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ORIGINAL RESEARCH

Emotional reactions to concepts of racism and white privilege in non-Aboriginal professionals working in remote Aboriginal communities

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ABSTRACT:

Introduction: This research, conducted by a non-Aboriginal, White researcher, examines how health professionals working in remote Aboriginal communities engage with antiracism as instructed by national standards, whether strong emotions are elicited while reflecting on these concepts, and how these reactions impact on antiracist professional practice.

Methods: Eleven non-Indigenous allied health professionals were interviewed in a semi-structured format. Interviews were transcribed, thematically analysed and compared to existing literature.

Results and discussion: Every participant identified overwhelming emotions that they linked to reflecting on 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 that these emotions caused overwhelm, exhaustion, tensions with colleagues and managers, and disengagement from antiracism efforts, and contributed to staff turmoil and turnover.

Conclusion: 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 in Aboriginal communities. Wider research is needed to better understand how these reactions impact on health service delivery to Aboriginal communities, and to evaluate ways of supporting staff to constructively navigate these reactions and develop antiracist, decolonised professional practice.

Keywords:

Aboriginal communities, Australia, cultural competency, organisational culture, racism, systemic racism.

FULL ARTICLE:

Introduction

The need to address racism in health services in Australia is

recognised at every level of national and state governance. Policy documents now unequivocally state that for health services to be culturally secure, health professionals must identify their individual internalised racism[1] as well as 'identify, promote and build on good practice initiatives to prevent and reduce systemic racism'[2]. This national standard is essential for improving health outcomes in Aboriginal and Torres Strait Islander communities; however, antiracism and decolonisation initiatives have always faced considerable resistance[3-6] when introduced to educational and community settings, so it should be anticipated they will face similar obstacles when introduced to workplaces.

Terminology used in practice guidelines such as 'racism', 'antiracism', 'Whiteness', 'White privilege' and 'decolonisation' rest upon decades of academic theory development and social movements and are not well understood at a practice level. 'Whiteness', the way White cultural ways are taken for granted and considered the norm, and the 'White privilege' one derives from being classified as belonging to dominant White groups are often invisible to White health professionals[7]. 'Racism' remains a 'contested concept'[8], a singular term carrying multiple meanings that not every practitioner is aware of; for example, the difference between the overt racist attitudes of an individual and systemic racism, embedded into laws, organisations and culture, which means that even well-intended individuals participate in a racist system[9].

'Decolonisation', a term emerging from Indigenous academics to refer to the unsettling of dominant narratives about colonisation and the centring of First Nations perspectives[10,11], is mentioned in professional practice guidelines, but less commonly than terms such as 'racism' and 'antiracism' that emerge from African–American writers in the US. Arguably, this is a significant omission that obscures the way racism is inextricably intertwined with colonisation in Australia[7].

One barrier to developing antiracism reported by educators and activists both in Australia and internationally, is the strong emotional reactions that White people have when confronted with the topic of racism. Commonly reported reactions include denial, anger, guilt and shame, fear, loss of belonging and disgust[9,12-16]. These reactions shut down critical reflection about racism, with White people becoming defensive, shutting down and stonewalling, collapsing into tears and self-pity or withdrawing entirely from the conversation and process of antiracist education and decolonisation[9,12,16,17].

These emotional reactions are important to consider because of their power to interrupt antiracist efforts and uphold White supremacy. It is theorised that these reactions are a result of implicit bias and intergenerational social and cultural learning[16,18,19]. The vehemence of these emotional reactions suggests they could also be an expression of intergenerational trauma among 'settler' or White families from perpetrating, witnessing or failing to prevent harm to Indigenous people[18-22]. Neurophysiology suggests these intergenerational implicit biases express as emotions, muscle tension, movement and expression, that emerge from the procedural parts of the brain without conscious thought or control[18].

This is significant because it suggests antiracist efforts need to take into account the emotional, autonomic nervous system responses rather than rely on education that only supplies 'corrective facts and evidence'[23]. If antiracism was widely recognised as an emotional process, proactive supports and strategies could be put in place to build 'racial resilience' in non-Indigenous health professionals, to move through these challenging emotions and engage productively with antiracism[16,21,24,25].

Currently, these strong emotional reactions and their impact on antiracism have been documented mostly in universities. However, as antiracism activists also observe them in the wider community, it is likely they occur in workplaces too. With antiracism now an inherent part of professional practice guidelines in health, it is necessary to resolve this gap in the research and identify how emotional reactions impact on antiracism and decolonising health service delivery in Aboriginal communities.

