Chapter 3 from ABORIGINAL WORKERS AND MANAGERS, HISTORY, EMOTIONAL AND COMMUNITY LABOUR AND OCCUPATIONAL HEALTH AND SAFETY IN SOUTH AUSTRALIA (2003) Claire Williams, Bill Thorpe with Carolyn Chapman, Seaview Press: Adelaide, further details at end of chapter.

Aboriginal Health Workers, Emotional Labour, and Obligatory Community Labour

> The health encompasses all in the Aboriginal life.
> I give all of myself. (Aboriginal woman, health worker, Adelaide)
>
> Injuring yourself at work (brickies' labourer) was a hazard, bricks falling on you. Here it's abuse from the community and lack of sleep from being overworked.
> (Aboriginal man, manager in the health area, Adelaide)

Introduction

The present chapter is concerned specifically with South Australian Aboriginal primary health care workers who can be health workers in communities, liaison workers in hospitals, members of health teams in health centres, and those dealing with Aboriginal people facing alcohol and substance misuse issues. Of the total sample of 133, 29 were primary health care workers (22%) and, in addition, there were 5 Aboriginal managers and team leaders who worked closely with them, and 2 project officers in the sobriety area. Of the 29 health workers, 13 (43%) were men and 16 (55%) were women.

Various commentators had suggested that Aboriginal Health Workers (AHWs) were an 'at risk' group in OHS terms. For example Trompf (1995) had provided examples where they could be placed in situations of immense strain. They could relate to, and be responsible for, all Aboriginal people. They could be required to do what was mental health work but it was difficult for them to look after themselves as workers. Aboriginal health workers themselves and those working with them have characterised the occupation in terms of high levels of burnout, absenteeism, chronic illnesses associated with stress, and early exits from their careers (Flick, 1995; Winsor, 2001). Winsor, an Indigenous patient support officer, points out that AHWs are 'caught in a vice', devalued by other health care professionals, and their own communities, and she goes as far as to

describe this experience as constituting 'horizontal violence', that is, a type of bullying which includes racial prejudice.

Emotional labour, burnout, and obligatory community labour

Two of the driving forces for this study were firstly to include Aboriginal people as workers in the Sociology of Work in Australia. They tend not to be regarded as 'workers' and are usually excluded from the main accounts of work. The study aims to rectify this omission. Secondly, after a lifetime of studying flight attendants, the author became something of an expert on a concept called 'emotional labour' which was developed in a book on flight attendants called *The Managed Heart* (Hochschild, 1983). Emotional labour, which will be discussed in more detail below, is about the use of one's own emotions as a central part of doing one's job. The author through observations during serious personal illness, followed by further study noticed that many physicians had the ability to avoid doing emotional labour, and took the opportunity to do so. She then began to have concerns about Aboriginal liaison workers who she surmised could be doing the most difficult emotional labour of all, and yet might not be in a position to protect themselves. She then decided to try to use the 'emotional labour' academic literature to see if there was a way of speaking about this. There is a real shortage of ways of speaking about stress-related debilitating states, because most of the concepts have become stigmatised and linked to psychiatric labels. Secondly stress research in Psychology has a history of being developed outside any social and political frameworks such as occupational health and safety (Newton, 1995; Peterson, 1999). She devised the strategy of trying to measure emotional exhaustion but in an occupational health and safety context.

'Emotional labour' is a concept Hochschild created in relation to service workers, namely flight attendants and debt collectors, to name the emotion-based skills involved in many modern occupations, to handle customers and clients (Hochschild, 1983). Emotional labour refers to the way certain jobs require employees to use, but also control, their own emotions to deal with their clients. Along with other sociologists of emotion, Hochschild broke with the out-dated view of emotions derived from Ancient Rome, which stigmatised them as diseases of the mind (Averill, 1996). Instead she was concerned with the strain employees might experience in using and managing their emotions to do their job as part of providing services. More generally, and since Hochschild, the emotional labour literature has been mainly concerned with the short-scripted interaction of workers such as flight attendants (Macdonald & Sirianni, 1996). Yet physicians in the same health field as health workers have been trained to keep interactions brief and emotionally neutral (Morris & Feldman, 1996: 986-1010). However, unlike doctors and police who can use their autonomy and authority to minimise the duration and intensity of emotional labour, Indigenous liaison and health workers are there precisely to provide longer, more intense and supportive relations.

