caring' relationships can 'recoil' or distance-seeking of the 'other' still in action. Understanding how repressed disgust might operate within 'caring' relationships is particularly pertinent in health, where professionals are employed to care.

The problem with caring

Care towards oppressed communities often comes in the form of an empowered white person, 'helping' a 'poor' oppressed person. The role of the Aboriginal person is to submit to the help, and to be grateful (Land, 2015). The pattern of white power over Aboriginal lives remains in place (Valenzuela, 2010), repeating the colonial dynamic. This power differential allows a white person to retain a distance, recoiled back from the 'poor person' they're helping. They can congratulate themselves for being a 'good person' without ever having to challenge the oppression impacting the lives of those they supposedly help (Boler, 1999). This dynamic not only fails to empathise with and care about a major source of suffering in Aboriginal lives, but perpetuates the harm and traumatisation of oppression within the very relationship that is supposed to be 'helping'(Ogden, 2021). Examining power imbalances in 'caring' relationships, therefore, offers a useful entry point for examining repressed feelings of disgust (Boudreau Morris, 2017).

It is particularly relevant to health professionals who are employed to 'care'. Healthcare services in Aboriginal communities are frequently delivered paternalistically, treating Aboriginal communities as 'a group of people who just don't know what is good for [themselves]', informed by colonial imaginations of Indigeneity as deficient (McPhail-Bell et al., 2015, p. 197). Indigenous status' is listed in health literature as a risk factor 'not dissimilarly to the colonial framing of Indigeneity as a source of disease contamination' (McPhail-Bell et al., 2015, p. 197). Healthcare services rarely examine the power imbalance and 'Indigeneity as deficit' assumptions, implicit in their service delivery. They also usually fail to address the impacts of oppression and racism on the lives of their clients.

‘Care’ can also communicate ‘disgust’ for the other when the care only superficially engages with difference or ignores difference entirely. Valenzuela’s work interviewing American-Mexican students about their experience of school describes how disgust was communicated to them through their English speaking teachers.

> So, in other words, when you [white teacher] ask for parent involvement my parents give you a hard time because they can’t speak English? You’re acting like it’s a sin for us to know our tongue…(Valenzuela, 2010, p. 258)

> In a world that does not value bilingualism or biculturalism, youth may fall prey to the subtle yet unrelenting message of the worthlessness of their communities.(Valenzuela, 2010, p. 264)

The failure of white people to meaningfully come to understand and respect cultural differences, to instead remain at a distance from that difference, communicates disgust with the other; a sense that the ‘other’ isn’t valuable enough to be worth learning about. ‘The enemy of solidarity is not difference but the lack of engagement with difference’(Boudreau Morris, 2017, p. 466).

Another way white people can repress their disgust but still retain their distance is by sentimentalising the ‘other’. Some cultural awareness trainings can add to this sentimentalisation (Hollinsworth, 2013b; Shepherd, 2019; Watt et al., 2016), conveying exoticised or romanticised descriptions of a particular cultural group’ (Shepherd, 2019, p. 4)**.** This enables white people to avoid genuine intimacy with Aboriginal people by allowing them to ‘care’ for an imaginary version instead (Matias & Zembylas, 2014).

Relationships based on equality, respect and mutuality.

It’s clear that relationships without equality aren’t genuine expressions of care (Boudreau Morris, 2017). How can they be, when one person, or one group, holds power over the other? The power dynamic implicitly communicates that one person is better than the other, transforming the ‘other’ into an object of disgust. In contrast, if a white would-be ‘helper’ consciously examines power dynamics, works to dismantle them, and develops relationships with Aboriginal people that are founded on equality, respect and true mutuality, they can find themselves positioned

in a radically different role. Valenzuela (2010) suggested the teachers of American-Mexican students undertake

> A sincere search for connection [that] will reposition the ill-informed teacher as "student" of the U.S. Mexican community and its history of subordination. As students of the U.S. Mexican community, majority teachers (and even minority teachers who adhere to the majority paradigm) will become reflective and arrive at an awareness of their own contradictory position vis-à-vis the community. Their intention of investment and the unintended consequence of divestment becomes their central contradiction. Resolving this contradiction becomes a central concern. (p.263).

The same thinking is reflected by Aboriginal academics and white allies. Genuine connection repositions white allies as students of Aboriginal communities, who inevitably discover their own fate is more entwined with the Aboriginal person they sought to help than they originally thought (Land, 2015). That they are not helping with the 'Aboriginal problem', rather as settler Australians they are implicated in the unresolved issue of Aboriginal sovereignty (Moreton-Robinson, 2004). Sincere connection can be delineated from superficial 'care', by the recognition of oneself as a 'battleground for forces raging to which she must pay attention to properly carry out her task' (Boler, 1999, p. 265); true engagement leaves 'no hiding place intact. As one comes to know the survivor, one really comes to know oneself' (Felman and Laub, 1992: 72). Gumbainggir academic Foley explains, 'It's not just a question of 'Oh I'll go and help the poor little blackfellas.' Don't come and help us, we don't need you. But if you're fair dinkum about achieving social change, your agenda is much bigger than us' (Land, 2015, p. 205).

Literature suggests care, unexamined for power imbalance isn't caring at all. Rather, it perpetuates colonial oppression, communicates repressed racial disgust, and keeps white 'helpers' recoiled at a distance from the Aboriginal people they reportedly care for. This has significant implications for health professionals, who are in the business of caring. Literature suggests that true care across culture and the racial disparity is characterised by a deliberate dismantling of power imbalance and a recognition of the shared interest in addressing unresolved sovereignty and racial disparity, a considerable challenge given it can also be argued that non-Indigenous

Australian's have 'too much to lose to be reliable allies of Indigenous people' (Land, 2015, p. 214).

Section 2.4: Other emotional factors in remote work

While this research seeks to understand the emotions arising from issues of racism and privilege, it is useful to briefly summarise previous research into the subjective experience of professionals in remote Aboriginal communities, to not falsely assign all emotions to racial causes. Previous research has focussed on staff retention of professionals in rural and remote communities (Campbell et al., 2012; Cosgrave et al., 2018; Onnis & Pryce, 2016). This research rarely differentiates rural contexts from remote Aboriginal communities, which may fail to capture some of the emotional challenges unique to immersion in an Aboriginal community. The emotional challenges commonly reported by rural and remote professionals are summarised below:

- Isolation: professionals working in remote communities are geographically isolated; have moved away from friends and family; sometimes live apart from their partners. They are also professionally isolated, sometimes sole practitioners, often geographically isolated from their managers and cut off from professional support and development opportunities. They are also unable to access many of the facilities and services larger towns and cities have to support health and wellbeing (Campbell et al., 2012; Onnis & Pryce, 2016).
- Relocation: Relocating anywhere is a process that takes time and can be characterised by feelings of alienation and not belonging. In remote Aboriginal communities this is compounded by the cultural differences and loss of all familiar supports(Cosgrave et al., 2018).
- Not feeling valued by the community or effective in one's work (Cosgrave et al., 2018): The various challenges of work in this context including cultural difference and systemic oppression can limit's ones effectiveness as a health professional.
- Not feeling valued, understood or supported by management, especially regarding the unique challenges of remote work (Onnis & Pryce, 2016).

- Social dynamics of a small community: Personal and professional relationships overlap in remote communities, and the high staff turnover rate destabilises both professional and personal lives (Cosgrave et al., 2018; Onnis & Pryce, 2016).
- Family factors: Rural and remote locations can make it difficult to meet the schooling needs of children, there may not be work available for one's partner, and one may have to live apart from one's partner (Cosgrave et al., 2018; Onnis & Pryce, 2016).
- Trauma and vicarious trauma: staff in remote communities can directly witness, be first responders, or hear graphic re-telling of traumatic events such as domestic violence, suicide and motor vehicle deaths (Lenthall et al., 2009). As communities are small, they often personally know the people involved in these events (Jahner et al., 2020).

Significantly, previous research into the subjective experience of professionals in remote Aboriginal communities does not mention racism, except where it is identified by Aboriginal health workers in remote health services as a contributor to their stress and burnout (Deroy & Schütze, 2019). That racism is only reported by Aboriginal people could be an indication of the invisibility of race and whiteness to non-Aboriginal Australians.

Section 2.5 Summary and implications for research

At all state, territory and national levels, healthcare guidelines instruct health professionals to examine individual and systemic racism and 'identify, promote and build on good practice initiatives to prevent and reduce systemic racism'(*National Aboriginal and Torres Strait Islander health plan 2013-2023*, 2013, p. 15). These policies rest upon decades of work theorising whiteness, racism, antiracism and decolonisation, theory that is often not well understood at practice level, contributing to confusion about one's professional responsibility to 'address racism' in healthcare. 'Whiteness' is often invisible to white health professionals (Moreton-Robinson, 2015), impeding critical reflection on the impact of their race and culture on their service delivery. 'Racism' remains a 'contested concept' (Winston, 2004), carrying different meanings for each individual—overt versus unconscious racism, individual versus systemic racism.

Clarity is further muddied by ‘coded language’, terms that effectively identity and perpetuate racial control without having to use racialised language such as ‘culturally diverse’, ‘remote’, ‘low socioeconomic’(Castle et al., 2019; DiAngelo, 2018; S. Schulz, 2017). ‘Decolonisation’ is used less widely than racism’ and ‘antiracism’ in documents guiding professional practice in Australia, arguably omitting crucial Indigenous perspectives in favour of language emerging from African-American communities in the United States. The terminology used to guide professional practice is complex and nuanced in literature which raises important questions around how health professionals interpret practice guidelines utilising terms such as ‘racism’ and ‘white privilege’?

Strong emotional reactions have been consistently observed in white people when confronted with discussions about race and colonisation. It is inherent to the antiracism process. Why such emotions are evoked isn’t definitively determined. It could be the result intergenerational trauma (Tarakali, 2010), or at the very least, implicit bias, passed down through the generations through social and cultural learning (Ahmed, 2015; Ogden et al., 2021). Neurophysiological research suggests these implicit biases express as emotions, muscle tension, movement, expression, that emerge from the procedural parts of the brain without conscious thought or control (Ogden et al., 2021). This is significant because it suggests antiracist efforts need to understand the emotional and nervous system responses rather than rely on education that only supplies ‘corrective facts and evidence’ (Ioanide, 2019, p. 87).

This research responds to that need, seeking to better understand the emotional aspects of racism and antiracism. Understanding these emotions, and how to productively work with them, is critical because emotional reactions of white people ‘block, diffuse and distract’ from tackling racism (Srivastava, 2005, p. 29).

As a result of this literature, this research project asked the following questions to non-Indigenous healthcare professionals working in Aboriginal communities:

1) Is antiracism and decolonisation part of professional practice?
2) What language (e.g., racism, whiteness) is used, and what is meant by it?
3) Do professionals experience strong emotional responses to issues of racism, whiteness, and colonisation in their work?
4) How do these emotional responses impact health service delivery and professional practice?

This research studies the emotional reactions described by health professionals working in remote Aboriginal communities, comparing, and contrasting them with descriptions offered in the literature written by antiracist activists and educators. Existing literature provides a critical framework through which to examine participant responses. Mapping the emotional terrain of antiracism is a foundational step towards understanding how to support non-Indigenous health professionals to engage more productively in decolonising health care delivery and antiracism.

CHAPTER 3: METHODOLOGY

3.0 Introduction

This chapter explains and justifies the methodology of this research project. It describes the guiding paradigm as well as the research design, including the recruitment of participants, data collection methods, and the data analysis process. It also explores the ethical issues considered during the design of this research.

3.1 A constructivist approach to research

This research adopts a constructivist paradigm of knowledge. As discussed in the literature review, race and racism are social constructs. The meaning of the terms like 'race' and 'racism' remains highly contested, understood differently by different individuals and communities (Hage, 1998; Vanidestine & Aparicio, 2019; Winston, 2004). The variety of meanings ascribed to terms like 'racism', 'antiracism' and 'white privilege' influence thinking and behaviour. For example, one's construct of racial difference affects how individuals and institutions treat people of colour. One's understanding of racism impacts how and to what extent one engages in antiracism. If an individual understands racism as a systemic issue rather than an individual one, the target of their antiracist intervention will change accordingly. Oppressive power dynamics like racism and white privilege, as well as anti-oppression movements like antiracism and decolonisation, gain their influence in society through the meaning people ascribe to them, and how that meaning guides their thinking and behaviour. Therefore, it makes sense when researching racism, white privilege, antiracism and decolonisation, to adopt a research approach that examines, through reflective interviews, how health professionals construct the meaning of these terms, and how holding these different meanings influences their behaviour.

Constructivism asserts that knowledge is not a 'single, concrete reality' (Krauss, 2005, p. 761) that can be defined and then tested. Rather, this theoretical approach proposes that understanding and meaning are constructed by people as a result of their experience. I interviewed eleven health professionals exploring their conceptions of racism and white privilege, and their experiences of encountering

racism and white privilege while working in Aboriginal communities, without imposing a singular set of meanings for these terms. I asked about feelings they had during those experiences, and what meaning they ascribed to those feelings. I compared their descriptions and meaning to how race and white privilege are conceptualised in professional practice standards such as Australian Health Practitioner Regulation Agency's (APHRA) *Aboriginal and Torres Strait Islander health and cultural safety strategy* (2020) and *Aboriginal and Torres Strait Islander health curriculum framework* (2014), as well as documents guiding health service delivery such as *National Aboriginal and Torres Strait Islander health plan 2013,* and each state and territories heath service's cultural security policies. I also analysed participant experiences and ascribed meanings to similar conceptions and experiences described in literature written by academics, writers, and antiracism educators.

I then shared all these meanings back to participants, so they could reflect on their own experience and understanding considering all these other descriptions of experience and meaning. Returning participant responses analysed through a lens provided by antiracism educators offered an opportunity for participants to be exposed to different perspectives about their behaviour and possibly formulate new meaning or understanding. The goal of this research was not to ascertain a fixed description of racism or how antiracism should be implemented in health services, but to understand in a constructivist approach what Krauss describes as 'the multiple realities constructed by human beings who experience a phenomenon of interest' (2005, p. 760).

3.2.2 Research design

The following section describes the recruitment and demographic information of participants, the method of data collection, and the process of data analysis.

3.2.1 Participants

Participants were purposely sought as individuals who epitomised the phenomenon being studied: emotional reactions to racism and white privilege in non-Indigenous health professionals working in Aboriginal communities (Warren, 2001). Participants were recruited through my professional networks from twelve

years of working in remote Aboriginal communities. Five (out of eleven) participants had worked with me as a colleague for a minimum of six weeks and a maximum of twelve months. I assessed from our previous contact that they had already reflected on issues of racism and privilege, and experienced strong emotions in the context of their work. Six participants had never met me before. Of these six, four heard about the research through the other participants, and two I approached after hearing about their work in Aboriginal communities. This snowballing sampling method is widely used in qualitative research, where one person who meets the theoretical criteria is located in places they can identify others (Creswell, 2009). Health professionals, who I knew had experienced strong emotions to racism and white privilege identified others they knew in their network. The impact of my relationship with participants and the ethics of 'insider research' is explored below in the section on ethical considerations.

Twelve professionals were invited by email to participate, and only one declined, initially reporting she 'didn't feel it productive to label myself as white privileged or racist'. When I explained the research was interested in that perspective, she thanked me and expanded that the terms have a 'loaded nature' and 'leave no room for positive exploration of the experience without negatively painting them in the white privilege light, and then where do you go from there?' She subsequently agreed to participate but went on to report not having time when invited to schedule her interview.

Eleven participants were a small enough sample to be practical for a single researcher to complete interviews and transcriptions for, but large enough to explore a range of perspectives, to find both 'common meanings' shared by the group, and 'unique meanings' particular to each professional interviewed to construct a comprehensive understanding of the phenomenon being researched (Krauss, 2005, p. 763).

This participant group, therefore, does not represent a norm. It was small, and all participants volunteered for the project, indicating a level of particular interest in the topic. A different sample of eleven professionals working in remote Aboriginal communities could have significantly different experiences and understanding of racism and white privilege to the experiences and understanding of those interviewed in this research. However, this sample of participants self-

reporting emotional reactions to racism and white privilege does provide a meaningful benchmark to define a phenomenon not yet described in the literature.

The participants were selected because they worked in remote Aboriginal communities in Western Australia and Northern Territory, as well as Aboriginal communities in regional towns and cities such as Alice Springs, Darwin, Broome, and Port Hedland. Most of these allied health professionals were based in bigger town centres and worked across community and town locations. Some had experienced living for short periods in very remote communities. Participants' experience working in Aboriginal communities ranged from one year to forty years. I deliberately sought this range as I was intending to identify if and how perspectives and experiences developed over time.