Methods

Participants

This research interviewed 11 allied health professionals working in remote communities in Western Australia and the Northern Territory for a range of government and non-government health services. All participants identified as 'non-Indigenous'. The research did not exclude non-Indigenous Australians of non-White backgrounds (eg Asian, African) as Australian society has an extensive history of constructing 'Whiteness' among 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[7].

Participants were purposely recruited through the researcher's professional networks established through 12 years of working in remote Aboriginal communities. Five participants had expressed strong emotional reactions to racism in prior conversations, and these participants identified six more, resulting in a sample where the phenomenon was present in 'high concentration'[26]. Self-selecting participants are more likely to have a particular interest in the topic and therefore these data should not be mistaken as representing a norm or be over-generalised to assume the prevalence of these emotional reactions. However, it does provide an initial example of a phenomenon not yet explained in research. 'Insider' or 'backyard' research is used in qualitative research and carries both risks and benefits[27]. In attempts to reduce the impact of bias, results are largely presented as direct quotes and both results and analysis underwent two rounds of member checking. The insider status of the researcher contributed to the candidness and detail of the interviews, particularly in a community of practice characterised by feelings of isolation from other professionals and the broader mainstream Australian community[28]. It also meant, at times, past interactions or conversations between participants and researcher appeared in interviews or formed part of participants' understanding of the topic prior to the interview.

Data collection

Research entailed 60–90-minute interviews by video call. Interviews were semi-structured, exploring:

- whether participants considered antiracism and decolonisation part of their professional practice
- what language participants used (eg racism, Whiteness) and what they meant by it
- whether participants experienced strong emotional responses to issues of racism, Whiteness and colonisation in their work
- how these emotional responses impact on health service delivery and professional practice.

Initial broad questions provided a form of initial 'bracketing' to suspend the researcher's prior knowledge and bias[29] and privilege participant viewpoints. More directed follow-up questions were then used to repeat back participants' answers and ask them to elaborate, clarify or try to articulate further, so the interview developed into a dialectical reflective conversation[29] and an important meaning-making process in its own right[30] as researcher and participant co-created a supportive space to unpack constructs around racism and Whiteness[25].

Interviews were audio-recorded and manually transcribed. Participants' names were removed and replaced with pseudonyms, and other identifying features were removed from the transcripts. Transcripts were sent to the participants to check for factual errors as well as to ensure nothing risked revealing their identity or location or posed a professional risk.

Data analysis

Transcripts were manually coded using NVivo v20.5.0 (Lumivero; https://lumivero.com/products/nvivo [https://lumivero.com/products/nvivo]) and thematically analysed into categories such as 'definitions', 'challenging emotions' and 'positive emotions'. Emotional categories were identified by finding 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 the literature to compare it with participant responses, examining, for example, '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?'. Observations of emotional reactions and their impact found in the literature review provided a lens through which to analyse the emotional responses reported by participants; for example, 'Does anger emerge because individuals feel personally attacked?', 'Does anger shut down discussions of racism and derail antiracism efforts?'. This process operated as a conversation, drawing the voices of 11 health professionals in remote communities into a discussion with the existing knowledge base on this topic. This is in line with a constructivist approach[27], 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. The results have similarly been presented in this article interwoven with discussion to orient the reader to review the data through decolonising and antiracist lenses.

Ethical considerations

This research relied on interviews and is therefore limited by the self-awareness of the professionals 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[31,32]. 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 give a more complete understanding of the impact White health professionals' emotional reactions have on racism within health service delivery. These important elements were beyond the scope of this research conducted by a solo White master's student researcher.

There is a risk that this research once again centres and privileges White perspectives over Aboriginal ones. Advice was sought from Aboriginal academics about this issue, and the following decisions were made. Practically, including both Aboriginal and non-Aboriginal perspectives was beyond the scope of a master's-level research project. Ethically, as a non-Aboriginal researcher, I was focused on understanding non-Aboriginal perspectives in response 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 a White peoples' construct, upheld by the White people who benefit from it. As a White, non-Aboriginal health professional and researcher, I have a social and professional responsibility[25] to understand and deconstruct Whiteness in health services and work towards decolonised professional practice.

Ethics approval

Research design underwent ethics assessment and approval with USQ HREC (H19REA259) in 2019, and with NT Health (20203832) in 2020.