Because of the 'lower life expectancy and higher mortality and morbidity… relative to their non-Indigenous counterparts' (Cunningham, Sibthorpe & Anderson, 1997: 1), grief is a common emotion among Aboriginal people. The complexity of the emotional labour required in this context is captured below where the Aboriginal health worker cannot insulate himself from grief by using emotional neutrality. The quotation illustrates core aspects of the job, making sure cultural protocols are observed and cultural sensitivity is exercised in other health care workers and professionals in health and dying situations. This Aboriginal health worker experiences not only the demands of the emotional labour linked to cultural values in the Aboriginal community, but also is aware that his job involves complex professional skills:

> There are times when you are run off your feet and you think: 'Man, this is hard work!' There was an incident that happened a couple of weeks ago where I work at the _____ hospital at 11 pm that night in a morgue because I had to make sure things were culturally appropriate for a traditional family, ringing up the coroner at 5 am to get them to meet you there at 6.00 for the family to go back to Alice Springs for Sorry Business. We had to take a lock of hair and things like that. Just sort of advocating with the nursing staff right up until the viewing of the body and arranging all that part of it. But an Aboriginal Health Worker, that's the sort of stuff, at the end of the day you come back and think where's the grieving procedure? It's not there because even to come back to work the next day is pretty hard for the workers. (Aboriginal man, health worker, Adelaide)

Ashforth and Humphrey were among researchers who began to apply Hochschild's concept beyond service work to 'human services'. While Hochschild had been more concerned with the stress involved when employees engaged in surface and deep acting to produce displays of emotion they did not actually feel, Ashforth and Humphrey added a third way of doing emotional labour, namely 'identification'. In many instances the employee is not 'acting' when they deploy their own emotions to do their job. Instead they genuinely feel the emotions they are required to display. However Ashforth and Humphrey warned that in human service work this involved the possibility of 'burnout' in situations where the emotional labour was consistent with an important and valued social and personal identity. The individual might risk becoming emotionally exhausted from providing care and support to needy people. For example, it had been observed that exhausted employees are unable to give any more of themselves ((Ashforth & Humphrey, 1993: 104-5).

These ideas are insightful but as a sociologist I was more concerned to relocate them within broader institutional and OHS contexts. Notwithstanding their contributions, Ashforth and Humphrey adopt an individualised approach where employees are regarded as personally weak for identifying too much with their work roles. The author had similar reservations with the 'blame the victim' assumptions present in the Maslach Burnout Inventory -- a potentially useful

measure of emotional exhaustion developed in Psychology, including a depersonalisation scale and feelings of reduced personal accomplishment among Human Service professionals. While she drew on the emotional exhaustion part of the scale, she has been at pains to use it in a way that does not import this tendency to stigmatise employees who show signs of burnout as 'failed' human service workers. Rather she has emphasised the structural and OHS contexts that may have produced what are in fact social and occupational hazards.

While a case can be made to for the emotional exhaustion part of the Burnout scale, at the very least it has to be modified culturally and ideologically for Aboriginal Health Workers. [1] The pilot study made it clear that they have a passionate and unshakeable commitment to improving the health and well-being of their communities. They are postcolonial workers who are acutely aware of the damage wrought to Indigenous health from the colonial past and present -- hence the designation 'postcolonial' here (Ashcroft, Griffiths & Tiffin, 1998). Their commitment to the social movement for the advancement of the rights of Indigenous Australians, including the right to good health, acts as an ideological boundary within which they not only interpret, but also experience, their emotions within this occupation. Indifference to Aboriginal people's social subordination and poor health is therefore unthinkable for them.