Participants included physiotherapists (4), occupational therapists (4), psychologists (1), and speech pathologists (2). These allied health disciplines were chosen because they share employing organisations and regulating bodies, meaning they all share standards requiring antiracist professional practice when working with Aboriginal communities. Participants worked for private service providers, state and territory health and education services, and Aboriginal controlled organisations. This diversity of employers was unavoidable, as most participants had worked across organisations during their career. It was also interesting to explore participant reflections regarding how different health services offered different service delivery models, workplace supports and processes.

Participants were chosen for their identity as non-Indigenous Australians. This research deliberately excluded participants who identified as Indigenous (Aboriginal, Maori, First Nation) as it focussed on the experiences and understanding of 'settler' Australians. It did not exclude settler Australians of other ethnic backgrounds (e.g. Asian, African) as Australian society has an extensive history of constructing 'whiteness' amongst a culturally and linguistically diverse population not based on skin colour but on an individual's (or community's) ability to adhere to white customs, habits and behaviour (Moreton-Robinson, 2015). Participants were asked to reflect on and self-identify their ethnicity, ancestry, and culture. Only one participant identified cultural identity beyond white Australian, identifying as Anglo-Indian.

3.2.2 Data collection

This research entailed interviewing eleven allied health professionals working in remote communities via a 60 to 90 minute video call. Prior to the interview, participants were sent a participant information sheet, a copy of the interview guide, and a link to The Aboriginal and Torres Strait Islander Health Curriculum Framework (2014) This was not only to inform participants of their rights and support available during and after the interview, but also to offer some introductory reading on the racism, privilege and decolonisation in the context of health service delivery to Aboriginal communities.

Interviews were semi-structured. Interview questions, and how they link to the research questions are shown in full in Table 1. Interviews began with broad questions (such as 'Can you tell me a bit about your background? What's your cultural background and how did you come to work in remote Aboriginal communities?) to more directed (Do you feel like reflecting on racism and white privilege is a part of your professional practice? What do these terms mean to you? Does reflecting on these topics evoke any emotions in you?). Broad questions elicited a wider spectrum of responses from participants and offered more flexibility in the data collection process than would starting with narrow questions, ensuring unanticipated viewpoints were collected in the data set, rather than the research being limited to the researcher's preconceived conceptualisation of the topic (Sidani & Sechrest, 1996). These broad questions provided a form of initial 'bracketing', suspending the researcher's prior knowledge and bias (Sidani & Sechrest, 1996) to privilege participant viewpoints.

More directed follow up questions were used to ensure the interview remained focussed and developed into a dialectical reflective conversation (Sidani & Sechrest, 1996) through which participants made meaning of their experiences. This process inevitably involved some interaction and exchange of ideas between myself as the researcher and participant (Krauss, 2005), however, at all times the I minimised the imposition of my prior knowledge and elicited participants' point of view. This was achieved through interview techniques of repeating back participants' answers and asking them to elaborate, clarify or try to articulate further. I noted when participants stumbled on words, did not finish sentences, or struggled to articulate something, as this often occurred when they felt emotional discomfort, ambiguity, or uncertainty about an experience, were nervous to discuss sensitive

topics like racism, or lacked the lexicon to articulate their thinking. Participants were then prompted to reflect on the emotions they felt, both retrospectively in the experiences they were describing, and during the interview as they reflected on their experience and the topic of racism. As a consequence of this approach, participants had their experiences mirrored and empathised with and were praised for the articulation of their experience, rather than critiqued or judged for any of their responses. In this manner, the interview became an important meaning-making process in its own right (Warren, 2001), as researcher and participant co-created a supportive space to unpack constructs around racism and whiteness (Zembylas, 2018b).

Table 1 Interview questions as they relate to research questions

Research questions	Related interview questions
Demographic and icebreaker questions	Tell me a bit about your background—where did you grow up, what's your cultural background, and how did you end up working in remote Aboriginal communities. What motivated you to first come and work in Aboriginal communities and has that changed over time?
Is antiracism and decolonisation part of professional practice?	Have you come across the *Aboriginal and Torres Strait Islander Health Curriculum Framework*, or similar Aboriginal and Torres Strait Islander professional competencies frameworks before? How do you feel about the idea of reflecting on your own and dominant culture, privilege, and racism as being part of your professional practice? Is it something you feel you do? Has racism or privilege impacted your professional practice? If so, can you tell me more about how?

	Can you speak about any experiences of racism you've observed during your time in this community?
What language (e.g., racism, whiteness) is used, and what is meant by it?	What do the words used in the framework mean to you? Dominant culture? White Privilege? Racism?
Do professionals experience strong emotional responses to issues of racism, whiteness, and colonisation in their work?	Have you experienced an emotional response when reflecting your own culture, dominant culture, privilege, or racism? If so, can you tell me more about it/them? *Expand on emotional responses by observing participant behaviour during other responses (e.g. stumbling on words, signs of emotion, pausing etc) and prompt participant to reflect on what emotion they're experiencing/experienced.
How do these emotional responses impact health service delivery and professional practice?	Have you experienced an emotional response when reflecting your own culture, dominant culture, privilege, or racism? If so, can you tell me more about it/them? Has racism or privilege impacted your professional practice? If so, can you tell me more about how? Can you tell me about your own relationships with Aboriginal people?

Interviews were audio-recorded and I manually transcribed them, facilitating an initial careful reading of the interviews that deepened the 'submersion' into the experience of participants (Sidani & Sechrest, 1996, p. 304). In line with the ethics approval transcripts were then sent to the participants to check for factual errors as well as to ensure nothing in the transcript risked revealing their identity (all are represented by a pseudonym) or location or posed a professional risk. Participants were invited to email me after their interview with any further reflections they wanted to add to the dataset, an offer taken up by two participants. This gave participants additional time to reflect on the interview, a meaning-making process in

itself (Sidani & Sechrest, 1996), and these further perspectives were added to the data. This process also allowed participants to clarify, or reassert, their perspectives with more separation from the conversation with me, providing an additional check that the participants' perspectives were separated from researcher bias (Warren, 2001).

This research relied on interviews rather than observation of behaviour or professionals' interactions with Aboriginal people. This research is therefore limited by the self-awareness of the professional and their ability to articulate their experience. Previous research has found white people frequently minimise, deny, or fail to recognise issues of racism and privilege (Lee et al., 2018; Moreton-Robinson, 2004). Direct observation could reveal demonstrations of whiteness and racism that participants are unaware of. Gathering perceptions of Aboriginal people within the communities that professionals work in would contribute to a more complete understanding of the impact white health professionals' emotional reactions have on health service delivery. These important elements were beyond the scope of this research conducted by a solo, white, Masters student researcher.

3.2.3 Data analysis

Transcripts were manually coded using NVIVO software. Initial coding included categories such as 'definitions' 'descriptions of cultural background' 'challenging emotions', 'positive emotions'. Emotional categories were identified from the data utilising key reoccurring words such as 'overwhelm', 'guilt' and 'frustration'. The second round of coding used the word search function of NVIVO to look for synonyms within transcripts of these original emotional categories. The third round of coding involved returning to literature to compare it with participant responses. I asked questions of literature and the data such as 'This is how literature defines racism, how did participants define racism? This is how participants described guilt, what does literature have to say about guilt?'

I used the literature review to develop a framework of key questions to analyse emotional responses through, for example, 'Does anger emerge because individuals feel personally attacked?' 'Does anger shut down discussions of racism and derail antiracism efforts*?'* This approach meant participant responses were examined using critiques of whiteness and racism written by Black, Indigenous, and

People of Colour academics and writers. Equally, I used participant responses to ask questions of literature: participants express this feeling of relief and relaxation to work alongside Aboriginal people instead of 'fixing'; is there anything in the literature about that?

The process operated as conversation, drawing the voices of eleven health professionals in remote communities (or twelve, including mine), into conversation with the existing knowledge base of this topic. This is in line with a constructivist approach, constructing an understanding, or 'knowledge', of the topic based on the experience and meaning of participants and the experiences and meaning described by others in the literature.

Participants were sent draft copies of the literature review, results and discussion as well as the conclusion by email and offered three months to read and contribute feedback. Sending their responses contextualised with the full body of research aimed to elicit another round of reflection and meaning-making from participants. Only one participant shared further reflection with the researcher at this point, with five other participants responding with approval and appreciation of the research, and five participants not responding.

3.3 Ethical considerations

Research design underwent ethics assessment and approval with USQ HREC in 2019, and with NT Health in 2020. Consideration was given to not harming participants' reputations or work by ensuring the confidentiality of individuals, workplaces, and communities and using pseudonyms to conceal identities. Individual interviews were chosen over focus groups because of the sensitivity of the topic. Individual interviews not only protected confidentiality but allowed the participant to direct the emotional depth of the interview and the interviewer to carefully observe and manage any emotional distress experienced by participants.

'Insider' or 'backyard' research is used in qualitative research and carries both risks and benefits (Creswell, 2009). I have attempted to reduce the impact of bias by presenting participant responses in their own words and relying heavily on direct quotes when presenting results and data. Participants have reviewed both their transcripts and the results and discussion, and their feedback on this is also represented in their own words to accurately present participants' points of view. By

explicitly outlining my position, experiences, and understanding in the opening chapter of this thesis, I offer the reader a clear insight into the 'knowledge' I am bringing to this topic (Creswell, 2009) and I offered the same clarification to interviewees.

My position as an insider meant I either already knew some of the participants, or at the very least knew the remote Aboriginal communities they worked in and had similar experiences as the professionals I interviewed. This strong sense of shared understanding contributed to the candidness and detail of the interviews, particularly in a community of practice often characterised by feelings of isolation from other professionals and the broader mainstream Australian community (Onnis & Pryce, 2016). It also meant, at times, interactions, or conversations I have previously had with participants when we worked together, showed up in their interviews and had formed part of participants' understanding of the topic even before the interview.

I maintained a journal throughout the research process to capture my reflections and to document the way my own meaning-making shaped the research. The journal captures my initial impressions after interviews, my early analysis of participant responses, and how this thinking shaped subsequent interview questions. It also captures the way participant responses were sending me back to review the literature again with questions like, 'Does antiracism/decolonisation belong in cultural competency training?' The journal outlines the way I as a researcher was making meaning, weaving together participant responses with literature, and often taking these questions into the next interview, ensuring my influence as a researcher as another participant in the constructivist process is transparent and explicit, rather than an unknown influence (Creswell, 2009).

There is an ethical risk that this research once again centres whiteness and white perspectives, privileging non-Aboriginal voices in research over Aboriginal ones. Advice was sought from Aboriginal academics regarding this issue, and the following decisions were made: Practically, including both Aboriginal and non-Aboriginal perspectives was beyond the scope of a Masters-level research project. Ethically, as a white, settler-Australian researcher, the focus on understanding non-Aboriginal perspectives responds to calls from Aboriginal people, and people of colour internationally, to position whiteness as the problem; to begin the work of understanding white supremacy as white peoples' construct, upheld by the white

people who benefit from it. As a white, non-Aboriginal health professional and researcher, I see it as my social and professional responsibility (Zembylas, 2018b) to understand and deconstruct whiteness in our health service and work towards decolonised professional practice.

CHAPTER 4: RESULTS AND DISCUSSION

This chapter presents participant responses analysed thematically and framed by relevant literature. Section 3.1 explores how participants related to the concepts and language of antiracism and decolonisation. Section 3.2 summarises participant reflections on whether emotions were a component of antiracist professional practice. Section 3.3 explore the emotional reactions professionals reported in depth: denial; anger; guilt and shame and responsibility; fear, anxiety and perfectionism; destabilisation, loss of belonging and finding a new one; and disgust and expressions of care. Section 3.5 captures other factors professionals reported impacting their emotions. Finally, Section 3.6 shares some of the strategies and supports they found useful in navigating this challenging emotional terrain and developing antiracist and decolonised health practice.

4.1 Is antiracism and decolonisation part of professional practice?

All levels of health service governance direct health professionals to identify whiteness/white privilege, as well as individual and systemic racism. So how much did the health professionals interviewed identify these tasks as part of their professional practice? Table 1 summarises participants feelings towards use of language like ‘racism’, ‘white privilege’ and ‘decolonisation’.

Table 2 Participant use of antiracism and decolonisation language

Use of language of racism/ white privilege / decolonisation	**Number of participants**
Had not considered the terms	2
Found the terms useful	5
Conflicted about using the terms	4

Two participants had never really considered the terms racism, white privilege or decolonisation in relation to their work ‘before [I] read [the research participant information sheet] and before you contacted me with the questions and everything’ (Lisa). ‘It was the first time I'd come across it.’ (Violet). Lisa described

how when debriefing in her workplace ‘more of the focus is on the Aboriginal culture rather than reflecting on our own privilege and culture’, a characteristic of whiteness and cultural competency frameworks where Aboriginal culture is the subject of study and whiteness positioned as an invisible norm not requiring analysis (Moreton-Robinson, 2015). For Violet, ‘race wasn't relevant, and race isn't really relevant to me. Humanity’s relevant, you know?’ Violet explained how

> over the years I've done a lot of thinking about social justice and privilege. There's something really wrong with how society treats some groups of people like rubbish bins, you know…That we use prisons as a dumping ground, and we don't think about the brokenness and the need for healing and change if we're going to restore society. And so that was both Aboriginal and non-Aboriginal.”

Violet’s response could be considered ‘colour-blind’, minimising race and thereby inhibiting the ability to dismantle racism (Bonilla-Silva, 2003). Her response also positions her own whiteness as unraced (Moreton-Robinson, 2004).

Five participants were very comfortable using the terms ‘racism’ and ‘white privilege and thought them essential in understanding their professional practice.

> You can't deny that racism exists and the effect that it has on Aboriginal communities and health outcomes, so I think you are doing a disservice to your practice if you don't reflect on that. (Olivia)

These five participants believed failure to reflect on racism and white privilege increased the chances of them performing damaging dynamics in the Aboriginal communities they worked in.

> Who you are as a person will always come through as who you are as a therapist, I think and if you leave it unchecked then you might be bringing baggage or perceptions or opinions that are unhelpful. (Erin)

> Unfortunately, the white privilege...with that comes white power, unfortunately. And whether that is formalised or whether that's invisible, it exists, unfortunately. I think as professionals in remote communities we just have to have some awareness of that and try to make the platform a bit more even on a daily basis. (Olivia)

Robin, Rose, Carl and Jacki had considered the terms in depth but were undecided regarding their usefulness. Some participants said this was because it triggered reactivity and defensiveness in themselves or other people.

> I can still remember when you said those words dominant culture and white privilege—bristling, thinking that's not me. I don't act on my privilege and I'm not dominating. So, the negative connotation is that you know, dominant is as an aggressive word, so that's what comes across. And privilege is sort of, to me, reeks of entitlement. So, it's the typical association of those words that we have. That's why I wanted to rail against them. (Robin)

Participants' observations are congruent with all the literature documenting strong emotional reactivity in white people when confronted about racism. Along with Robin, Tara also wrestled with what the discomfort means.

> It's a much more comfortable conversation for people to come back from trips and observe [Aboriginal language group] ways of raising kids. But for people to come back and think about themselves and the effect that had on them, the effect they had on other people, just seems like a more uncomfortable space. (Tara)

Robin and Tara articulate the same questions present in literature, wondering if these reactions make non-Aboriginal professionals withdraw from constructively learning about difference (Shepherd, 2019), or whether these responses are an important part of realising how racism and colonisation continue in Australia (Saad, 2020b).

> I would love it if they didn't have to have that negative connotation, because I think people would address it more, but I also think that we need to own that we have that stuff. So, does it need to be a confronting... Mm, two things: if it's too confronting, we all walk away from it, which is what I had done. But then at some point like now, I think far out, that is what we are, we do need to own that. So, I don't know...it's both. (Robin)

A number of participants felt the term racism was 'negative' (Rose) and not 'strengths-based language' (Robin, Jacki), insinuating it wasn't helpful to Aboriginal people 'to have to have someone say that about you all the time. *Oh, you're always suffering from racism*. It just seems really, really bleak.' (Rose) 'We consciously aim to use strengths-based language at all times, not deficit model words. Our Aboriginal

staff are particularly sensitive to this, wanting to avoid stereotyped, so-called 'sad' stories.' (Robin) This view is reflected in literature by Kowal (2015), who wondered if antiracism fails to emphasise Aboriginal agency and choice enough. There's also a school of thought that identity rooted in past and present oppression is self-limiting, and needs to focus instead on an alternative, emancipated future (Gilroy, 2000). Interestingly, participant hesitations about using the term 'racism' because it wasn't strengths-based, were all when considering speaking to Aboriginal people about it, whereas antiracism focuses on white people as the target or site of change. Is it possible to examine an 'oppressor' identity, without limiting Aboriginal people in 'oppressed' identity?

Carl argued it wasn't applicable or inclusive of non-Aboriginal people of colour, or other groups who experienced discrimination for other reasons.