Results and discussion

Antiracist professional practice

Five participants were comfortable using the terms 'racism' and 'White privilege' and thought them essential in understanding their professional practice in Aboriginal communities. Two participants had never really contemplated the terms in relation to their work before the research project. Four participants had considered the terms in depth but were undecided about their usefulness.

Those who had not considered the terms cited their reasons as there being 'more focus on the Aboriginal culture rather than reflecting on our own privilege and culture' (Lisa), and 'race isn't really relevant to me. Humanity's relevant, you know?' (Violet). Lisa's response reflects Whiteness, in that Aboriginal culture is the subject of study, with Whiteness positioned as an invisible norm not requiring analysis[7,33]. Violet's response fits the definition of 'colour-blind racism', minimising race and thereby inhibiting the ability to dismantle racism[29]. Her response positions her own Whiteness as not racialised[32].

The five participants comfortable using the terms believed failure to reflect on racism and White privilege increased the chances of performing damaging dynamics in the Aboriginal communities. For Erin, this was important because 'if you leave it unchecked then you might be bringing baggage or perceptions or opinions that are unhelpful'. Olivia reflected that with:

> *White privilege comes White power. 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.*

The four participants conflicted about the terms were concerned with how the words triggered defensiveness:

> *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 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. (Robin)*

A number of participants felt the term 'racism' was 'negative' (Rose) and not 'strengths-based language' (Robin, Jacki). One participant, Carl, argued the term 'White privilege wasn't applicable or inclusive of non-Aboriginal people of colour, or other groups who experienced discrimination for other reasons', a response demonstrating a lack of familiarity with intersectionality – the ways different types of oppression and power can influence an individual's life[34].

Of the terms 'White privilege', 'racism' and 'decolonisation', racism was the most used by participants, and decolonisation the least. Ten participants used the term 'racism' in reference to something performed by an individual. They reflected on the difference between 'overt' or 'conscious' racism and 'unconscious', 'subtle' or 'internalised' racism, defining it as '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). Seven participants spoke about institutional or systemic racism, identifying examples such as people not being offered interpreters (Tara), services that require English or computer literacy (Erin), and reliance on a 'Western healthcare model, which just doesn't fit' (Eve).

Nine participants reflected on Whiteness or White privilege. Their definitions varied widely from one another and from literature. Lisa defined White privilege as the privilege of not having to live 'so tied down by [Aboriginal] values'. Carl and Jacki defined it as the privilege of not experiencing the same social barriers as Aboriginal people. Eve, Olivia and Lisa defined it with 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) such as being brought up in 'majority culture' (Eve, Olivia, Lisa). The range of definitions and their lack of usage by some participants suggests that Whiteness and White privilege are inconsistently understood among the health professionals interviewed.

No participants volunteered the word 'decolonisation'. This is congruent with the health professional practice frameworks that also rarely use the term. Eve did reference living on 'stolen' land and 'paying the rent', concepts central to decolonisation[31] 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. All 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). However, these reflections stop short of the decolonisation perspective that colonisation remains an ongoing project[10], with colonial mentality imposing on Aboriginal sovereignty and control[35].

Impact of emotions

All participants described strong emotions in their work with Aboriginal communities. They described feeling 'a lot more emotion than I think I ever have in my life' (Eve); 'I honestly can't articulate some of it well, because I just recall being so overwhelmed and emotional' (Joanna). Eight participants used the term 'overwhelming' to describe the intensity of their emotions. Nine of the 11 participants explicitly linked their own, or colleagues', emotional reactions to 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 ... This extreme guilt that I ... was ... racist. (Joanna)*

For many participants, it was noticing their emotional reactions that alerted them to their internalised racism. Participants identified times when emotions like denial, anger and guilt 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' (Robin), and that 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 the feelings contributed to 'high turnover' (Rose) 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:

> *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)*

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. While other stressors such as 'long hours and the travel' (Carl) and 'frequently seeing the worst things, like I've seen someone hanging from a rope from a tree' (Rose), contribute to staff stress, participants identified the emotional component of antiracism as:

> *... 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)*

Denial

Denial is identified by Kendi as the 'heartbeat of racism'[14], systemically woven into White colonial society in order to justify the subjugation of a racialised other[36]. It's widely believed that White people are schooled not to see race, and that this denial inhibits the examination and dismantling of racial inequality[33]. This systemic 'colour-blind' 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).