According to the anthropology and sociology of emotions (Rosaldo, 1984; Scheff, 1996) the values held by these social actors, (including Indigenous workers), play a decisive part in forming the emotions they feel. Indeed culture and history at the very least can be looked upon as volume adjustments which permit the expression of certain emotions (Lutz & White, 1986). Historically, in western thought, emotion and reason have been falsely separated and regarded as opposites. It is now recognised that reason and rationality contain emotions and that emotions have a rational aspect. Indeed emotion is essential to reason because it shifts the balance between competing motivations (Planalp, 1999: 37).

The preceding discussion has described some relevant ideas on emotional labour and burnout. However a new concept of 'obligatory community labour', emerged out of an engagement with the concept of emotional labour to relate to the Aboriginal situations that are detailed in the rest of this article. This came about initially through discussion with an Indigenous interviewer. He described the sense of duty that comes into play when anyone is identified as 'Aboriginal', or as being part of the 'Aboriginal community'. These profound responsibilities are not left behind when someone is employed as a liaison or health worker. There is an obligation to look after friends and family, some of whom for example

[1] Moreover Dutch researchers have found only the emotional exhaustion part of the burnout inventory really effective. They recommend leaving out the depersonalisation and personal accomplishment aspects because in their view they are measuring very different aspects, quite independent of emotional exhaustion. (Enzmann, Schaufeli, Janssen, and Rozeman, 1989)

are four times removed from other relatives. In other words, 'the extended family and kinship obligations continue' (Hooper, 1999: 42). As two Aboriginal health workers in this study from the far west put it, this responsibility is grounded on core Aboriginal traditions and values about 'closeness, caring and sharing' and 'mutual respect'. It applies with special significance at Aboriginal funerals where, 'no matter whether the deceased was a close relative or community acquaintance, attendance is unashamedly commanded' (Huggins & Huggins, 1994). At one level, individuals jeopardise their identity if they do not do this or questions will be raised about Aboriginality. At another level, while the term 'labour' in both 'obligatory community labour' and 'emotional labour' may overemphasise non-voluntary aspects which the people themselves often do not regard as 'work', it is retained explicitly here to make visible the energy, effort and emotional stamina involved in *Aboriginal* liaison and voluntary community work. However, before we consider the stress/emotional exhaustion aspects of the primary health care worker job, it should be noted that Aboriginal primary health care workers and their managers come to health work often carrying chronic injuries/illnesses from hard working lives.

Occupational Health and Safety Profile

This South Australian study reflects the profile of injuries/illnesses and hazards found for Aboriginal workers in the Mayhew *et.al.* Queensland study. The SA health workers had work histories in hard manual labour linked to casual and insecure work. Mayhew *et.al.* (1996: 80) clarify this as 'labouring and related work' and the main injuries were musculo-skeletal. Here too 46% of men (6) and 38% of women (6) were carrying chronic injuries, particularly back injuries, compared to 59% for all men and 50% of all women in the study.

These work histories reveal inferior working conditions compared with those of non-Aboriginal workers and a greater vulnerability to occupational injury/illness. Individuals described doing highly dangerous work, for example under casual employment mooring ships for 10 years with the ever-present danger of cables snapping. Both men and women gave accounts of manual handling, other injuries and hazards: 'back injury from labouring'; 'a bad back in a recycling bottle depot -- I tore my disk three times from lifting'; 'lifting Coca-Cola crates as a storeman-driver'; 'being cut in the meat works'; exposure to lead in a battery factory; 'being sprayed in a vineyard'; 'exposed to chemicals in the stores'. Some women came with a history of exposure to the risks in health and caring work. This included being subjected to infectious diseases (such as HIV) handling blood with inadequate gloves, and being subjected to violence. Others had a history of lifting elderly and disabled Aboriginal people in Aboriginal community projects where there was no OHS cover of any kind. A project officer in drugs and alcohol had been a miner for 3 years, was nearly killed and sustained a back injury. During his 18 years as an ambulance officer he further injured his back from lifting patients in awkward positions. A woman manager

had industrial deafness which she attributed to noisy machinery in previous employment for Australia Post.