> If you come from an Indian background, or a middle-class family, you know, it's not really white privilege. It's more.... I think that statement probably gets a few peoples back up because its more kind of directing at them. My mate K—, he's Indigenous and he's got more money that I'll ever have, from his business, you know what I mean? And he comes from a family that has a business background who are well off. He's had a very well-off upbringing so to speak.

This response lacks analysis of intersectionality (Carbado et al., 2013) and the different types of oppression and power that can influence an individual's life. An intersectional analysis would argue someone from an Indian background may enjoy privilege for being a settler-Australian, middle class, possibly male and being able to move successfully through white culture but simultaneously be impacted by the oppression of being non-white and Asian. Literature clearly describes racial hierarchies in the United States, where, for example, Asian people experience more white privilege than black Americans, but less than white Americans (Forrest-Bank & Jenson, 2015). Carl's friend K— may enjoy privilege from wealth and education, from gaining access to white systems of power, but still experience oppression for being Aboriginal. This response can also be critiqued as using an isolated Indigenous success story to distract from the broader issues of inequality and to justify maintaining the status quo.

4.1.1 What language did participants use, and what did they mean by it?

Literature has shown that racism is a disputed term with multiple meanings associated to it (Winston, 2004). Therefore, when participants used words like 'racism' or 'white privilege' I asked them to define what they meant. Equally, if they conspicuously failed to use these terms, used 'coded language' (DiAngelo, 2018) to stand in for these terms, or did not identify as having a cultural background, I probed further.

Whiteness and white privilege

Seven (out of eleven) participants identified as white Australian with various European backgrounds such as Irish, German, French, English and Scottish.

> White Australian. Like my ancestors were convicts and, yeah, basically I've grown up in a very white Australian culture. (Joanna)

> I grew up in Southeast Queensland on a cattle property and it's a very, very Caucasian world-white European—small school all white grazier kids. Then I went to high school in D—, which is not a lot more diverse. (Erin)

> I was born in Melbourne spent my Early Childhood primary school and high school there, you know, pretty sheltered middle-class inner city of Melbourne type environment. (Tara)

Their responses associate their whiteness not only to their ancestry from Europe, but a lack of interaction with other races and cultures, and a mono-cultural world view.

Three participants, when asked, 'What is your cultural background?' didn't identify one or explicitly stated not having one. Lisa described having 'a normal suburban Melbourne life,' and Olivia classified herself as 'Australian. I don't follow any particular cultural practices.' This is a significant when examined through the lens of whiteness that presumes itself to be the norm and reserves race for the 'other'(Moreton-Robinson, 2004).

Nine participants reflected explicitly on whiteness or white privilege and offered definitions for those terms. The definitions varied from one another and from

literature. Lisa defined white privilege as the privilege of not having to live according to Aboriginal values:

> I guess I certainly agree that there's such a thing as white privilege. One reason being the way that society is sort of headed, and what's important, and what's valued in the two different—the Indigenous culture and the majority Australian culture is quite different and so, we're… I guess...So for example, the idea that everything should be shared amongst your family and community, is a beautiful thing but at the same time can be really challenging in the society because if one person, or only one person works in the family, then they have to share everything, and it's not technically fair and it ends up being quite stressful for that person. And I've seen it happen quite a lot, where they just don't want to work anymore even though they're doing some fantastic work, the reason they don't want to work is because it's too stressful […edited for length]. I think we're privileged to not be so tied down by those values as much.

Carl and Jacki defined it as the privilege of not experiencing the same social barriers as Aboriginal people. 'I'm lucky in way I was brought up, I didn't have to deal with all the things that are happening with Indigenous people, the inequality and everything—diet, cultural degradation, stuff like that.' (Carl) 'Having a different level of privilege can come with a lot of barriers.'(Jacki)

Eve, Olivia and Lisa defined it with a details aligned with literature, things being 'easier' (Lisa) because 'you're part of the majority' (Lisa and Eve), that privilege was obtained through 'being white in appearance' (Eve, Olivia), but also for things that had 'nothing to do with skin' (Eve) like being brought up in 'majority culture' (Eve, Olivia, Lisa).

The range of definitions and its lack of usage by some participants, suggests whiteness and white privilege is inconsistently understood amongst the health professionals interviewed.

Racism

Racism is a disputed term (Winston, 2004), and participant responses reflected this. Many of them explicitly distinguished between different types of racism. Table 2 summarises the terms they used.

Table 3 Use of the term racism by participants

Language used	Number of participants
No definition offered	1
Racism of individuals	10
Conscious/overt racism	8
Unconscious/subtle racism	10
Systemic racism	7

In total, ten participants used the term racism. Ten identified racism as something performed by an individual, consciously or unconsciously. Seven participants spoke about institutional racism.

Individual racism

Individual racism was defined as racist thoughts held, or actions carried out, by an individual. It was a 'discrimination based on skin colour' (Olivia), the assumption that 'I'm superior' (Jacki), that 'there's something within you that's better than that person from that race, who is lesser than you are' (Eve). Individual racism was considered a product of 'preconceived ideas' (Carl), developed by 'what we had been told while younger or what we had seen on the media where different races are depicted as being violent' (Jack), made up of 'stereotypes' like 'wasting our taxpayers money; they don't have a job; sitting around always drunk;' (Eve) 'blackfellas are lazy' (Eve). Racism was characterised by 'fear' (Jacki) and 'discomfort' (Tara) of the racial other. Individual racism could be 'explicit' (Eve) and 'overt and obvious' (Olivia) such as 'shouting something about someone's colour across the street' (Jacki), or 'name calling, teasing' (Tara). Individual racism could also be 'invisible' (Olivia), 'unconscious' (Robin) and 'subtle' (Tara, Carl).

This 'subconscious' (Eve) racism was defined by 'ingrained feelings of being uncomfortable and sometimes fearful of people of different races' (Jacki); 'preconceived ideas and biases that overshadow your actions, thoughts, and interactions' (Eve); and 'judging people by our own expectations and our own

culture...' (Robin). Unconscious racism was characterised by 'not knowing' (Eve) that what you're saying or doing is hurtful or racist (Eve, Lisa), and is unintentional––often performed by people who would never 'actively be a racist human being' or 'consciously say something racist or even think something racist' (Carl). Unconscious racism may not carry the same 'malice', 'distaste' or 'hate' as 'overt racism', but may be as harmful or even more harmful, as unconscious racism can be enacted by 'the people that are actually most involved with Aboriginal people—like often those real racists, they stay away' (Eve).

The definitions offered by participants are congruent with literature and shows recognition that one can be racist without intention or awareness of being so (Trepagnier, 2010) simply as a result of being raised in whiteness amongst negative messaging about the racial other (Ricketts, 2021). Black, Indigenous, and People of Colour antiracist activists critique white antiracists for focussing too heavily on individual racism. They argue this is a distraction from the systemic racism that impacts Black, Indigenous, and People of Colour lives the most. Considering this, it is interesting to reflect on the fact that more participants reflected on individual racism than systemic racism.

Systemic racism

Seven of the eleven participants spoke explicitly about institutional racism. Definitions of institutional or systemic racism were often inextricably connected with definitions of white privilege. Participants recognised both white privilege and institutional racism as setting up 'systems and infrastructure (Erin) that weren't 'universally accessible' to Aboriginal people (Lisa), including the use of 'Western healthcare models that don't fit Aboriginal culture' (Eve, Erin).

Examples were of systemic racism given included:

- Court: 'someone not being offered an interpreter and just the language that was being used, was being used so they couldn't understand.' (Tara)
- Centrelink: 'If you need to update your Centrelink information then just give them a call or like send them an email and well like no, neither of these are the things are accessible to some families.' (Erin)
- Health: 'The systems, the policies, that make it more difficult for Aboriginal people to access our service. So, I mean, for example, patient

travel policies around women coming into birth in Darwin with minimal escorts.' (Tara)

- 'I don't think it's necessarily the fault of clinicians or even of the organization's but just of a system that's not conducive to providing the best care for people and a lot of it's coming from a western healthcare model, which just doesn't fit.' (Eve)

Decolonisation

No participants volunteered the word 'decolonisation'. This is congruent with the health professional practice frameworks that also rarely use the term, suggesting its usage remains largely academic. In one interview, I inadvertently introduced the term when discussing professional frameworks with Carl and he attempted to define it:

> Decolonisation....That for me that means transitioning from a European model of colonisation, so like one person, one nation, one model of society. It would look like equality. That would be the ultimate goal. Everyone can still make their own choices and decisions about what they want to do. If they want to be on the dole for sixty years...get married, be gay whatever, and not have any hang ups about their background, or have opinions which are derogatory of other people. That's the dream.

The lack of usage amongst participants, and Carl's definition not aligned to definitions of decolonisation literature suggests the term was unfamiliar to participants, consistent it's lack of usage policy and practice guidelines in health services.

Table 4 Use of term 'decolonisation' by participants

Language used	**Number of participants**
Volunteered the term 'decolonisation'	0
Volunteered the term 'colonisation'	5
Volunteered the words 'history'/'intergenerational trauma'	3

Eve did reference living on ‘stolen’ land and ‘paying the rent’, concepts central to decolonisation without using the term. She reflected on her own identity and position as a non-Indigenous Australian and the discomfort and responsibility of that position:

> There’s always this talk of how we benefit from this system of oppression and like, you know stolen land and stolen children and we have been able to—‘We’ being a generalized non-Indigenous Australian term—have lived this life of benefit in some way or another to the detriment of these other—these First Nations people. And I just think that as much as I don't want to just feel sorry for them, I think that we owe so much to First Nations people and I think as long as we're ignoring the fact that they're living—a lot of these people, not everyone––but, you know a lot of people living in horrific conditions with you know, health issues that no—like that are almost unheard of anywhere else that you know, rheumatic heart disease is so prevalent in these children and it's like not even a known disease anywhere else! I just don't think that I can be okay with just living in Australia and not feeling like I mean... at least in some way contributing to making the world a little...even just a little bit better. Or like share... I guess using my privilege to improve or to share or yeah, almost pay my rent I guess, to use a current buzzword. (Eve)

There is a sense in Eve’s response that the relationship of non-Indigenous Australians benefiting from the oppression for First Nation Australians is a current issue, acting now, congruent with decolonisation’s framework of recognising the ongoing colonial dynamics occurring in Australia today. Eve also described how ‘there's such a collide between like Aboriginal culture and like colonizers,’ using a present tense, happening now, focus that contrasted with other professionals interviewed who referenced ‘colonisation’, or ‘history’, as a past event with ongoing impacts into the present—rather than a presently occurring event. The term ‘intergenerational trauma’ was also used by Rose and Robin to describe this impact of past events in the present.

Participants described their work as helping ‘people that are suffering from colonisation’(Rose), ‘rectifying some of those damages done’ (Jacki) because ‘you see on a daily basis the impact and outcomes that have come from colonisation and

dispossession' (Olivia). You see 'see a population going through a hard time and poor health outcomes and all that disparity and inequity because of history,' (Olivia) how 'the stolen generation, the being taken away has left irretrievable... not irretrievable... just terrible damage and it needs release. If you don't release it, it still stays there affecting the person in their outlook. So, I'm totally aware that those adverse childhood situations left unworked continue to wreak havoc in terms of parenting and later life.' (Violet).

These reflections stop short of the critical thinking to which decolonisation refers. They recognise the impact of colonisation in the past, but their responses do not reflect decolonisation's framing of colonisation as an ongoing project (Maddison, 2019) or the continued imposition of colonial mentality over Aboriginal control and sovereignty (Tuck & Yang, 2012). Participants understand 'history's lasting impact' (Tara) and 'join the dots about how history/intergenerational trauma etc. have affected [Aboriginal] students and hence our responsibility to provide access and success' (Robin) but it is framed as events of the past, with consequences still reverberating into the present. Robin for example, explicitly links the present to the past events of the Stolen Generations, without reflecting on the higher than ever rates of Indigenous child removal occurring now: 'We all say, look it happened in the past, move on. Whereas it didn't happen in the past. The *effects* of that, of the Stolen Generation [sic], are now, now, now.'

Participants focussed on Aboriginal communities when reflecting on colonisation, rather than colonial systems or settler communities. Participants more frequently critiqued their own communities, culture and institutions through the lens of racism and white privilege, rather than through the lens of decolonisation, examining the ways health services continued to force colonial mentality onto Aboriginal communities. This is congruent with participants being able to define racism with more accuracy than they could define decolonisation, whiteness or white privilege. It suggests racism is a more familiar concept than these other terms.

4.2 Do emotions matter?

All participants described strong emotions elicited by their work in Aboriginal communities. They described feeling 'a lot more emotion than I think I ever have, ever in my life' (Eve); 'I honestly can't articulate some of it well, because

I just recall being so overwhelmed and emotional,' (Joanna); 'That dense learning was overwhelming at times, and anger inducing and frustrating,' (Robin).

Eight participants used the term 'overwhelming' to describe the intensity of their emotions. Participants reported feelings of fear, denial, anger and frustration, sadness, grief, shame, helplessness, anxiety, gratitude, joy, curiosity, responsibility, satisfaction, and relaxation. The emotions are explored in depth in the following section of this discussion.

Literature suggests emotions are important in antiracism because:

- Transformative learning is an emotional as well as intellectual process, especially in light of the denial and numbing effects of white supremacy and colonialism (Saad, 2020b).
- Emotions are produced by, and perform, white supremacy (Ahmed, 2015; Ogden et al., 2021; Srivastava, 2005).
- Emotions shut down and derail discussions about racism and antiracist efforts (DiAngelo, 2018).
- Adequately understanding and working with emotion can help white people develop racial resilience in order to effectively engage in antiracism (Ogden et al., 2021; Saad, 2020b).

Nine of the eleven participants explicitly linked their own, or colleague's strong emotional reactions to the challenge of learning about racism and white privilege.

> I became so emotional. So emotional and guilty that I had been brought up in a world that for me, there were a lot of preconceived ideas about racism, and I was like, oh my gosh, I'm here living in this community, and I'm racist. That was the biggest thing…[edited for length]This extreme guilt that I...was...racist. (Joanna)

> We can't face that what we did to them is still affecting them. We can't face that...The massive change to the way we operate that needs to occur for their futures to be different. We can't comprehend that. (Robin)

> It's really inner turmoil about, you know, all those things we've been talking about, which is digesting what you're seeing and the inequality

> and how best to contribute; make sense of what you're seeing—the trauma. (Rose)

As discussed in the above section about language, Lisa and Violet didn't use terms like racism and white privilege, but they still associated their emotional reactions to history, colonisation, or the intergenerational trauma resulting from colonisation. Violet for example, recounted an Aboriginal woman telling the story of seeing her uncle taken away in 'shackles around his neck', and feeling 'sad' and 'appalled' in response to this story.

Participants identified how their emotional reactions were produced by, or continued to perform whiteness, racism and colonial dynamics. For many participants, it was noticing the strong emotional reactions and reflecting on them that alerted them to their internalised racism.

> To be totally honest with you, to have a strong Aboriginal voice telling you, you know, you are wrong, and this isn't okay, it is confronting, and you know, you feel a bit affronted to start with…Probably, to be honest, the first thing [I thought] was—*that's really harsh. I'm trying and I'm not one of those people*. So that happened. But then maybe a bit more*, Well, you're really experienced working in this space, so this is really hard to hear, but maybe I should listen*. But then yeah, I probably took the words away and processed it more over time [edited for length]. I suppose I just wasn't used to being talked to like that. I think maybe it's just a conversation we're not used to having and someone standing up and being stern with you—we're just not used to it. We're not used to it. I'm not used to it. I suppose you're used to being in more of a position of power. (Tara)

> We consulted with some of the elders, and we talked about having the after-school program and that that would work for them, and we set it all up and then nobody came, and I remember being so furious and just yeah, *We asked them, they didn't respond, what's the point?!* And you said to me, that is unconscious racism. And that was a real light bulb moment for me because it was...It was, let's look behind that. Let's be curious. Let's withhold judgment. (Robin)

Participants also identified times when emotions such as denial, anger and guilt had caused themselves, or colleagues, to avoid or shut down examination of racism and colonisation in their work. Participants described feeling ‘so overwhelmed’ (Joanna), ‘it’s too confronting’ (Robin), ‘a kind of heaviness, a weighted feeling’. These feelings caused them to ‘withdraw because it just got too much’ (Joanna), ‘walk away from it’ (Robin), ‘switch off from it a little bit’ (Lisa) and contributed to ‘high turnover’ because of the ‘emotional turmoil that [staff] are in, that is unsupported’ (Rose). Difficult reactions from other white people also shut down antiracist efforts initiated by participants:

> Usually, the type of people that are saying things like that are very argumentative and will stick to their point of view because that's all they know. They won't use a bit of abstract thinking and look at this from a different angle and it just upsets me, I suppose, essentially. I have in the past tried to have discussions, but it just ends up in arguments and it’s not worth it, because some people won't change their thinking because they've been conditioned for so long to think that way. (Carl)

> If I were to go take some of this stuff further [edited for length], essentially the principal could, if she really wanted to, turn around and say, well, then, your service is not welcome to come and work in our school. (Joana).