Boler[13] describes denial 'as neither knowing nor ignorance', rather a 'twilight zone' buffeting us from our feelings of overwhelm, helplessness and lack of agency to change things. A number of participants described epiphany moments where, as denial lifted, they saw their internalised racism and immediately felt 'overwhelming' emotion:

> *For the first time in my life this is actually me being a minority and it was something I had never experienced before. That was a moment when all the reflections started coming: 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 and guilty. (Joanna)*

Seven participants described the process of confronting their own privilege and position as White Australians as 'overwhelming'. Other terms used included 'powerless' (Lisa, Tara), 'helplessness' (Lisa, Carl, Erin, Tara), 'inadequate' (Olivia), 'uselessness' (Tara), and five participants reported 'lots of tears'. 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 'focusing 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).

Anger

Six participants described their own angry reactions, or those of other White people when confronted about racism. They described feeling as if 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[31]: '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). Participants described how feeling 'confronted' had caused them to 'walk away' (Robin) from discussions about racism. They also described how defensive reactions of colleagues had deterred them from having conversations about racism:

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

These responses are congruent with descriptions in literature of angry reactions from White people derailing antiracism work[37], diverting focus from systemic racism towards individual outrage[9], and leading White people to withdraw physically or emotionally from discussions of racism[12].

Guilt, shame and responsibility

Six participants discussed guilt in their interviews. 'There's definitely guilt associated with this work' (Rose); 'guilt was a huge a one, a massive one [when] reflecting on White privilege, reflecting on racism' (Joanna). Participants felt 'guilty, purely for the fact that after being out there for four days I can come home to a really comfortable house' (Lisa) and 'guilt about being racist' (Joanna).

Participants described guilt as 'such a self-defeating emotion because you need to be able to forgive yourself …' (Rose), and guilt leads 'very quickly to tears and exhaustion' (Joanna), aligning with Spanierman and Cabrera's observation that self-focused feelings of guilt can be unproductive if an individual does not move from that self-flagellating position[38].

As Zembylas[25] identified, a feeling of social responsibility instead of guilt filled participants with a sense of meaning and satisfaction in their work:

> *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. (Jacki)*

This sense of responsibility, rooted as it is in understanding colonisation and privilege, contrasts with 'White saviour' motivations to help the 'poor/dying race/Aborigines'[39].

Fear, anxiety and perfectionism

Four participants observed fear of Aboriginal people in themselves or others. Literature suggests that fear is taught through generations of White supremacy and colonisation[18,19] and encoded on the collective and cultural level[19,22]. Correspondingly, fear in participants was linked to 'stories you'll hear' (Lisa) and 'media depictions' (Tara, Joanna) rather than personal experiences.

Another kind of fear discussed by participants and in literature is fear about facing one's own racism[38], and perfectionism and anxiety around getting antiracism right[40]. 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 [staff] don't know enough, that they're going to do something wrong'.

Participants 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[41]and Saad[24] describe as a way White people avoid feeling the discomfort of racism. 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), 'taking on roles that aren't theirs' (Erin, Carl) and 'trying to fix' (Rose, Robin).

Many participants described a turning point, when they learnt to slow down, 'relax a little bit in a way' (Tara) and 'get 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 by Margaret[42] about allies learning to

change their position from 'knower' and 'fixer' into a receptive, learning mindset. Instead of rushing around 'fixing', participants focused 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. (Rose)*

Letting go of 'fixing' allowed participants to be more receptive to learning Aboriginal perspectives.

Though very different causes, both the fear of Aboriginal people and the anxiety driven by perfectionism decreased the efficacy of health professionals with Aboriginal clients. When fear is present in the nervous system, it inhibits one's social relating ability[18,21]. 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.

Destabilisation of identity and sense of belonging

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 previously held ideas of oneself and one's society as 'wholly good'[43], the impact of culture shock disorienting professional competency and provoking feelings of isolation[44], and the tensions created with the White community when one begins to critique racism and Whiteness[14].

Participants touched on all these aspects in their interviews. They described 'complete culture shock' (Olivia, Jacki, Tara), feeling 'stupid', 'oblivious' and 'unprepared' (Olivia) and 'completely foreign' (Jacki). They reported '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), and realising these attitudes had been taught by 'my grandparents, my mother …'. Participants found themselves questioning everything they'd ever been taught, and their own motivations and intentions, as they realised 'historically there's been so many well-intentioned people who have gone out to help but it's not been right' (Erin).