Among the primary health care workers, six individuals (26%) had a work related illness/injury in the last 12 months prior to the interviews with no difference between men and women. Moreover, the injuries are likely to be underestimated. Aboriginal health workers have less understanding of OHS than their counterparts (liaison officers) in other spheres such as education. These work-related injuries and illnesses over the last 12 months included injuries such as a hurt elbow and shin from tripping. Mostly AHWs blamed their symptoms on stress: 'bronchitis – get busy and get run down'; 'on medication for depression'; 'had a stroke last year, I thought I had the 'flu … I was wondering why I was starting to lose my teeth in the last 12 months. It was stress through my gums'; 'neck injury through stress'. In addition, an Aboriginal health manager said: 'My diabetes is work related because if you are stressed out your sugar levels jump'. Individuals talked a great deal about the hazards of coping with aggressive clients: 'putting up with volatile situations in the community'; but they encapsulated this as a hazard and tended not to take the next step of relating it specifically to illness and injury. This is not surprising given the lack of non-stigmatising, non-psychiatric OHS categories available to describe emotion-linked debilitating states. Furthermore, poorer general health amongst the Aboriginal population serves to obscure the part occupational hazards play in overall health. Significantly five (42%) men and seven (47%) women South Australian Aboriginal primary health care workers, like 45% of the sample, carried to their employment a doctor's letter to support a health problem.

The pleasure and pain of liaison health work: exhausted or not?

In the face of the higher mortality and morbidity rates and admission to hospitals more than twice that of non-Indigenous people (*National Health Survey: Aboriginal and Torres Strait Islanders*,1999: 8) liaison health workers play an important role in advocating for Aboriginal people. They are today's cultural brokers between Aboriginal communities and western medicine (Dollard et al, 1999; Willis, 1998: 74-76). As emphasised above, most seek this work or remain in it because of a positive passion to help Aboriginal people to survive, to keep 'Aboriginal culture alive in every sense' (Nungas access to health, 1989: 38). These aspects are captured in these statements:

> I help my people and that sort of stuff. It's a frightening thing coming to a hospital and they didn't know what the procedures are. At least they have a face (Aboriginal Liaison Officer) here to assist. (Aboriginal man, liaison officer, Adelaide)

There was a commonly expressed desire to give back to the Aboriginal community in some way:

> I thoroughly enjoy my job. Being part of changes in the community. Hoping for changes for the better. I just enjoy giving back. I've had an education and I want to give it back to my community. (Aboriginal woman, family support worker in Aboriginal health, Adelaide)
>
> Working with my own mob. (Traditional man, health worker in remote community)
>
> Aboriginal women support groups are deadly ('deadly' is Aboriginal for 'really good' or 'magical'). We do family well-being which empowers women. (Aboriginal woman, Aboriginal women's health worker, Adelaide)

This strong impetus toward working with other Aboriginal people and being part of the social movement for better Aboriginal health is part of the genuine satisfaction and pleasure derived from this work. A resounding 83% (24 people) never identify with the statement that 'working with people directly puts too much stress on me'. Similarly, 68% (19 people) answered that working with people all day 'is never really a strain'. Furthermore, very few of these AHWs believed that they were 'at the end of their rope'.

Nevertheless on the remaining part of the emotional exhaustion scale, women in particular did show signs of depletion and exhaustion. As is usual practice, feeling exhausted on a weekly or daily basis is taken as a sign of a high degree of being emotionally over-extended and exhausted by one's work, compared to feeling this way rather than just occasionally during the month, which is regarded as an average degree of being emotionally over-extended and exhausted. [2] Aboriginal managers were the most emotionally drained/exhausted in this study, are, followed by health workers (who were more tired than their counterparts in education). A majority, (54% of men (7) and 63% of women (10) felt emotionally drained once a week or every day, and this finding was significant for women at the 0.05 level. (See Table 1) This is likely to result from the intense levels of contact with clients which occurs in some settings. Some of these workers and managers are responsible for 6,000 people:

> It can be very stressful dealing with lots of clients all at once. I've got to go and see them all. When there is a mass of people and you can't help everyone and the demanding ones, when you can't do things quickly enough for them when there are so many others. (Aboriginal woman health care worker in rural health centre)

An Aboriginal woman, manager in a rural area said:

[2] Those interviewed were not sensitised to the general issues of burnout during interviewing. (Maslach, Jackson, and Leiter,. 1996: 5.)