Participants reported that the research interview was the only time they’d had space to reflect on the emotional aspects of their work, despite observing ‘high staff turnover rates’ (Rose), that this work ‘does burn a lot of people out’ (Eve), and reporting ‘emotional turmoil’ (Rose), ‘emotional toll’ (Lisa), ‘overwhelm’, ‘strong emotion’, and ‘tears’ (Tara) in staff. Participant responses suggest workplaces aren’t tending to the emotional aspects of antiracism that professional frameworks ask for, nor strategically developing the racial resilience required for white people to effectively engage in antiracism. ‘It's like the elephant in the room, isn't it? And [this research] is actually giving it the light of day and it needs to be... Just yeah, there’s too many people like these ones that came and went…’ (Rose).

4.3 What emotions are elicited in antiracism and decolonisation work?

4.3.1 Denial

Denial is characterised in literature as the 'heartbeat of racism' (Kendi, 2020), systemically woven into white colonial society in order to justify the violent subjugation of a racialized other (Giannacopoulos, 2011). Its widely believed white people are schooled not to see race, and that this denial inhibits the examination and dismantling of racial inequality (Bonilla-Silva, 2003). This systemic 'colourblind' expression of denial was evident in the responses of three participants who described not having a cultural background or being 'normal' (Lisa) as well as the statement that 'race isn't really relevant to me (Violet).

Tara and Joanna both reflected on the moments they became aware of themselves as people who had a race and culture, and the way that whiteness had operated in their lives to make this racial identity invisible.

> Tara: When I first moved up here, even moving to Malawi, you know, the emotion was probably curiosity about you know, my surrounding environment and people I was working with. So, the curiosity was all about others and I think it took me a while to reflect on, you know, culture isn't just something that other people have or experience. It took me a long time to turn inward as well. And I observed that with my colleagues to it's just a more uncomfortable thought to think about our own culture than others.
>
> Q: Why was it uncomfortable?
>
> Tara: I think it's just your attention being brought to something you've never thought about before but also realizing that you're othering people, and as a white Australian setting yourself apart from everyone else, you know, thinking that you're somehow different and you don't have a culture. I think it's more uncomfortable to turn inward. I think it's easier to study others. And I suppose when you think about your own... when you think about white culture it just, you know, it then starts that journey of what does that mean?

Tara describes how the shift from denial into awareness was almost immediately accompanied by discomfort. This is congruent with the assertion that denial operates as a defence against feeling other overwhelming emotions that might

come up if one were to examine racial inequality (Menakem, 2017). Joanna described a moment she experienced where denial lifted and was replaced by a dawning awareness, and them almost immediately, overwhelming emotions.

> So when we arrived in [community name], I remember the four of us students, we just went for a walk down the street, and we got to the end of the street, three or four houses down, not far at all, and a car full of local people from that community drove past. And as they saw us, they slowed down incredibly, and drove so slowly and they all stared at us. And then they got to the end of the street, turned around and then drove back again to look at us a second time. And my mind was like, wow, for the first in my life this is actually me being a minority and it was something I had never experienced before. And, you know, that was a moment when all the reflections started coming, like, I am the minority, and I've lived in the world where most decisions have been made for the majority, which was me. You know, the privileges that we have as white Australians, you know socioeconomically. I came from a family, we weren't completely well off, but we were comfortable. All of those things started rushing through my mind. So that was the Monday, and I think by the Friday, I remember doing an assessment first thing in the morning, and just coming in and completely breaking down afterwards…I became so emotional about...um...so emotional and guilty.

Some participants described a gradual, growing awareness of their blind spots— 'attitudes and racism that you didn't know you had' (Robin) and gaps in their knowledge and understanding that were a result of the denial built into white Australian culture.

> Robin: Like I think, and my host family say this, why don't we know this stuff about the history? And it is true. Why don't you know it? And given that we don't know it, why isn't it being shoved in our face, all this great literature that is there. You know, why doesn't it just get to the mainstream? It's really incredible.
>
> Q: Why do you think it doesn't get to the mainstream?
>
> Robin: I think it's around those words no one likes to hear, racism and so on. And thinking that we're not that. Thinking, oh yeah, I'm open to Aboriginal people. I just haven't come across any, that's not my fault. But

> actually, you know, why aren't book clubs doing an Aboriginal book? And my book club's interesting. We've never done a book that has an Aboriginal focus. And from time to time it'll come up as part of another book and they are not interested in my experience at all. Just do not want to hear because you know, we're all okay. We're very forward-thinking and open-minded and this doesn't need to be discussed. We are so…We think we're not those things. We think we're not racist or privileged. We think we're not behaving in that way. So therefore, I don't need to brush up on that. I don't behave like that. But we do behave like that. We do need to brush up on it.

Eve described the difficulty of trying to grow awareness of these blind spots:

> Though I would like to think, and I hope that I'm not a racist person, I'm also aware of the— how many things are subconscious and that—and I try and reflect as often as I can in every interaction on how it could have been perceived from someone else—but then at the same time, I don't yet know how to reflect on something that I'm not perceiving.

Motivations and intentions to 'help' Aboriginal people were a common site for participants to interrogate assumptions they held as result of their whiteness:

> I just started to realise that all these thing people were trying, well-intentioned, to measure or to support or improve the lives of these people, [but that] was in itself a condescending and discriminatory sort of position. (Rose)

> Like the whole history of colonization has been—even the Stolen Generation—it was well-intentioned—very wrong, but I think the people genuinely thought they were doing the right thing. And this is the conflict, isn't it? I hope that my intentions are the right type of intentions. They could be. They could be wrong, and that's really…yeah, I don't know. I don't know! I don't know if it's the right thing. (Erin)

Participants explicitly linked denial to avoiding overwhelm and feelings of helplessness, echoing Boler's assertion (1999, p. 143) that the 'twilight zone' of denial is a result of feeling powerless and lacking agency to bring about change.

> We can't face that we have a massive ongoing role in supporting Aboriginal people. We can't face that what we did to them is still affecting them. We can't face that... The massive change to the way we operate that needs to occur for their futures to be different. We can't comprehend that. (Robin)

> I guess people ignore it…How we benefit from this system of oppression and stolen land and stolen children. We—we being a generalized non-indigenous Australian term—have lived this life of benefit in some way or another to the detriment of these other-—these First Nations people. I think as long as we're ignoring the fact that they're living— a lot of these people, not everyone-—but a lot of people are living in horrific conditions with health issues that are almost unheard of anywhere else. (Eve)

Eve takes care here to specify who she means in her usage of the term 'we', and in doing so demonstrates an explicit awareness of her position as non-Indigenous Australian and how that locates her on unceded country. She goes on, in a quote used in the earlier section on decolonisation, to describe how 'I just don't think that I can be okay with just living in Australia and not feeling like I mean... at least in some way contributing to making the world a little...even just a little bit better.' This response indicates a grappling towards agency, a sense she might have an impact, that perhaps enables Eve to examine colonisation more directly. This a contrast to the inability to face things that Robin describes, coupled with a less examined use of the term 'we'.

When professionals begin working in remote communities, denial is less of an option as they see, hear, and experience the reality of Aboriginal lives. The experience of confronting this reality was described by seven of the eleven participants as 'overwhelming'. Other terms repeatedly used included 'powerless' (Lisa, Tara), 'helplessness' (Lisa, Carl, Erin, Tara), 'inadequate' (Olivia), 'uselessness' (Tara), and five participant reported 'lots of tears'.

> We do a lot of trip reflections and at that overwhelm stage there are a lot, a lot, of tears. I don't think it's necessarily about what people are seeing. And you know, it's confronting seeing overcrowded housing for the first

> time, but I think the tears are sometimes about, *what's my place in it all,* and just feeling totally useless. (Tara)

Participants identified strategies they used to feel a sense of their own agency, so they did not collapse into those feelings of overwhelm. These strategies included 'focussing on the small wins' (Lisa, Erin), asking 'what can I do within the confines of my role?' (Carl, Tara), and the satisfaction of building 'connection and trust' with Aboriginal people (Eve, Robin). Violet described feeling that

> at the very depths of despair you get this kind of reward of human contact and yeah, I don't know… appreciation? It's not appreciation. That's not the right word. It's just real and that that's why I like my work.

Participant responses contained the spectrum of denial responses described in literature. They described denying racism exists, the moment their denial lifted and they saw their internalised racism, and the rush of overwhelming emotion and feelings of helplessness that accompanied this revelation. Some found ways to manage this overwhelm by focussing on what they could do to address racism, others focussed on the satisfaction of build connection with Aboriginal people, and Violet articulated the reward of being connected to what's real.

4.3.2 Anger

There are copious documented examples of angry responses from white people when confronted about racism (Ricketts, 2021; Saad, 2020b; Srivastava, 2005). Literature suggests that anger results from white people feeling personally attacked for being a 'bad person', rather than viewing racism as a systemic issue (DiAngelo, 2018). Six participants described their own defensive and angry reactions or angry reactions in other white people. They described feeling like the criticism was directed at them personally and used phrases such as 'bristling' (Robin), 'getting people's back up—affronted' (Tara), feeling 'taken aback' (Erin) and 'put in their place' (Erin). Participants described moves to innocence (Tuck & Yang, 2012): 'that's not me' (Robin), 'I'm trying' (Tara), 'I'm not one of those people'(Tara), 'I don't act on my privilege and I'm not dominating…' (Robin) and 'it's not a problem' (Olivia).

Literature describes how angry reactions from white people derail antiracism work, diverting focus from systemic racism towards individual outrage, and leading

white people to withdraw physically or emotionally from discussions of racism. Participants described both how feeling 'confronted' had caused them to 'walk away' (Robin) from discussions about racism, and how defensive reactions of colleagues had deterred them from having conversations about racism.

> Usually, the type of people that are saying things like that are very argumentative and will stick to their point of view because that's all they know. They won't use a bit of abstract thinking and look at this from a different angle and it just upsets me I suppose. I have in the past tried to have discussions, but it just ends up in arguments and it's not worth it, because some people won't change their thinking because they've been conditioned for so long to think that way. (Carl)

> It is confronting, and I think it's not always an easy conversation and you have to try to tread carefully somehow…[edited for length]…I still think today it's pretty challenging and people deal with it regularly. (Olivia)

> When anyone criticises you about anything to do with yourself, your first response is to push back against it. But then when you have that learning mindset, you then turn it around, thinking, once the initial push back is there, okay, what do I need to learn from this. (Robin)

Like Robin, several participants expressed initial defensiveness, but taking some time to reflect, to deescalate their reactions, and shift into a learning mindset.

> Probably, to be honest, the first thing was, you know, *that's really harsh. I'm trying and I'm not one of those people.* So that happened. But then maybe a bit more.... *Well, you're really experienced working in this space, so this is really hard to hear, but maybe I should listen*. But then yeah, I probably took the words away and processed it more over time. (Tara)

Participants reported relationships, both with Aboriginal, and non-Aboriginal people, that supported them to unpack their initial reactions and move towards a deeper understanding of racism.

> I think I've learned a lot just say driving around with mothers of clients and them teaching me more in gentle ways. So just learning about

> people's lives and what day-to-day looks like for them and why people might have a right to be angry. (Tara)
>
> Having a colleague like you that could... You'd been where I'd been. So, it's the translating again. It's the translating of the experience allows you to confront what you see as frailties in yourself because you don't want to see those things. So, it allows you to confront them. And allows you to confront them and see it as a growth opportunity rather than as a criticism of yourself. (Robin)

Congruent with literature, defensive and angry responses were reported by participants both in themselves, and in colleagues when confronted about racism. These responses worked to silence and avoid examinations of racism and stalled the development of antiracist professional practice. Participants identified that it was helpful to take some time to move through this initial reactive response so they could then reflect and learn. Mentors, both Aboriginal and non-Aboriginal, could help this process by providing safe spaces in which to explore one's own racism.

4.3.3 Guilt, shame and responsibility

Two expressions of guilt and shame are described in antiracism literature. One is an unproductive guilt or shame; a self-focussed emotion that wrestles with racism as moral character flaw, diverting focus from addressing systemic racism, and leading to defensive anger, protestations of innocence, and collapses into despair and inaction. The second is more productive guilt that motivates white people into a sense of social responsibility (Zembylas, 2018b). Literature describes how guilt can lift white people out of denial and apathy and lead to feelings of individual and collective responsibility, and action against systemic racism (Todd, 2003).

Six participants discussed guilt in their interviews. They reported that 'there's definitely guilt associated with this work' (Rose), that 'guilt was a huge a one, a massive one' (Joanna), emerging when 'reflecting on white privilege, reflecting on racism,' (Joanna). Participants felt 'guilty, purely for the fact that I was...I am able to just go home after being out there for four days and come home to a really comfortable house' (Lisa), 'guilt about being racist' (Joanna), 'disappointed in how we are. Like how I am where I am and I just wish that wasn't the case and it's almost

like if I could be someone else, from somewhere else then I wouldn't have contributed in some way to this harm that has occurred and is still occurring.' (Eve) 'Guilt because when you talk about privilege and you realise you have it, guilt definitely comes in. That you've had the resources to get the education you have and be lucky enough to do the work you do. You feel so guilty that you're working with people who haven't had the same opportunities.' (Tara).

These responses reflect discussion in literature that guilt can be focussed on the individual—guilt for realising one's internalised racism, guilt for one's privilege, comfortable house, education. Participants described these guilt feelings as 'such a self-defeating emotion because you need to be able to forgive yourself…' (Rose) and that this guilt leads 'very quickly to tears and exhaustion' (Joanna), aligning with literature that these self-focussed feelings of guilt can be unproductive if an individual does not move from that self-flagellating position (Spanierman & Cabrera, 2014).

However, participants also reflected on ways they moved through this guilt, metabolising it in ways the spurred them into action and fuelled their passion for this work.

> Not so much guilt but responsibility. I don't believe when people say that we shouldn't be sorry, and we shouldn't feel responsibility for what people did like two hundred years ago. I think that we should still feel responsible for that because we've benefited from it continuously every single day since that day. I don't necessarily think I feel guilty. But I definitely feel a sense of responsibility to pay my rent, pay my way a little bit. (Eve)

Participants framed their work as expression of their sense of social responsibility and the deep satisfaction this gave them.

> I think for me to be doing something meaningful…I feel like I've found the space that sits the closest with my values. What I want to devote my energy to. And I know that this exists within our country, the same country I was born into and there's such a disparity. I just don't feel like there's any more meaningful work that I could be doing in this country. When the people that we're working with, when there's been such efforts to oppress that, to try and rectify some of the awful things that have been done, if that can be where I spend my energy that's...I would be proud. I

> think about [my son] and think about how I want him to see me and think, yeah, I want him to be able to see that I'm doing something that's important to me. (Jacki)

> I just don't think that I can be okay with just living in Australia and not feeling like I am at least in some way contributing to making the world a little...even just a little bit better. I guess using my privilege to improve or to share or yeah, almost pay my rent I guess, to use a current buzzword. (Eve)

Participants used phrases such as 'feeling very privileged and also a bit of an obligation to do something' (Lisa), 'Join[ing] the dots about how history/intergenerational trauma etc. have affected our students and hence our responsibility to provide access and success' (Robin) and the 'satisfaction'(Erin) and 'meaning' (Jacki) of 'help[ing] some of the most vulnerable and disadvantaged people, and misunderstood people' (Erin).

While the majority of participants experienced feelings of guilt and shame, it was identified as a 'self-defeating' and unproductive emotion that led to exhaustion. As Zembylas (2018b) identified, a feeling of social responsibility instead of guilt, filled participants with a sense of meaning and satisfaction in their work to improve things for Aboriginal people. This sense of responsibility, stemming from an understanding of history and privilege, expressed by participants as a core motivator for working in remote communities' contrasts with the 'white saviour' motivations to help the 'poor/dying race/Aborigines' that has dominated many Aboriginal community services for decades (Samantha Schulz, 2017). Perhaps this in an indicator of how language and sensibility have changed over recent years as movements such as the Referendum Council's meetings that led to the *Uluru Statement from the Heart* and *Black Lives Matter* have increased the profile of white privilege, racism, and colonisation.

4.3.4 Fear, anxiety and perfectionism

Literature suggests that fear of Black, Indigenous, and People of Colour is taught through generations of white supremacy and colonisation (Ahmed, 2015; Ogden et al., 2021) and functions to obscure to reality of power relations that are

stacked in the favour of white people (Giannacopoulos, 2011). In their interviews, two participants admitted to feeling personally afraid of Aboriginal people. Two others observed fear in other white people they worked with. For Lisa, fear was a predominant emotion experienced during her work:

> Safety as well comes up quite often…There's always stories about things that happen in communities and you'll hear a story every time. Like the last one, you know, I go jogging, in a group—you wouldn't go on your own in one of the communities that we go to. Them telling me that there was someone out running on their own, it was light, and she was attacked. There's always that safety concern, it does happen, and you hear about it all the time. I've never really had anything happen to me, touch wood. I mean there's some dogs around [laughs] that definitely nip at you, and I don't like that but more just the stories because I've never really met anyone I felt unsafe around out in community as yet, and that's pretty good for how long I've been in this work. I'm just trying to think if I have… not just walking around outside anyway. So, I think it's just the stories actually.