Participants experienced tension with their White community, criticising colleagues for not gaining 'informed consent' (Joanna) or not properly consulting Aboriginal clients (Olivia), and family members for holding overtly racist views (Olivia, Rose). This sparked 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 [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.*

This tumultuous transition also offered positives, in the form of an 'opened up world' (Olivia), 'outside the bubble' (Jacki), where participants found 'value' (Jacki), 'interest' (Tara) 'creativity' (Olivia), 'learning' (Rose, Tara), 'curiosity' (Tara) and 'genuine enjoyment' (Tara) from being exposed to diversity. Participants valued what they learnt 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)*

Disgust and care

Disgust is a recoil from the racial 'other', a distancing behaviour that shapes physical space and social groups into 'them' and 'us'[19]. Due to racial disgust being socially unacceptable to express[45], its unsurprising that most participants did not report experiencing it, with one exception, where Robin offered a story from her childhood of thinking an Aboriginal girl in her school smelled and pinching her under the desk.

Matias and Zembylas[45] assert the same recoiling from 'the other' and retaining of distance can instead be observed in some expressions of 'care'. Care where difference is ignored or only superficially engaged with as though learning from another culture is unimportant[46], and care that directly reproduces the colonial oppression, such as when a White health professional is positioned as 'knowing best' over an Aboriginal client who is considered deficit, and expected to be a submissive grateful receiver of care[47]. This makes 'caring relationships' a useful entry point for examining repressed feelings of disgust[11], and especially so within health care where 'caring' relationships are shaped by policies, procedures, key performance indicators and contracts.

Participants discussed how the scope of their roles, or the health service delivery model of their employing health service, prevented them from addressing the impact of racism or colonisation. 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 described how his occupational therapy service often did not address the central concerns of Aboriginal clients, such as overcrowding in poor quality housing because it is 'way out of the scope of my work, it's just too big'. Tara described feeling unable to challenge systemic racism:

> *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?*

Covering multiple communities across a large geographic area, coupled with the sheer number of people on their caseloads, inhibited 'deeper level rapport with Aboriginal people', keeping relationships 'superficial' (Olivia), and limiting ability to meaningfully grapple with difference:

> *… 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 you're 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. (Oliva)

Feeling restricted by institutional factors was more acutely felt by participants such as Tara and Carl who worked for government than those who worked for non-government organisations such as Jacki, Violet and Eve. Those who felt equipped to address oppressive power dynamics within their work highlighted the importance of flexible models of care (Eve, Violet, Jacki) like key worker models, not restricted to one's discipline (Eve); having support from management and legal teams to advocate for higher level change (Jacki) and delivering services in community and on country, focused on relationships (Jacki and Violet). The relationships with Aboriginal people described by participants working in these more flexible service delivery models were characterised by honesty, 'people were just sharing what their burden was' (Violet), 'reciprocal friendship' and 'sharing with one another' (Jacki).

Conclusion

This research was limited to only 11 self-selecting professionals; however, it provides an initial descriptive example of how strong emotions occur when non-Indigenous health professionals reflect on concepts of race, privilege and colonisation. It focused on mapping a problem not yet described in the literature as an initial step.

This research omitted the perspectives of the Aboriginal communities these health professionals worked for, as well as their Aboriginal colleagues, drastically limiting its ability to illuminate the true impact of racism in health services. Future research needs to foreground a more critical perspective, driven by First Nations Peoples, linking the emotional reactions of non-Aboriginal professionals to the racism in health care experienced by First Nations communities[32,48].

Future research could also trial and evaluate supports for antiracist professional practice at both the individual and organisational level. Although beyond the scope of this research, workplace supports identified by participants and the literature review included:

- ongoing antiracism/decolonisation mentoring by both Indigenous and non-Indigenous mentors
- techniques to notice physiological signs of unconscious bias being activated[18] and methods to regulate through intense emotional reactions[21]
- at systemic levels, examining models of service delivery to ensure they do not reproduce colonial power dynamics, that staff can build reciprocal, learning relationships with the Aboriginal communities they work for, and that pathways exist for staff to action antiracism without negative repercussions.

Currently, there is a gap between the aspirational antiracism standards set out by registration bodies such as the Australian Health Practitioner Regulation Agency, as well as all federal, state and territory government health services, and their implementation at the service provision level. Terminology such as 'racism', 'White privilege' and 'decolonisation' is not widely understood and evokes emotional reactions that derail critical reasoning and reflective practice. In order for antiracism and decolonisation to be effectively achieved in health professionals and services, the neurophysiology of implicit bias needs to be considered, addressing the unconscious ways racism and White supremacy is expressed through emotions, muscle tension, movement and expression[18,19]. If antiracism and decolonisation were more widely understood as an emotional process, workplaces could plan to support professionals to move through this constructively.

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