> A few times a week (feels emotionally drained). I've got depression problems. I'm dealing with all our (Aboriginal) problems.

At least once a week, 63% of women (10) but only 17% of men (2) felt 'used up' at the end of the workday and similar numbers of men and women 45% (13 people) felt fatigued when they got up in the morning and had to face another day on the job at least once a week. Thus a sizeable group, more women than men felt very tired more or less continually. High scores across these questions is a clear sign of distress. Every week 28% (8 people) every week felt that they were working too hard on their job and a similar number felt this a few times a month; 24% (7 people) feel burnt out daily or weekly, while 28% (8 people) felt it a few times a month. The causes of this are taken up in the next sections which consider the inadequate boundaries surrounding the job, verbal abuse, and the everyday social hazards of racism.

'Job bigger than mainstream job'

The sense that the work of the AHW has too few boundaries arises not only from a lack of understanding by non-Aboriginal mainstream professionals and human service workers that they work with, but also from Aboriginal communities and client groups. The non-Aboriginal human service workers often had an inadequate grasp of the liaison or health worker function and this raises the levels of pressure. *Every* problem concerning Aboriginal clients or patients was often 'handballed' to the liaison or health workers and these patients simply avoided. This results in mainstream workers failing to engage with the necessary learning to develop cultural awareness in regarding Aboriginal clients and patients. Consequently they lost crucial opportunities to learn to deal more effectively with individuals from these groups in the future. The inappropriate demands made on liaison health workers could be intrusive and prevent the liaison health workers doing their core task:

> We've got the hospital just here, as soon as they think they (patients) are Aboriginal it comes to us and they might need a psychiatrist, a social worker, a nurse and it will come straight through here. I just ring them up and say, 'Haven't you got the same directory?' They can easily do referrals as well as Aboriginal Health. Too much passing the buck. (Aboriginal woman, manager, rural health facility)

However, the demands are more onerous than this and can be linked to the racism of the non-Aboriginal mainstream where, for example, security guards in hospitals and the police often try to get Aboriginal employees to do difficult parts of their job for them. Correctional Services wardens even expect Aboriginal Liaison Officers (ALOs) to know the whereabouts of Aboriginal prisoners and help track down those who had left while waiting to have medical treatment in hospitals.

> They think we know everything. They expect us to get the clients back. (Aboriginal man, liaison officer, hospital, Adelaide)

> The police will ring us and get us to try and do their job for them. We're not here to sort out everybody's problems. (Aboriginal woman, community health worker in a health service outside Adelaide)

'Aboriginal community' is the main constituency of these health centres, (ALO) units, and other workers -- a combination that has complicated interpersonal and political contexts with their own stresses. An Aboriginal woman team leader in an Adelaide health centre talked about the way the community was 'very close knit', everybody knows everybody; we're related to a lot of them'. The interpersonal context and the way obligatory community labour and emotional labour are so closely interwoven results in intense pressure to deliver better health outcomes in terms of community expectations. 'The pressure is on us out there to deliver and if you don't deliver in the right way the community will let you know about it'.

Furthermore, Indigenous communities themselves can place inappropriate demands on health workers because expectations were raised by the presence of Aboriginal people. Many joke about the way some members of Aboriginal communities believe that health workers would be 'at work' around the clock.

> 24 hours, 7 days a week (laughter). (Aboriginal woman in Aboriginal health team, health centre, Adelaide)

> They expect you to be there 24 hours a day, you get that sort of stuff. (Aboriginal woman health worker in health centre, Adelaide)

Pressure intensifies for health workers when living in the Aboriginal community itself and this makes it difficult to have a genuine break. This pressure is exacerbated by the poverty of Aboriginal people (who have less access to vehicles of their own and are usually seeking lifts). In addition, the effects of the long history of colonisation and racism has made the needs so acute. Sick Aboriginal people inordinately seek out AHWs from because they put greater trust and confidence in them at least in the data reported here than in the non-Aboriginal health system and professionals. Doctors can even be associated with the removal of Aboriginal children. Consequently many struggle to construct a social boundary so that they could have a social life and a well-deserved rest.