Lisa's response indicates her fears were a result of stories heard from others, rather a result of direct experiences, supporting the view in literature that fear narratives of Aboriginal are shared collectively in white Australian society. Joanna explicitly connected those collective stories to the fear she held about Aboriginal people:

> For me part of the racism was also having a little fear in me, of oh gosh, there's an Aboriginal person walking towards me, and do I look away, do I look at them, do I wave, you know? Racism for me isn't just when you shout something about someone's colour across the street, it was much more in-depth and from an ingrained feelings of being uncomfortable and sometimes fearful of people of different races. Due to what I had been told while I was younger or what I had seen on the media where different races are depicted as being, um...violent, or...yeah, violence mostly was where I felt a lot of that fear. (Joanna)

Joanna used her fear to develop her antiracism in the way Ogden (2021) recommends, noticing the fear and examining the bias it indicated, and where that bias came from.

Tara also reflected on how the representation of Aboriginal people created feelings of fear

> We've got a couple of communities that I think undeservedly have a bad reputation. So [community name] is one of them and I think just the media around [community name] has been terrible. So, people come in with fear based on sensational media and it just having a bad reputation, but for us it seems to be attached to particular places. There is a difference between local staff, so I've noticed people that have grown up in the NT, you know gone to school with other Aboriginal kids, they're more familiar with the context. So yeah, there's probably more fear from people who are coming from another world like Melbourne. (Tara)

Tara distinguishes between local staff, who presumably have more direct, personal experience with Aboriginal people, and urban staff who perhaps have had less, again suggesting fear is based on representations and stories of Aboriginal people more than scary lived experiences. Carl commented that 'generally as you go through life you meet people and they feel safer in their cultural group, in their European cultural group…' which echoes Ahmed's 'fellow feeling', the turning away from the object of fear involves turning towards home'(2015, p. 74).

Another kind of fear discussed in literature centres around white people's discomfort about facing their own racism (Spanierman & Cabrera, 2014) and the perfectionism and anxiety about getting antiracism right (Ricketts, 2021). A number of participants articulated this kind of 'nervousness' (Tara), 'fear that I'm going to do the wrong thing' (Robin) or ask 'a dumb question' (Robin). Tara reported 'just how scary it is' because of 'fear that they don't know enough, that they're going to do something wrong.' Participants reported feeling 'a little bit wary' (Rose), 'tiptoeing around young students because I might do the wrong thing', 'holding [Aboriginal children] differently' with more 'tension' more 'rigid' because 'I don't get you, you don't get me, we're so different, our backgrounds are so different. I don't have the answers. I'm trying. Am I worthwhile here?' (Rose)

These feelings correspond with observations in literature that race is an area of new learning for many white people, and they can feel that they 'don't know the rules' or 'don't know how to get it right'(Frankenberg, 1993, p.3), and are afraid of their racism being 'found out' (Srivastava, 2005).

Participants also described a kind of anxiety or going into 'overdrive' that occurred in their work, rushing to find the answers and fixes, similar to the urgency Yancy (2015)and Saad (2020a) describe as a way white people avoid feeling the discomfort of racism.

> I reckon I probably did double the hours. In other words, I'd go home and just read constantly and think about it constantly. It was very frustrating. I was really exhausted. I think I was trying to fix. I was seeing a lot of problems and I was trying to do a whole lot of fixing…All weekend, I would just shut myself away and… the texts that I was reading would range from like Googling 'The Healing Foundation' and trying to understand what was our national response. That was at the same time as the Royal Commission into the juvenile detention centres and I used to—I was spending a lot of time trying to canvas everyone that I knew to write a submission to that. I was trying to write my own....It was a whole lot of running on the spot. (Rose)

Participants describe 'doing too much' (Erin), 'working long hours' (Erin, Rose), having 'a million plans in my whitefella head of things we're going to do to get it right'(Robin) and 'taking on roles that aren't theirs' (Erin).

Many participants described a turning point, when they learned to slow down, 'relax a little bit in a way' (Tara), 'realise that there is no right way to do thing. You can never learn everything and it's a journey that lasts your whole career'(Tara). They describe 'getting out of that that fix-it mentality' (Robin, Erin). 'I just needed to be able to switch off all of that and unlearn it and just be able to listen and see more clearly what was in front of me'(Rose). This mirrors the discussion in literature about allies learning to change their position from 'knower' and 'fixer,' into a receptive, learning mindset.

Instead of rushing around 'fixing', participants focussed on the 'interpersonal part of the work' (Tara), 'making these relationships with people and going back to see them every month' (Erin) and 'just listening to people' (Robin). 'On the ground, when I had experiences of just collaboration and engagement with Indigenous people, it was more about, just stop already. There's no need to do anything other than just sit here' (Rose). Letting going of 'fixing' allowed participants to be more present and engaged in their relationships with Aboriginal people, and more receptive to learning Aboriginal perspectives.

Violet articulated her process towards receptivity through the lens of her Christian faith:

> Violet: Quite honestly, every time I had to call somebody, I'd pray. Say, *for goodness sake, God knows I don't know anything but help me to be useful*, you know. And somebody'd come in and then I'd say the first thing that came into my head and then they would teach me whether that was a good thing to say or not and we would go from there. So, I was very much not in... not in a sense of feeling in control or having anything to offer and I did talk about that with my Master's thesis supervisor because I was a bit reluctant to say how much my religious faith was informing how I was working. *Oh no,* he said, *there is some understanding that if you—like for Buddhists and things—if you surrender then you're actually doing something to the therapeutic alliance, that is quite powerful*. Yes, even though he wasn't necessarily believing in Christianity or anything, he did believe in that attitude of asking for help. Because it's a kind of reflective space from which you're coming rather than a reactive space.
>
> Q: It sounds like your faith gave you a container that allows you to kind of be receptive...?
>
> Violet: And not do anything. Yeah, it did. It helped me to keep my mouth shut [laughs].

Participants described the result of slowing down and focussing on relationships as 'so relieving and relaxing and helpful' (Robin), and reported feeling 'calm' (Robin, Joanna) and feelings of 'joy' (Robin); 'like I was doing a mindfulness exercise and when I got down to that true level of calmness, it felt like it was easier to see the person in front of me as the person in front of me, and let go of racism and preconceived judgements and ideas' (Joanna).

Participants echoed literature as they expressed feeling fear about Aboriginal people that they could link to stories they'd been told. They also expressed anxiety and perfectionism about getting 'antiracism' wrong. Though very different causes, both these fears deceased their efficacy as health professionals with Aboriginal clients. When fear is present in the nervous system, it inhibits one's social relating ability (Ogden, 2021). Fear maintained distance between participants and the

communities they worked for and prevented them from relaxing into relationships characterised by trust, receptivity, and reciprocal learning.

It would be helpful to identify how health professionals can be better supported to recognise and reassure these fears so they can more readily shift out of anxiety-driven overdrive into a receptive learning and relating, as discussed in Section 4.3.

4.3.4 Destabilisation: losing belonging and finding a new one

Literature suggests white health professionals in remote Aboriginal communities face a potent cocktail of experiences to destabilise their sense of identity, competency, and belonging. This includes the 'difficult mirrors' of learning about race and whiteness, challenging previous held ideas of oneself and one's society as 'wholly good'(Bailey, 2015), the impact of culture shock disorienting professional competency and provoking feelings of isolation (Trudgen, 2000), and the tensions created with the white community when one begins to critique racism and whiteness (DiAngelo, 2018).

Participants frequently expressed feelings of feeling 'overwhelm[ed]', 'helplessness' and 'uselessness' in their work but it is hard to definitively ascribe the cause of these feelings. At times participants ascribed these feelings to witnessing challenges their clients were facing that were out of their professional scope to address such as housing (Carl). Some assigned it to the ineffectiveness of the Western model of health care (Olivia), or the constraints of their service not allowing adequate time to build relationships (Erin). At other times it was ascribed to culture shock:

> It was a complete culture shock. A vivid memory I have is, I did a neuro placement up here and I was treating an Aboriginal fella from community and my supervisor was like, go in and treat him. And I just asked him stupid question like, you know, your basic physio questions like sit to stand and do you do—all of those complete textbook things and as a student you just don't think outside the square. Wasn't for ages—he was being ultra-polite—and it wasn't for ages and my supervisor finally had to stop and was like, 'He doesn't have a chair, like he sits on the ground under a tree,' and I was like right, okay....' He also

> doesn't have a bed,'…Right, okay… So, I was doing all these, you know, assessments that you do in white man's world and they just didn't transfer and I just remember at the time going, I have no idea what I'm doing! …I guess I just felt quite stupid really, I don't know. Quite oblivious. I just had no concept of that and completely unprepared really. Knowing that I would have to do a very steep learning curve for the rest of the placement. (Olivia).

Olivia articulates the jarring moment of realisation that one's professional skills are not directly transferrable to the Aboriginal context and her language of feeling 'stupid', 'oblivious' and 'unprepared' captures the impact culture shock can have on one's sense of self. Tara described culture shock as 'feeling a bit useless in a lot of situations.' Jacki reflected on culture shock as '…really hard, coz everything I was talking about was completely foreign. There weren't many times that we could connect or have similar approaches,' capturing the feelings of isolation culture shock can create.

Participants also described how 'you confront a lot of your own attitudes when you're in that sort of space and racism that you didn't know you had' (Robin). Working in Aboriginal communities held up 'difficult mirrors' causing participants to see themselves in new, painful ways.

> I became so emotional about—emotional and guilty as well— that I had been brought up in a world that for me, there were a lot of preconceived ideas about racism, and I was like, oh my gosh, I'm here living in this community, and I'm racist. That was the biggest thing. And having to learn that actually, a lot of that wasn't my fault. That was what I see in the media, that was what my grandparents and my mother and you know everyone around will make racist comments on the fly, whether that was their intention or not. And this extreme guilt that I ... was...racist. (Joanna)

> Erin: Historically there's been so many like well-intentioned people who have gone out to help but it's not been right. It's not been the right help…The whole history of colonization has been, like even stolen generation is, we're going to—you know, it was well-intentioned, very

wrong, but I think the people genuinely thought they were doing the right thing.

Q: How do you know your well intentions are the right types of intentions?

Erin: Exactly. This is the conflict, isn't it? I hope that they are… Yeah, again, it's just my belief system. It could be wrong and that's really…I don't know. I don't know Caitlin! I don't know if it's the right thing.

Participants' critique extended beyond themselves, to other white people, including colleagues, experiencing strong emotions about their treatment of Aboriginal people:

> Often in hospital situations especially in emergency people will make decisions based on assumptions, for Aboriginal people a lot. So, for example, I dealt with a lot of broken bones and if I did a cast there would be an assumption they're long-grasses they won't be able to look after that cast. If you put them in a boot they will be better off for it. So, there's a lot of that type of discussion that's not based on having a discussion with Aboriginal clients. It's an assumption that they've made without any consultation and to me that's taking someone's power away. I think that happens a lot. Possibly, I don't know, if it's nearly a daily basis? I feel really upset that it's happening. (Olivia)

> There was a woman who came around, I think something to do with eyedrops for glaucoma.... or something to do with the eyes and was just walking around community and was like, *give us your kids, I'm going to put drops in their eyes*. Like, no informed consent, talking a hundred miles an hour and I was doing a session on this family's veranda when she came around and there was this fear from Mum for two reasons. So, one of it was, what are you doing with my child? This white person is telling me that I need to do this for my child, I don't know what she's saying, she's talking too fast, she's not talking my language and... So that really, really frustrated me. (Joanna)

Some participants described how accumulative resentment and loss of belief in their colleagues, friends, family and own culture effected their sense of belonging within their own culture.

> When I go to my hometown, I was grown up with...It was a very common view for example, in my hometown that Aboriginal populations get a lot from welfare and you know, they leave rubbish everywhere, have a problem with alcohol etcetera etcetera. Pretty much not doing anything to help themselves, essentially. And I really don't think at all like that now. It's probably not until I go home, and I hear something like that or someone suggesting something along that theme, and I'm like, Huh! Okay! Woah! How has that view not changed? It's shit, and it makes me go, oh my god, views should have changed by now… It's disappointing and frustrating to know that that view still exists from educated people, especially. (Olivia)

> I definitely had to sort of watch myself coming back and Christmas holidays for example, and I could really quickly get into an argument with someone that's never left Brisbane telling me the state of Aboriginal politics. I probably was sort of biting at the bit to have a really good argument with someone about, you know...An argument with someone from my culture, from my family, because I was probably still resenting and cross at the culture that I came from… (Rose)

Participants described intense feelings of 'frustration' (Eve) and 'anger' (Eve) towards other white people, wanting to 'tear people apart' (Rose). They described feeling disappointed (Olivia, Eve) in white people, even to the point of wishing they were not white: 'almost like if I could be someone else from somewhere else then I wouldn't have contributed in some way to this harm that has occurred'(Eve). Some participants expressed alienation from their own culture, such as Joanna who reported that she 'really struggled with being back [in her hometown]. It was like, reverse culture shock for me,' and Rose 'was just like, what am I? All of a sudden I was like, I need to go back, need to be near people to make sense of my culture again.'

Alongside the 'overwhelming' emotions and difficult insights about oneself and one's community and colleagues as 'racist', participants described the way

working in Aboriginal communities ‘helped to really open up my world’ (Olivia). ‘I felt like a whole new person, getting out of my little bubble where I’d been my whole life’ (Jacki), ‘not being surrounded by people who are privileged all the time. Not being surrounded by the privilege. I think it adds to so much value’ (Jacki). Participants found ‘value’ (Jacki), ‘interest’ (Tara) ‘creativity’ (Olivia), ‘learning’ (Rose, Tara), ‘curiosity’ (Tara) ‘genuine enjoyment’ (Tara) from being exposed to diversity. ‘I suppose that it helps you understand the world a bit better. I suppose it's easy to stay living in Melbourne, going to school in [suburb] and working in a hospital, and you've got friends who all look like you, who all have the same level of education and think and vote in a similar way. I think the appeal is diversity to be honest. I love up here that there’s diversity in lots of different ways. Like within my work, it's a lot of cultural backgrounds, ages, beliefs about health and what that means. It's just interesting.’ (Tara)

Participants also reported valuing what they learned from Aboriginal people.

> There's so many parts of Aboriginal culture that I really respect, and there's so many strengths to Aboriginal culture and they have such resilience and capacity. (Olivia)

> I found it really inspiring I think, because these people that I had grown up learning about such sad things about were just teaching me just so much about you know, what was on trend—mindfulness. Without a book and without a uni degree or anything. It was very powerful. (Rose)

> Indigenous families co-sleep with their kids. They adore them. They don't do controlled crying. You know, they have aunties and grandmas and four mothers, and you know, I just think that is so great. I had my children by myself in a unit when my husband wasn't there and my family were nowhere near me and I was completely at sea and I just, I didn't even know it. So, I just think the way they adore storytelling as well. Because I see that as just the ultimate seed for creativity and originality which I think is healing in and of itself. Those two things just speak so profoundly to me about their culture that we've managed to sort of... I, even as a mum, you know, and I'm a creative person, I would say I struggle to, after I've done everything— made sure the homework's done

> and the dishes are done—and there's like, okay now it's creative time as opposed to just like a hundred percent creative time. No matter, come what may... I think it's just being beaten out of us. We've just got far too many rules around stuff. So that's what I resent about my culture. (Rose).

Working in remote Aboriginal communities greatly shifted participants' sense of identity and belonging. This was a difficult experience at times, making them feel ineffective as professionals, isolated in the communities they now lived in, and creating tension with their home cultures and communities as their perspectives changed. This tumultuous transition offered gifts also, in the form of an 'opened up world' (Olivia), 'outside the bubble' (Jacki), where participants enjoyed relating with people from diverse backgrounds and benefited from learning things from Aboriginal culture. The isolation of this process is acute. Professionals struggled to find understanding from friends and family at home, their professional frameworks did not fit the context of their practice, and they increasingly realised the health services offered to the communities they worked in were racist. It should not be left to the individual professional to navigate these pressures alone. How can professionals be supported as they dismantle their professional practice to apply it differently in this new context? How do we provide pathways for professionals to address the systemic racism within health services as they become aware of it? What social and emotional supports to professionals need to navigate moving between the culture they work in, and the culture they return home to?