> As soon as I get home they ring you up. Sometimes it gets me down. (Aboriginal woman liaison officer at an Adelaide hospital)

One Aboriginal male heath worker in a rural area described being approached about health problems 15 to 20 times a night when he was trying to relax at the local football club. This example shows that Aboriginal people do not feel

comfortable going directly to mainstream institutional settings, but if they feel at ease they will approach an Aboriginal person they trust about their health. Obviously these liaison workers are crucial in the complex process of improving Aboriginal health but the constant nature of the job elevates the stress risk in OHS terms without adequate resources, sufficient funding for positions, the availability of counselling, and the recognition of the need for special leave for rest breaks.

> We go down to _____ football club and people come and ask: 'I need to make a doctor's appointment; I need to do this; I need to do that. You got to say to them, 'Look, I'm not working now. I'm here to have a good time'. *But you are more or less working*. You say, 'Alright, come and see me on Monday and we'll work something out'. It probably happens from 15 to 20 times a night. *I suppose you could say that that is voluntary work*. (emphasis added)

In a series of questions about attending to other business related to the needs of people in the Aboriginal community in outside of work time, 21 (75%) of primary health care workers did this more than twice a week compared to just 18% (2) of Aboriginal people who worked in administrative positions.

Indeed the man quoted above moreover was showing signs of intense fatigue (high emotional exhaustion), answering that he felt fatigued 'a few times a week':

> One of the worse things is getting up in the morning. It's alright once you get going.

Occupational violence: Bullying, verbal abuse and physical violence

The sample as a whole disclosed examples of occupational violence across all groups surveyed. Here a majority of primary health care workers (62% or 18 people) had been abused or threatened in the previous 12 months before interview by clients whereas this was only true for a minority of the sample. Most of it was verbal abuse. However most health workers did not regard the abuse as bullying behaviour although a few perceived it this way – mainly from drug-affected patients and demanding clients.

> Yes, by patients here. Difficult clients, mostly are drug addicts. We had two or three last year who were very difficult. (Aboriginal woman, liaison officer in an Adelaide hospital)

> Yes, from clients if they are not picked up on time. Demanding clients. (Aboriginal woman, liaison worker, Adelaide)

> Verbally abused screamed at only from the escorts (relatives and friends escorting the patients from the Aboriginal community). (Aboriginal man, liaison officer, Adelaide hospital)

In remote communities these issues pose their own difficulties and pressures. An Aboriginal health trainer who works in Aboriginal clinics there highlights the possibility of threats to her person, working very long hours continuously and sometimes without relief or assistance in difficult situations where the worker is part of the social relationships:

> Well, I worked in the Sobering Up Unit and there was always a potential for someone going off and attacking you. I worked in domestic violence and I was actually confronted by a male; it's in a small community and I was known by everyone, I was actually confronted by a spouse a client of ours, and I was verbally abused. It wasn't so much threat it was difficult. In the community I was alone and I saw all the other fellows around that knew me well too. What I did was I went up and confronted him and he just shut up. I wouldn't dare do it if it was just him and me by ourselves. Stress, it's a big factor in remote community. The hours were very very long. We got a very small addition to our wages for doing on-call. So we had to work from nine till five and then we do about three on-calls, so it was like nine till five, then five to nine like it was continuous where the nurse was on-call and the health worker with people coming in and asking for panadol you know, things that weren't emergency. I was really really tired and really really stressed out and it's such a big load on you being like the nurse practitioner you are expected to know everything and this was the first remote community I worked in and the other nurses said yeah yeah we'll be there for you if anything comes up. And when something did come up they were all out of the communities. I was left sort of do it myself. My next thing was to contact the Royal Flying Doctor, speak to them about the health conditions.