4.3.4 Disgust and care

Disgust is a recoiling away from the racial 'other', a distancing behaviour that shapes physical space and social groups into 'them' and 'us' (Ahmed, 2015). Due to racial disgust being socially unacceptable to express (Matias & Zembylas, 2014), its unsurprising that most participants did not report experiencing it. There was one exception, however, with Robin offering a story from her childhood:

> When I was at school in grade one the circus used to come through town every year and there were Aboriginal kids as part of that. Now when I look back and at the time, I don't think I even knew that, but the grade one teacher said to me, *And [Robin] you can sit next to Blah*—and she was the Aboriginal girl travelling through town with the circus. And no

> one explained anything. She said *You're kind, you can sit next to Blah* and I did, and she smelled and she wasn't good at school work and I pinched her under the desk. I never pinched anyone in my life! And you know that has stayed with me forever and in a funny way when I.... actually, when I had my interview for my current job, they said what has led you to this, and I said that whole thing, I've just told you but I also talked that little Aboriginal girl and how it makes me choke up now, but you know, I just think wow, I was a good girl and yet that's what I did. So yeah, I feel like there's some karma in getting to try and change the way people might respond to that little Aboriginal girl.

As racial disgust is socially unaccepted, its expression is usually repressed (Matias & Zembylas, 2014), which explains why the only experience of disgust reported is one recalled from childhood, perhaps before Robin had learned to repress these feelings, although even then she hid her actions under a desk. The same recoiling from 'the other' and retaining of distance can instead be observed in some expressions of 'care' including:

1) Care that retains power dynamics of a white person in a position of power, 'who knows best', and the Aboriginal person in the position of a submissive, grateful, receiver of care with Indigeneity implicitly considered deficit. This kind of help both directly reproduces, and fails to challenge, the colonial oppression impacting Aboriginal lives (McPhail-Bell et al., 2015)
2) Sentimentalising the 'other' to allow one to care for an acceptable fantasy version of the other (Matias & Zembylas, 2014).
3) Ignoring or only superficially engaging with difference as though learning from another culture is unimportant (Valenzuela, 2010).

This makes 'caring relationships' a useful entry point for examining repressed feelings of disgust (Boudreau Morris, 2017), and especially so within healthcare where 'caring' relationships are a professional service, defined by practice frameworks, policies, procedures, key performance indicators and contracts. The nature of 'care' that a health professional delivers to an Aboriginal client is not only a result of their personal attitudes and choices, but that of the organisation they work for. Therefore, it is important to examine healthcare services and the kind of 'care' they provide to Aboriginal communities. Do they retain or dismantle power

imbalances? Ignore oppression or address it? Engage with Aboriginal people superficially or sentimentally? Does healthcare service delivery express racial disgust towards Aboriginal people?

Participants discussed how institutional factors limited their engagement with Aboriginal people. They felt restricted by the scope of their role, the model of health service delivery, and how their organisation defined their professional 'care'. Olivia reporting feeing 'really ineffective' because as a physiotherapist she was expected to deliver a 'Western model of health to Aboriginal populations who don't necessarily have a Western lens of health.' Carl celebrated the shift from 'the medical model' to a 'client-centred model' resulting from a change of CEO in the Health department. 'As soon as service delivery becomes more client-centred then you can address those cultural backgrounds and make your service delivery a bit more flexible.'

Participants felt that the service they provided often did not address the central concerns of Aboriginal clients, such as overcrowding in poor quality housing that was contributing disease because it's 'way out of the scope of my work, it's just too big' (Carl). Participants felt unable to challenge systemic racism as it seemed beyond the scope of their role:

> I work for this Department of Health where there's lots of structural racism, but I'm in this job. I'm employed as a physio. I've got to work within the confines of my current role. You know, which isn't always what people want or need. So where does that... What can I do within the confines of my role and the service? (Tara)

These feelings of restricted scope were more acutely felt by participants like Tara and Carl who worked for government than those who worked for non-government organisations (NGO) such as Jacki:

> I'm really lucky because I work with an organisation that does heaps of advocacy and we're constantly evolving and changing to make things better for people, so we're better able to support. And we're really well resourced that we don't have limitations on how much we can support someone to do all those things that I was talking about. But we also, at high levels—if there's like consistent things that are coming up that are obviously discriminatory, we have like lawyers and people that advocate to higher parties and we engage the legal services and things so that we can actually have an impact on that kind of stuff. And we're really

> encouraged, everyone is really encouraging in our workplace to advocate for change so it's not like...I don't ever hear from the top, well that's just the way it is. In our organisation it resonates at all levels, the unfairness. And trying to advocate for change. (Jacki)

Violet likewise compared her NGO role to government run service providers:

> Like the police, they have a particular way that they can move in and out, but it's not a very warm welcome right? Though it can be, if they like the person. The nurses and the doctors are always so stressed out and overworked. And so, whenever they finish their work, they just retire and hide in their houses, you know […] The service providers have their own roles that constrict them. I think that's why...that's one of the reasons why we're a little bit...we've got more access.

Violet's description evokes the movement through space that Ahmed (2015) describes as the essential impact of disgust, distance or proximity seeking that expresses disgust versus intimacy. Violet also gave an example another service provider attending a workshop Violet facilitated, and describes how this interaction, outside the service providers usual role, elicited a new kind of empathy:

> But the service providers that have joined in have been very moved by it. There was a woman who was working with domestic violence and she's an ex-policewoman and she came to our groups, and she was just flabbergasted at what she heard the women saying about their lives and what was going on in the community. She just could have never been in a situation where people were just sharing what their burden was, you know. Like they were saying, you know, what do you do when your grandchildren come and humbug you and say if you don't give me ten dollars for gunja, I'm going to hang myself and they're looking for the tree to hang themselves from and occasionally they do, you know. This is, you know—it's horrible stuff that they're sharing. Their trauma of what do you do for our young people and things, and she was just sitting in and she was just blown away. (Violet)

The service providers' understanding, and emotional intimacy with the Aboriginal community grew more nuanced because of Violet's model of service delivery, in comparison to their own. Similarly, Eve who worked for an Aboriginal controlled

health service described having flexibility to stretch the scope of her speech pathology role to deliver effective care to clients.

> I've got some wonderful relationships with a lot of the mums that we work with but I think the nature of the work is that it goes beyond being a speech pathologist. I'm now, for a lot of the families, I'm almost a key worker. I'll be the person that she asks to attend her Paeds appointments if she's not feeling comfortable, any school meetings or if she wants advice about coronavirus and what she should be worried about. I'm the person that she calls. It's very beyond being a speech pathologist. I think, we've said that a lot, that I reckon maybe forty percent of my work would be actual Speech Pathology related and the rest is like almost family support kind of work, but I really love it that way. So I think most of my relationships with the mums or nanas that we've built relationships with is in that way where it just you become that, almost, their person, like their professional. I think a big thing is that you need to be prepared to do more than just be a speech pathologist or be an OT. You need be a support person for them in other areas of their world, otherwise they're just not going to engage. (Eve)

Multiple participants pointed to this model of flexible 'care' beyond a strict definition of their professional scope as being helpful for 'engaging' (Eve) and 'building rapport.' Arguably, this is an example of professionals developing services that care for the central issues Aboriginal clients are facing, following the fault lines of oppression in their client's lives.

Participants also described the realities of covering multiple communities across a large geographic area, coupled with the sheer number of people on their caseloads, as severely impacting the intimacy of their relationships with Aboriginal people:

> The speechie and I went there, I think maybe seven or eight times over a two-year period. Just consistently showing our face and by the end of like the last trip families were coming up to us and it just felt like we had really made a difference in a small way with a couple of kids at least. And then because there's so many communities to get to and there's not enough staff to go to all of them regularly then [community name] didn't get a service for twelve months and then it just had huge gaps. It's really

> tricky to manage. And now I manage a team and there's more communities here. There's forty-four. (Erin)

> I still feel like an outsider. I would say my relationship with Aboriginal people, going in as an outsider, to visit remote communities is still superficial. Because I fly in and fly out and the longest, I stay in a community for four days at a time, once a month. So, it's really hard to gain the rapport that you need to, when you fly in, fly out. (Olivia)

Olivia offers the word 'superficial', demonstrating an awareness of the distance between her and the community she is caring for, reflecting on how the structure of the health set up this dynamic. She goes on to explore this further:

> Q: Rapport that you need to for what?
>
> Olivia: I guess, to get a deeper trust. For a deeper level of rapport. Like I think you can only get so far. Unless you go out for years and years and years on end, it's really hard going, flying in/flying out. I mean that's a challenge, I guess. I find that developing relationships with Aboriginal people when I work is always...like...because of the differences with culture and you're always an outsider flying in, I don't feel like I can ever get really close with families and individuals. Not to say it can't be done. And I've been able to develop some strong relationships, but you've got to work hard at it. It's not as natural, maybe that's a way of saying it. It's not as natural as with some other cultures, or some other population groups.
>
> Q: Why is it not as natural? Can you articulate that?
>
> Olivia: Because you have a different base that you're working on and different...and you're always having a different lens, a different view on life and different life experiences. Their world, remote world and life is so different to anything we experience. And it's not really an even platform as much as it...Which makes it hard as you kind of have to work harder to make it an even platform from which you can learn from each other and have respect for each other. Without them looking at you like your just some outside person coming in and flying in and talking to them and giving them advice and telling them what to do. For five minutes of their life.

Olivia appears to recognise and grapple with difference, identifying how the structure of service delivery does not give her the time she needs to be a student of the community she cares for in order to meaningfully learn about that difference. She also identifies the role power imbalance plays in creating that distance. She explicitly reflects on the need to dismantle that power imbalance to establish a useful caring relationship. This was something she reflected on again when describing how she worked differently in remote communities:

> Olivia: I guess even just the basics for having communication, you know, you're sitting down and having a chat on the ground with them as opposed to the clinical space. You've also got their family around them, they're open to talking and I guess you can show them that you're... I guess it's a bit more of an open platform and a more even platform and it takes that... it takes that level of power away that you have in a hospital I would suggest. So, it just breakdown some walls and barriers a bit easier.
> Q: It's really interesting that you mentioned power. Do you think that power influences your professional practice or service delivery in this kind of cultural context?
> Olivia: I think you'd be naive to say no to that. Unfortunately, the white privilege... With that comes white power, unfortunately. And whether that is formalised or whether that's invisible it exists, unfortunately. I think as professional in remote communities we just have to have some awareness of that and try to make the platform a bit more even on a daily basis.

Like Olivia, a number of participants explicitly reflected on power imbalances in their relationships with Aboriginal people, recognising it was ‘really real’ (Tara) and needing to be ‘mindful of that power balance in your presentation’ (Erin). Erin spoke about ‘proving that you’re going to show up and listen and not go in guns blazing. Sit and listen. Even in terms of where you sit. Like if there's only one chair I will sit on the ground and let Mum sit on the chair, like just in no way am I pretending to be bigger or better.’ Violet reported that being an older woman decreased some of the power differential: ‘I'm a little old lady, you know, I'm not daunting and I'm not impressive, I'm just ordinary and they don't feel threatened by me at all.’

Jacki, who worked for an NGO with a more flexible service delivery model, described more intimate relationships with Aboriginal people where the power imbalance had shifted towards more equality, mutual vulnerability and reciprocal care:

> I think its sharing. And [my son] was definitely a huge step in that, because having [my son] around, they see a totally different side of me, and see my vulnerabilities as well. And we spend half the time—I very rarely bring up work stuff, or stuff that's about their client's disability. It just kind of comes out in conversations when we're talking about other things. So, we might cook a meal together or help do some tasks around the house, and things will come up. Like say, oh yeah, that's actually something I've been having trouble with, is there anything you can do to help me in this scenario? Or we'll go fishing or go looking for turtles or for a drive and go to the waterfalls and we'll see how some new difficulty has come up with getting in and out of the car or walking on uneven surfaces or something like that. So, it's just like organic. It's not like I'm going with a physio checklist to try and look at all these things. We have a relationship, and then these other things come after that. They come out after that. My son and I have always gone along, and you know, had family barbecues. It's just a totally different approach.
>
> It's like a friendship. Like, we share so much with each other [laughs]. Some of the families—like I've had two missed call from someone now, and she's probably just calling up to say hello. Just to see how we are and how we're going with everything that's happening in Darwin at the moment and checking on how [my son] is. We always talk about our kids to each other. This particular person who I spent most of my time, when I think about her, and her family, her daughter calls me mum now as well, and she'll call me when she's upset, and talk about, you know—it's a close relationship. She lets me see her vulnerabilities and when we see each other it's like hugs and ah! Haven't seen you in so long! It's really...It's different. They have photos of me and [my son] up on their fridge, like...It's...yeah. it's nice. It doesn't feel like work.

Violet also articulated how care felt different when there was more intimacy, describing a more reciprocal exchange:

> I remember the three of us, that A— and myself and the lady with the domestic violence thing, we were sitting in our car and there had been a terrible suicide and there was a whole group of women who were coming. They were sweeping. They were doing the grieving, you know, they sweep around the place, and they came over and when they saw us their eyes lit up and they came over and we hugged them, and they hugged us and that was just so... At the very depths of despair, you get this kind of reward of human contact and, yeah, I don't know… Appreciation or not…It's not appreciation. That's not the right word. It's just real and that that's why I like my work.

Violet uses the phrase 'human contact', she describes the proximity seeking activity of hugging, the intimacy of recognising the light in another's person's eyes. In Violet's description, everything is 'up-close', the opposite to the distance-seeking recoil of disgust. Interestingly, Violet falters over the word 'appreciation', settling instead for 'real'. She seems to be trying to describe the reward of human connection during a real, vulnerable moment. This vulnerability also features in Rose's description of caring relationships with Aboriginal people, 'You get to practice not having a mask on and just being vulnerable and I think that's only going to bring out with good things for a work culture, for professional practice.'

The 'appreciation' Violet referred to but then clarified to really mean connection and vulnerability, contrasts with the use of the word 'gratitude' by other participants who remembered at times feeling 'disappointed' and 'bit resentful' that 'I've put all this effort into doing all this stuff and they don't even...they're not grateful' (Jacki), or when Lisa noted that 'There are people who are really thankful, there definitely are... there's a lot that don't...you don't feel, you know... There's a lot that are, but there is a lot that aren't'. These comments contain an element of 'white saviour', expecting Indigenous people to be grateful recipients of help (Land, 2015). As Jacki reflected, 'That's such a terrible way of thinking about it now, thinking about gratitude, knowing the whole history of how everything has happened…'

Central to understanding whether repressed racial disgust is present is looking for signs of distancing from the racial other. In participant responses it was possible to see the set-up of healthcare services limited their ability to get close to

the communities they were employed to care for. Power imbalances, and an inability to learn about and meaningfully engage with difference limited many participants, particularly those that worked for government run health services. However, many participants actively reflected on power, dismantled this differential, and experienced close, vulnerable, reciprocal relationships with Aboriginal people—especially those working outside Western medical models of healthcare like Jacki, Violet, and Eve. These professionals worked for Aboriginal controlled healthcare services, or in small private practices, where service provision was characterised by the primacy of relationship, flexibility in scope of practice, and working in settings outside of health facilities. For repressed disgust to not be implicitly communicated during problematic performances of care, systemic change is needed in the healthcare delivery model.

4.4 Other emotional factors impacting remote healthcare professionals

It's important to contextualise the emotional impact of reckoning with white privilege and racism amongst the myriad of other challenges professionals face in this work. It is important to account for other possible causes for the emotion's professionals report, because the cause of an emotions can't be definitively pinpointed. Nervous systems also have a 'window of tolerance' (Ogden, 2021) regarding how much they can process and move through emotions at any given time. Other challenges, therefore, take up some of the available emotional bandwidth professionals have, and reduce their ability to engage in the emotional labour aspects of antiracist and decolonisation practice.

4.4.1 Trauma

The professionals interviewed frequently witnessed traumatic incidences in the communities they worked in. 'You know there's domestic violence going on, the kids are starving, there's substance abuse, sniffing or smoking heaps of dope, and family violence and how much it affects the kids'(Carl), 'I've seen someone hanging from a rope from a tree, and being hit or you know... as we know, the things we, you, can see in one week, you know. You can see a child being hit, you can see a drunk person terror-–You know, all the horrible, horrible, the worst things you see frequently.' (Rose). They described how the frequency of these events, overtime, to

people they knew and cared for, impacted them emotionally. ‘When you see things like that enough, it starts really, it's almost like PSTD, you know. I would equate it to that, if you did it long term, without any breaks or without putting in any measures in place to desensitize yourself’ (Carl); ‘It's still awfully upsetting every time and it's more upsetting because I've seen people that I know … I think I'm always looking, I don't pass by anyone without checking to see who they are, if they're someone I know that's in trouble.’ (Lisa)

3.4.2 Exhaustion from travel and physical demands

Participants described how ‘just the long hours and the travel…takes its toll on you’ (Carl). Participants had to travel frequently, driving anywhere between three (Violet) to seven (Carl), up to eighteen hours (Jacki) to reach communities, stay for a few days or a week, and drive back. They’d sometimes sleep on floors in lounge rooms (Violet). They might work ‘on country’ (Rose), managing dogs, heat, flies. ‘It’s really physical and hard work, you know packing up a Troopie and driving out.’ (Rose). ‘It was lovely up there. I adored it, but it was very exhausting, and it was just the logistics of it.’ (Violet).

4.4.3 Living far from home and family

Another challenge that impacted participants was living in remote locations away from family, and this was a contributing factor for many participants who left remote work. ‘Not having family around is the biggest one’ (Jacki). ‘Partly I left because I needed to be near family…’ (Rose) ‘I also found that WA was a bit far from home for me, like remote WA I had to get two flights back home. It's insanely expensive.” (Lisa)

4.4.4 Difficulty finding appropriate emotional support

Professionals living in remote locations have limited access to support services. ‘You could speak to a counsellor or psychologist, but like for me and I'm sure a lot of people, it doesn't feel particularly nice to think that the person your speaking to can often be a colleague or like someone you, even if you're not working closely with, they're someone that you see in the corridors or at work meetings and stuff and then in these small towns, there's really not much else.’ (Eve)

4.5 What helped professionals develop their antiracist and decolonised professional practice?

This research focussed on mapping out the emotional aspects of antiracist and decolonised professional practice. While emotion is understood as an element to be worked with by antiracist educators in universities, there has been very little research into its impact in workplaces where professionals are being asked to engage with antiracism. Concerned with the initial step of defining the problem, this research did not explore the support professionals require to successfully navigate through the emotional landmines of this work. Over the course of the interviews, however, some supportive factors for participants were consistently reported. These included Aboriginal and Torres Strait Islander mentors, non-Indigenous mentors, reflective practice, maintaining a learning attitude, and reading and studying widely.

4.5.1 Aboriginal and Torres Strait Islander mentors

Participants identified how relationships with Aboriginal people were fundamental in helping them learn how to work with Aboriginal people. Most frequently, these mentors were identified from within the client group the professionals served.

> I've learned a lot just driving around Darwin with mothers of clients and just them teaching me more in gentle ways. So just learning about people's lives and what their, what day to day looks like for them and why people might have a right to be angry. (Tara)

> I learned almost everything of value from the work I did with the men in the prison. They told me their stories and that has actually informed the way in which I work. (Violet)

> You cannot beat having lived with Aboriginal people in a really traditional sense, to feel like you have an understanding of why they might be responding like they are. (Robin)

Aboriginal professionals were also recognised as mentors, such as members of 'Indigenous Allied Health Australia' who taught Tara that 'white people…think

culture's this thing that other people have and they don't…' and cultural awareness trainers who 'you can absolutely say, you know, if I said this to you would that feel confronting? Could I ask you this question? Almost that... What's that show? You Can't Ask That.' (Robin)

4.5.2 Non-Indigenous mentors

Participants also commented on the different, but significant value, of non-Indigenous mentors who had worked in Aboriginal communities before. As Robin put it,

> …having a colleague like you that could... You'd been where I'd been. It's the translating again. It's the translating of the experience allows you to confront what you see as frailties in yourself because you don't want to see those things. So, it allows you to confront them. And allows you to confront them and see it as a growth opportunity rather than as a criticism of yourself.

Non-Indigenous mentors could articulate and normalise the thoughts, feelings and beliefs health professionals were experiencing. This 'normalising' operates much like strategic or reconciliatory empathy (Matias & Zembylas, 2014), empathising with affect without having to agree with belief, providing a caring space that allows problematic racial views to be unpacked and looked at.

4.5.3 Reflective Practice

Participants identified how crucial it was to be aware of their own reactions, and have enough curiosity to try and unpack them and learn from them. 'Reflective practice is really important…Why is that annoying me so much? What else can I do with that? What's another way in?' (Robin); 'having to kind of stop and think how am I….How am I reacting? And how am I going to work in this?' (Erin) 'That constant practice of reassessing your own thinking.' (Robin)

4.5.5 A learning attitude

Participants identified the importance of working in this context with a learning attitude. They described how 'completely unprepared' (Olivia) they were to work in this context and how the usefulness of their knowledge and skills was

limited in this context; they adapted to this best when they responded to this with ‘curiosity’ (Rose), and ‘willingness to be there’ (Rose) on ‘a very steep learning curve’ (Olivia). “I think I'm going to help these people and then I learned that I haven't got anything much to help them and I've never experienced what they've experienced, and they helped me to understand. So, I guess that that's where my homework happened.” (Violet)

4.5.6 Reading, study and research

This learning attitude led many participants to seek out additional reading, study and research in order to understand the Aboriginal communities they worked with better. This included researching ‘the whole history and how everything has happened’ (Jacki), putting together a ‘timeline of legislation and policies’ to get ‘more of an understanding of how the history led to the contemporary Australian health outcomes’ (Olivia). Participants read beyond health literature to understand the history of the communities they worked in, including ‘fiction, but which have an historical base’ (Robin) *Why Warriors Lie Down and Die* (Robin), *Guide to East Arnhem Land,* which has got pretty detailed accounts of massacres and the history of the area’ (Tara) and ‘Stan Grant…he's amazingly articulate and can explain why Aboriginal people have a right to be so angry.’ (Tara)

Participants commented on how this learning was ‘continual’ (Robin) and ‘ongoing’ (Robin) not ‘just at the start of your job because things grow and develop and you grow and develop as a clinician and you're always continually coming across issues’ (Olivia). Tara reflected on how ‘to start with [I] was trying to learn about other people and then the conversations and the thoughts about white privilege were just thinking more about colonisation.’

This is a very brief list of things participants identified as supporting them to navigate the overwhelming emotions elicited by their work in communities impacted by colonisation and racism. Chapter 5 will explore in more depth the possible directions healthcare services, professional practice and research could move in to better respond to the emotional terrain of antiracism and decolonisation.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

Professional practice guidelines from registration bodies such as Australian Health Practitioner Regulation Agency (AHPRA), as well as all Federal, State and Territory government health services, instruct health professionals to address racism at both individual and systemic levels. The health professionals interviewed in this research were mostly unaware of these guidelines, suggesting they are not widely referenced or used in workplaces. However, their experiences at work did lead them to reflect on the ongoing impact of colonialism, as well as issues of racism and white privilege. Workplaces offered little in the way of formalised support to support antiracist professional practice. No one received antiracism training. Professional supervision did not explore the topic of racism. Professionals were not set up in mentoring relationships to learn from Aboriginal people. Some professionals interviewed received one, two or three days of 'cultural awareness training' delivered as a one-off event. Only one participant reported repeating cultural awareness training regularly over the years. Racism was occasionally mentioned in these trainings, though most focussed on local history, or cultural differences such as skin groups, family structures and totems.

Several participants reported reflective learning through group debriefing with colleagues after community visits, however these reflections centred on analysing Aboriginal culture, rather than the professional's own. Most participants privately reflected without workplace support on power, privilege, and race. They described feeling limited by the scope of their role and constraints of the health service to act on their decolonising or anti-racist impulses, and felt frustrated, helpless, and overwhelmed. It's long recognised by antiracist educators and activists that feeling powerless to change racism feeds denial, despair and inaction (Boler, 1999; Zembylas, 2018b). Its therefore crucial professionals are provided not only with support to reflect on racism, but also pathways to act on their learning.

This concluding chapter offers a summary of the emotional experience of healthcare professionals engaged in antiracist/decolonising practice, the impact of those emotions on their professional practice, and suggestions about potential

supports that could be used in the workplace to ensure professionals navigate this emotional terrain constructively, delivering antiracist and decolonised healthcare to the communities they work in. This section also examines the limitations of this research, and directions for future research.

5.2 Mapping the emotional terrain of antiracism and decolonisation

Every professional interviewed in this study identified 'overwhelming' and difficult emotions in their work in Aboriginal communities. Nine of the eleven explicitly linked these emotions to racism and white privilege, and all eleven linked them to the impact of colonisation—learning about disturbing events of the past and witnessing its ongoing impact on Aboriginal families. Evidently, grappling with racism and colonisation is an emotionally evocative part of professional practice.

Previously these emotional reactions and their impact on antiracism have only been described in the context of universities, and by antiracist activists. This research identifies for the first time that these reactions also occur in health professionals working with remote Aboriginal communities in Australia. This indicates the need for wider research to understand how these emotional reactions impact health service delivery to Aboriginal communities. It also demonstrates the need to trial and evaluate ways to support staff to constructively navigate these reactions and develop antiracist, decolonised professional practice.

Those interviewed in this research reported that the emotions caused exhaustion, poor performance, tensions with colleagues and managers, burnout, leaving remote jobs and even changing professions. Angry, defensive responses around racism caused some professionals to refrain from addressing racism in their workplace. Fear and disgust inhibited relationships with Aboriginal people, and impeded the partnerships required for learning and developing decolonised healthcare. Perfectionism and anxiety drove professionals to overwork, ineffectively trying to fix an issue or avoid the pain of 'lingering' (Yancy, 2015, p.xvii) and developing a deeper understanding. Those who endured the discomfort navigated through overwhelming emotions to effectively learn from Aboriginal people, then found themselves in conflict with managers, service

delivery models and professional bodies who were not versed in antiracism, decolonisation, or cross-cultural practice. This left professionals frustrated and despairing, stymied by their workplace to address the systemic racism they saw.

Table 5 summarises the findings from this research, drawing on findings in the literature review as well participant responses (included in larger format in Appendices 1). For conciseness, literature has been summarised and only direct quotes referenced in the table. Source material can be found in the full literature review in Chapter 2. The table maps the emotions commonly experienced by white Australian's engaged in antiracism and decolonisation working in Australian Aboriginal communities; the risk and impact of those emotional reactions; what constructive response to those feelings might look like; and potential supports workplaces could implement to ensure professionals move through these reactions constructively and develop antiracist, decolonised professional practice. Supports are discussed in more detail in Section 4.3.

Table 5 Mapping the emotional terrain of antiracism and decolonisation

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
Denial	'I don't see race.' Whiteness as unraced White as the invisible norm Ethnocentric professional practice	Perpetuating racism, colonisation and white supremacy. Not engaging in antiracist/decolonised professional practice.	Recognise white as race and cultured Recognise racism (individual, systemic, conscious and unconscious) Tolerate discomfort	Coregulation with mentors / supportive community. Reconciliatory empathy Neurophysiological techniques to increase

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
	‘Twilight zone’: maintaining only a vague awareness of race/colonisation. Feeling powerless, helplessness, overwhelmed about racism and colonisation.	Delivering ethnocentric, culturally unsafe or racist healthcare.	and overwhelm Find agency to make a difference, to help combat feelings of helplessness. Value connection available with Aboriginal people once one is willing to confront colonisation/racism.	racial resilience Frame racism as systemic Provide clear pathways for professionals to action antiracism.
Anger	Bristling, defensive Feeling attacked Feeling accused of being a bad person. Tears Raised voices ‘How can you call me a racist?’	Derails discussions/examination of racism. Orients the examination of racism to the individual rather than focussing	Take time out to calm reaction See these flashpoints as learning opportunities Engage in reflective practice	Coregulation with mentors / supportive community. Reconciliatory empathy Neurophysiological techniques to increase

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
	Moves to innocence: 'I'm a good person because…' 'I'm trying,' 'I'm not a racist because…' Discrediting the person confronting	on systemic racism. Makes people reluctant critique/dismantle racism when they see it because of the reaction they'll get.		racial resilience. Framing racism as systemic Reading and research
Guilt, shame & social responsibility	Overwhelm Tears Exhaustion Self-loathing Self-flagellating Guilt about being racist Guilt about one's home/job/wealth/ privilege	Exhaustion, despair and inaction Poor performance at work Orients the examination of racism to the individual rather than addressing systemic racism.	Use guilt to fuel unlearning of privilege and making reparations Focus on accountability, responsibility and social action. Value moral congruency and satisfaction arising from	Coregulation with mentors / supportive community. Neurophysiological techniques to increase racial resilience. Dismantling the good/bad racist/not racist binary. 'No such thing as racial

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
			acting in line with one's values.	innocence, only racial responsibility or irresponsibility'.[1]
Fear	Fear of Aboriginal people based on images/stories Sweaty palms Racing heart Reduced eye contact Frozen smiles Overcompensating Seeking distance from Aboriginal people Seeking proximity to white people	Keeping distance from Aboriginal people compromising relationships and cross-cultural learning. Implicit bias colouring professional decision making. Implicit bias perceiving danger or risk when none exists, escalating conflict / restrictive practices	Recognise fear response and utilise it as a warning sign that implicit bias has activated. Engage in reflective learning to examine and understand fear response. Integrate and dampen fear responses utilising neurophysiological techniques.	Neurophysiological techniques to tolerate fear feelings long enough to examine and integrate/dampen them. Coregulation with mentors and supportive community.

[1] Thompson, A. (1998). Not the color purple: Black feminist lessons for educational caring. *Harvard Educational Review 68*(4), 522-553.

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
		towards Aboriginal clients.		
Anxiety & perfectionism	Nervousness Fear of getting it wrong Fear of asking dumb questions Tiptoeing/on eggshells Tension/rigidity in posture Going into overdrive, overworking, excessive hours Sense of urgency Rushing to fix	Avoids complexity of issue Rushes receptive, learning stage Avoids feeling, and empathising with the pain of racism/ colonisation. Rushing ahead to fix instead of building and maintaining relationship, compromising partnerships with Indigenous people,	Slowing down and relaxing: 'this journey takes a lifetime.' Mindfulness Showing up with receptivity, listening, *dadirri.* Maintaining a learner mindset, instead of a knower or fixer mindset. Accepting there is no 'right way' and you will	Workplaces and service delivery models that prioritise and measure relationship before other outputs. Health models that that focus on community engagement rather than 'expert models'. Neurophysiological techniques to tolerate discomfort of 'lingering' with

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
			make mistakes. Focus on relationship.	ambiguity and unknowns.
Destabilising / loss of belonging	Culture shock Disorientation Feeling stupid/ useless/unprepared. Loss of confidence and self-worth Feeling like there's nothing firm to stand on Withdrawing strongly into 'doing what you know' (ethnocentric practice) Feeling isolated and alone Feeling anger or a loss of faith in own culture	Decreased competence at work Decreased satisfaction at work Not learning and adapting healthcare practice to cross-cultural context. Misunderstandings about one's practice from employers or professional bodies due to difference in context, impacting career progression.	Accept plurality: no person, no culture, is wholly good or wholly bad. Develop a new sense of belonging to a wider world Develop and enjoy increased connection with Aboriginal people. Value learning from Aboriginal culture.	Professional supervision that understands the context and is literate in cross-cultural practice, antiracism, decolonisation, and the emotional terrain of this work. Clear pathways within workplaces for antiracist critique and change

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
	Increased tension with people from own culture (family, friends, managers, professional bodies).	Reverse culture-shock and feelings of alienation when visiting home community. Increased staff burnout.	Increased sense of moral congruency, connected to difficult reality of colonising Australia. Widen tolerance for ambiguity, uncertainty and not knowing.	Protection for professionals who critique racism within their workplace.
Disgust and care	Recoiling or seeking distance from Aboriginal people 'Them' and 'us' language Language evoking contamination risks (dirty, diseased)	Not developing respectful, reciprocal relationships with Aboriginal people. Inhibiting learning from Aboriginal people	Engage in learning the detail and nuance of cultural, contextual and individual difference. Dismantle power differentials.	Restructure health service delivery: Developing and maintaining relationships made the primary, central, principle.

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
	Care with a power imbalance Care with an expectation of attitudes Sentimental, exoticized or fantasy views of Aboriginal people. Superficially engaging with difference Failing to address oppression	Poor quality partnerships with Aboriginal people and organisations. Unable to meaningfully learn about difference and alter practice for context. Failure to support Aboriginal clients with central concerns in their lives.	Develop reciprocal relationships with Aboriginal people characterised by respect, receptivity, vulnerability, and intimacy.	Deliver health services outside hospital and clinic settings Offer flexible scope of practice / key worker model. Manage caseloads to allow time for relationships to be formed.

5.3 Supporting health professionals navigate emotions and develop antiracist, decolonised professional practice

Focussed as it was on establishing whether these emotions impacted health professionals in remote Aboriginal communities, this research did not set out identify solutions for these challenges. However, both from literature and participant experience, some potentially helpful supports for professionals became evident. These are briefly summarised here for the purpose of guiding future professional practice and future research.

5.3.1 Mentorship over time

Participants consistently identified mentor figures who helped them explore their emotional reactions and confront the privilege and racism present in their response. Helpful mentors meet participant's emotional reactions non-judgementally; they ask curious and compassionate questions and gently co-investigate with professionals where big feelings come from, and what racial beliefs are tied up with them.

Non-Aboriginal mentors can offer their own experiences with similar thoughts or feelings, decreasing the shame and isolation professionals experience. This shared experience contextualises these reactions as a personal expression of a systemic problem, rather than an individual moral failing one should be blamed for, a helpful framing of racism to constructively manage shame (Thompson, 1998). Mentors can employ what Matias and Zembylas (2014) call 'reconciliatory empathy'; a willingness to empathise with views one finds offensive and difficult in order to be emotionally present and supportive as an individual explores and understands their troubled racial knowledge. This approach is congruent with developmental understandings of emotion, that first one must experience 'coregulation' of unfamiliar emotions with another calm person, in order to learn that the emotion is safe and can be navigated before moving to independently managing those feelings (Ogden, 2021).

Indigenous mentors were also important to participants. Ongoing relationships overtime gives health professionals insight into how racism impacts on the lives of Aboriginal people daily. Mentoring can occur organically, as a product of witnessing racism in action whilst working with Aboriginal clients and colleagues. More formal mentoring relationships can provide professionals with a way to ask questions around racist or colonial beliefs they hold, or to check their own behaviour.

Mentoring relationships between Aboriginal and non-Aboriginal people are complex and contain within them racial and colonial dynamics that require careful reflection and negotiation (Burgess et al., 2020; Ricketts, 2021; Saad, 2020b). It is beyond the scope of this project to explore this in depth except to note that setting up mentoring relationships between Aboriginal and non-Aboriginal people in the workplace would require a detailed understanding of these issues and careful negotiation led by Aboriginal people. Importantly, mentorship needs to be available

over time, as participants described learning as ongoing, with different challenges emerging the longer they engaged with Aboriginal communities.

5.3.2 Psychobiologicaly informed strategies

As a result of psychobiological research (Menakem, 2017), it is now understood that strong emotions such as fear, anger, disgust, shame, denial and grief, involve the activation of body structures beyond the cortex, the conscious part of the brain. Through structures including the brain stem and the vagal nerve, emotion triggers responses in the body such a racing heart, sweaty palms, tightening muscles and facial expressions such as tight smiles, narrowed eyes or excessive blinking (Ogden, 2021). Physical actions like withdrawing or adopting a defensive stance can occur without a conscious choice ever being made (Ogden, 2021). As these reactions result from these deep brain structures, health professionals need approaches that work at that level; approaches that already exist in fields such as psychology and occupational therapy, and disciplines like mindfulness and *dadirri,* an Aboriginal deep listening practice (Atkinson, 2002). To constructively engage with implicit bias and emotional reactions, professionals would benefit from training to develop some core competencies:

1) Using mindfulness to identify signs and symptoms in the body that implicit bias has been activated (Ogden et al., 2021)
2) Increasing one's tolerance for discomfort by slowing down and staying present with the sensations, rather than fleeing from them or shutting those experiences down (Menakem, 2017).
3) Employing 'pendulation', a technique used in body-focussed psychotherapies, to manage overwhelm and gradually widen the window of tolerance for uncomfortable emotions. Pendulation involves feeling into uncomfortable emotions for a short moment, before diverting one's attention back to a grounding, comforting stimulus, such as a safe person, a comforting view, or a soothing visualisation. This is repeated, swinging in and out of exploring the discomfort, and returning to safety, until confidence is established that the emotion can be explored without being flooded (Ogden, 2021).

4) *Dadirri,* an Aboriginal listening practice shared widely Doctor Miriam-Rose Ungunmerr-Baumann, where one listens with silence, stillness and awareness; waiting, not responding, or even 'reflecting too much'(Atkinson, 2002). This kind of listening would assist professionals to slow down, be present with Aboriginal and Torres Strait Islanders, waiting to learn something new and connect with empathy, rather than racing to 'fix' and 'do' and avoid the discomfort of not having the answers. Professionals interviewed in this research consistently identified slowing down, being more present and mindful, and shifting into a relating, rather than fixing and doing mentality, as a critical shift in their professional practice in remote Aboriginal communities.

5.3.3 Framing racism as systemic

Both participant responses and literature highlight how racism is primarily understood by white people to be an individual issue rather than a systemic one (Trepagnier, 2010; Unzueta & Lowery, 2008). This is problematic for multiple reasons. Firstly, it increases feelings of blame and shame, what DiAngelo calls the 'good/bad' binary: bad people are racist, good people are not. When racism is viewed primarily as existing inside an individual, any identification of racism is perceived as a personal attack, and this increases the sense of threat. This in turn increases the activation of brain stem and vagal nerve responses that fundamentally function as a danger detection system (Porges, 2011). The ability to socially connect or think critically is compromised when an individual is in this heightened state (Porges, 2011), evident in the breakdown that often occurs when racism is mentioned.

Secondly, focussing on individual racism limits analysis of the systemic issues that have the biggest impact on Aboriginal lives and where change is most needed. It is essential that at university levels and in the workplace, there is an education process that widens white health professional's understanding of racism from the individual to the systemic. Internalised racism within the individual can then be contextualised as a result of growing up in racialized, white supremist society, rather than an individual failing. It provides a pathway for individuals to

navigate through shame and guilt, learning that there's 'no such thing as racial innocence, only racial responsibility or irresponsibility' (Thompson, 1998, p. 522).

5.3.4 Pathways for professionals to critique and impact systemic racism in health services

Given antiracism is written into health service strategy and policy, professionals require clear pathways within workplaces to identify racism and change practice. Particularly in large government run health services, professionals reported that when they identify racism within the workplace, they encountered defensive reactions from colleagues, misunderstanding about their professional practice from managers, and models of service delivery incompatible with the needs of their Aboriginal clients. If health services are sincere in their antiracism efforts, workplace procedures are required to support identification of discrimination; reflective learning as a team, including hearing and being guided by Aboriginal perspectives; and processes to change practice. Without pathways to implement systemic change, as individual professionals engage in antiracism and decolonisation, they become increasingly frustrated and disillusioned with their work, and as reported by participants of this research, leave their positions and even professions.

5.3.5 Relationship focussed, community engagement models of healthcare

Participants reported being limited by the medical models that still guide most health service delivery in remote Aboriginal communities. Whilst some professionals were from professions such as occupational therapy or public health and therefore aware of other approaches such as client-centred practice, family partnership models, community development, and anti-oppression, these professionals usually still had to operate within multi-disciplinary services that are shaped by the medical model. They identified limitations in this model due to how it is shaped by a Western understanding of health; because it positions health professionals as an expert who knows how to 'fix' a patient; and its limited scope of practice that does not address the central concerns of Indigenous lives such as housing, clashes with the law, and child protection services. The literature review

conducted as part of this research also highlighted the problem with caring relationships where there are power imbalances in a racially charged context, and how these power imbalances can express repressed racial disgust (Boudreau Morris, 2017; Matias & Zembylas, 2014). The medical model, with the health professional position as an expert, is therefore especially problematic in remote Aboriginal communities.

Health services in remote communities need to critically reflect on how power is held and expressed at every level of service delivery (McPhail-Bell et al., 2015). Where are services delivered, and who is most comfortable in that environment? Whose voices are heard and guide decision making of the service? Health services need clear community engagement structures such as engaging community members outside hospital and clinic environments (Trudgen, 2000), facilitating community participation and feedback processes (*Mia Mia Aboriginal community development: fostering cultural security*, 2017), and an openness to service provision looking radically different, as described by some participants in this research. Health services could design measures that evaluate the quality of relationships between professionals and their community, levels of engagement and community control of the health service, as foundational before output measures such as numbers of clients seen in the clinic or number of assessments completed.

5.4 Limitations of this research

This research only interviewed non-Aboriginal professionals and therefore reports only self-reflections on white privilege, racism, and its impact on professional practice. Perspectives of Black, Indigenous and People of Colour were drawn in from literature to provide a lens through which to analyse participant responses, however this is an incomplete remedy for not having the scope to interview Aboriginal people working with or being served by the health professionals interviewed. White people are often limited in their awareness of white privilege and racism and gaining feedback from Aboriginal people could offer significant insight into the impact of white privilege, racism, and emotional reactions on health service delivery in remote communities. That research would require considerable sensitivity to manage relationships between health services and

communities and to prevent harm to both community members offering perspectives and professionals being critiqued.

This was a study of eleven professionals and cannot be generalised. Professionals were recruited through my collegial network from working in remote Aboriginal communities, with participants I didn't know personally recruited by those I did. Participants therefore were more likely to have been exposed to guidelines and frameworks around antiracism and decolonisation through working with me, as well as more likely to have a personal interest on the topic to self-nominate participating in this research. Even still, there existed a range of familiarity with the concepts and different perspectives regarding their role and usefulness in professional practice. It's likely that in a larger sample of health professionals there would be less awareness of antiracist professional practice guidelines, and a wider range of perspectives on its place with health.

This research focussed on identifying the problems surrounding antiracism in professional health practice in remote Aboriginal communities. Specifically, it sought to understand whether emotional reactions, noted in student groups exposed to antiracism, occurred in professionals, and how this impacted health service delivery. Having established professionals do experience these reactions, it is now necessary to research how to support professionals so that these responses do not impact the quality of health service delivery and the decolonising of health care delivered to Aboriginal communities.

5.5 Future directions

This research was limited in scope to insights from only eleven non-Aboriginal professionals. To understand how emotional reactions to racism and white privilege impact health professionals and service delivery in Aboriginal communities, it would be helpful to interview professionals more widely. Most significantly, it is important that further research into this area include Aboriginal and Torres Strait Islander perspectives, both from Aboriginal and Torres Strait Islander staff working in or with health, and clients who access health services.

Further research is needed into how to support professionals constructively move through these reactions towards decolonised, antiracist practice. Over the past

two years, a number of psychologists and psychotherapists such as Resma Menakem (2017) and Pat Ogden (Ogden et al., 2021) in the United States have developed, or advocated for, antiracism workshops that incorporate psychoeducation informed by the neurobiological understanding of implicit bias and the autonomic basis of emotional reactions. A useful next step would be to trial and evaluate the impact of staff developing the core competencies of this approach (described in Section 4.3.2) Ideally, this would be coupled with long term mentoring, accurate framing of racism as a systemic issue, and pathways for professionals to initiate systemic change. These initiatives would be best developed through a participatory process with both health services and the Aboriginal community they serve, making each of these changes something to be developed over time. As Yancy (2015), Saad (2020b), Margaret (2010) and Ungunmerr-Baumann (Atkinson, 2002) all stress, it is important to 'linger' , to not rush to solutions but take time to develop full understanding.

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APPENDIX 1: MAPPING THE EMOTIONAL TERRAIN OF ANTIRACISM AND DECOLONISATION

This table summarises the findings from this research, drawing on existing literature as well participant responses. It maps the common emotions experienced by white people engaged in antiracism and decolonisation working in Australian Aboriginal communities.

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
Denial	'I don't see race.' Whiteness as unraced White as the invisible norm Ethnocentric professional practice 'Twilight zone': maintaining only a vague awareness of race/colonisation.	Perpetuating racism, colonisation and white supremacy. Not engaging in antiracist/decolonised professional practice. Delivering ethnocentric, culturally unsafe or racist healthcare.	Recognise white as race and cultured Recognise racism (individual, systemic, conscious and unconscious) Tolerate discomfort and overwhelm	Coregulation with mentors / supportive community. Reconciliatory empathy Neurophysiological techniques to increase racial resilience Frame racism as systemic

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
	Feeling powerless, helplessness, overwhelmed about racism and colonisation.		Find agency to make a difference, to help combat feelings of helplessness. Value connection available with Aboriginal people once one is willing to confront colonisation/racism.	Provide clear pathways for professionals to action antiracism.
Anger	Bristling, defensive Feeling attacked Feeling accused of being a bad person. Tears Raised voices 'How can you call me a racist?'	Derails discussions/examination of racism. Orients the examination of racism to the individual rather than focussing on systemic racism.	Take time out to calm reaction See these flashpoints as learning opportunities Engage in reflective practice	Coregulation with mentors / supportive community. Reconciliatory empathy Neurophysiological techniques to increase racial resilience.

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
	Moves to innocence: 'I'm a good person because…' 'I'm trying,' 'I'm not a racist because…' Discrediting the person confronting	Makes people reluctant critique/dismantle racism when they see it because of the reaction they'll get.		Framing racism as systemic Reading and research
Guilt, shame & social responsibility	Overwhelm Tears Exhaustion Self-loathing Self-flagellating Guilt about being racist Guilt about one's home/job/wealth/privilege	Exhaustion, despair and inaction Poor performance at work Orients the examination of racism to the individual rather than addressing systemic racism.	Use guilt to fuel unlearning of privilege and making reparations Focus on accountability, responsibility and social action. Value moral congruency and satisfaction arising from	Coregulation with mentors / supportive community. Neurophysiological techniques to increase racial resilience. Dismantling the good/bad racist/not racist binary.

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
			acting in line with one's values.	'No such thing as racial innocence, only racial responsibility or irresponsibility'.[2]
Fear	Fear of Aboriginal people based on images/stories Sweaty palms Racing heart Reduced eye contact Frozen smiles Overcompensating Seeking distance from Aboriginal people Seeking proximity to white people	Keeping distance from Aboriginal people compromising relationships and cross-cultural learning. Implicit bias colouring professional decision making. Implicit bias perceiving danger or risk when none exists, escalating conflict / restrictive	Recognise fear response and utilise it as a warning sign that implicit bias has activated. Engage in reflective learning to examine and understand fear response. Integrate and dampen fear responses utilising neurophysiological techniques.	Neurophysiological techniques to tolerate fear feelings long enough to examine and integrate/dampen them. Coregulation with mentors and supportive community.

[2] Ibid.

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
		practices towards Aboriginal clients.		
Anxiety & perfectionism	Nervousness Fear of getting it wrong Fear of asking dumb questions Tiptoeing/on eggshells Tension/rigidity in posture Going into overdrive, overworking, excessive hours Sense of urgency Rushing to fix	Avoids complexity of issue Rushes receptive, learning stage Avoids feeling, and empathising with the pain of racism/ colonisation. Rushing ahead to fix instead of building and maintaining relationship, compromising partnerships with Indigenous people,	Slowing down and relaxing: 'this journey takes a lifetime.' Mindfulness Showing up with receptivity, listening, *dadirri.* Maintaining a learner mindset, instead of a knower or fixer mindset.	Workplaces and service delivery models that prioritise and measure relationship before other outputs. Health models that that focus on community engagement rather than 'expert models'. Neurophysiological techniques to tolerate discomfort of 'lingering'

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
			Accepting there is no 'right way' and you will make mistakes. Focus on relationship.	with ambiguity and unknowns.
Destabilising / loss of belonging	Culture shock Disorientation Feeling stupid/ useless/unprepared. Loss of confidence and self-worth Feeling like there's nothing firm to stand on	Decreased competence at work Decreased satisfaction at work Not learning and adapting healthcare practice to cross-cultural context. Misunderstandings about one's practice from employers or professional bodies due to	Accept plurality: no person, no culture, is wholly good or wholly bad. Develop a new sense of belonging to a wider world Develop and enjoy increased connection with Aboriginal people.	Professional supervision that understands the context and is literate in cross-cultural practice, antiracism, decolonisation, and the emotional terrain of this work. Clear pathways within workplaces for antiracist critique and change

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
	Withdrawing strongly into 'doing what you know' (ethnocentric practice) Feeling isolated and alone Feeling anger or a loss of faith in own culture Increased tension with people from own culture (family, friends, managers, professional bodies).	difference in context, impacting career progression. Reverse culture-shock and feelings of alienation when visiting home community. Increased staff burnout.	Value learning from Aboriginal culture. Increased sense of moral congruency, connected to difficult reality of colonising Australia. Widen tolerance for ambiguity, uncertainty and not knowing.	Protection for professionals who critique racism within their workplace.
Disgust and care	Recoiling or seeking distance from Aboriginal people 'Them' and 'us' language	Not developing respectful, reciprocal relationships with Aboriginal people.	Engage in learning the detail and nuance of cultural, contextual and individual difference.	Restructure health service delivery: - Developing and maintaining relationships made

Emotion	What does it look, feel and sound like?	What is the impact or risk of this reaction?	Constructive response	Supports for professionals
	Language evoking contamination risks (dirty, diseased) Care with a power imbalance Care with an expectation of attitudes Sentimental, exoticized or fantasy views of Aboriginal people. Superficially engaging with difference Failing to address oppression	Inhibiting learning from Aboriginal people Poor quality partnerships with Aboriginal people and organisations. Unable to meaningfully learn about difference and alter practice for context. Failure to support Aboriginal clients with central concerns in their lives.	Dismantle power differentials. Develop reciprocal relationships with Aboriginal people characterised by respect, receptivity, vulnerability, and intimacy.	the primary, central, principle. - Deliver health services outside hospital and clinic settings - Offer flexible scope of practice / key worker model. - Manage caseloads to allow time for relationships to be formed.