Despite the stronger pressure of more intense and visible social relationships in remote and rural communities, full precautions to protect themselves against violence need to be taken by all health workers including Aboriginal (NHMRC, 2002; Fisher et al, 1995; Mayhew, Williams & Thorpe, 2003). Sometimes the abuse involves shaming, or shaming and threats together, and verbal intimidation from clients and/or relatives. Sometimes the shaming is expressed by non-Aboriginal supervisors :

> Deliberately shamed – deliberately put down by supervisors. Just their derogatory remarks. (Aboriginal man, health worker, rural area)

When questioned further, this man made it clear that this shaming carried racial overtones.

While abuse was not tolerated or accepted there was a tendency to play down the impact. Angry clients could be excused for example because it was a reaction to cuts in government policies, and this had not been adequately communicated by management using cultural protocols thus putting staff needlessly in the firing line. But at the same time, various directors, managers, and team leaders were singled out for praise in handling incidents. Also the workers did not just accept the abuse passively:

> They don't bully me because I fight back at 'em. (Traditional man, health worker in a remote community)

Aboriginal health managers related incidents of overt violence:

> You've got clients that suffer from depression or alcohol related issues. It can be occupational health and safety – get a flogging (get roughed up or punched).

However the presence of physical violence in hospitals is also brought about by a lack of cultural awareness and sensitivity in non-Aboriginal staff at best and by racism at worst. Aboriginal Liaison Officers (ALOs) see themselves as fulfilling a fundamental role in dampening down potentially violent situations when non-Aboriginal security guards are too heavy handed. Some of the latter appear 'punch drunk' rather than 'talking through': 'Half the violence is caused when the non-Aboriginal person can't understand what they've said and what they are trying to do'.

The pressure of occupationally-based racism in the health sector

Overseas research indicates that unpleasant contacts at work, such as racism, raise emotional exhaustion levels ((Maslach et al, 1996: 15). Hospital staff, nurses, midwives, security guards, police, and employees in public and private agencies could all be agents of racism. It is reported that racism came from non-Aboriginal and Aboriginal people but the majority came from non-Aboriginal people. It is also considered a hidden, rather than open, form of racism. The more blatant forms of it tended to be demonstrated outside of workplaces in the form of 'derogatory or racial remarks; we don't need it; it affects us deep inside' (Aboriginal male health worker in a rural area), and instances of forced assimilation.

A worker who was involved in native title claims outside of work said:

> I live at the Murray mouth but because of the bloody crap that's going on there, there's no fish, just sand. It's the four-wheel drives and the rug-rats that have knocked the sand-dunes down. 300 metres of sand-dune have disappeared in the last 18 months. I'm at that stage now where politics have turned me into a racist. White people get compensation; black

> people don't. I get very angry over racist inequity and the forced assimilation. Down here, you will never get land back, handed back, but we still share.

However nine health workers (41%) experienced racism from co-workers and ten (46%) from members of the public when they are trying to do their job:

> It's subtle but it affects you. (Aboriginal woman, health worker, Adelaide)

> It's just the way they (whites) look at us. (ALO, Adelaide hospital)

Nurses were singled out as perpetrators:

> You might get a few nursing staff that are a bit off. (ALO, hospital in Adelaide)

> The hospital actually gets a lot of money paid for them to look after Aboriginal people, and a lot of those people that run the wards, like we've had a few run-ins with a few of the nurses … down here about turning their noses up and stuff like that and we had a few meetings with their bosses … and a lot of them were not aware of actually how much money they do get to look after Aboriginal people. (Aboriginal man, health worker, rural area)

As noted above, most work-related racism comes from people outside their own workplaces, often in agencies where the AHWs may have taken a client. For example a woman health worker who works with families talked about 'a great deal of racism' while she was doing her job and she especially mentioned staff in a dental clinic:

> I took a client to the dental clinic, they're shocking. You can just see them thinking, 'No, we really don't want these people to be here'. I said, 'Excuse me, is there a problem?' It's frustrating. (Aboriginal woman, health worker, Adelaide)

Lighter-skinned Aboriginal primary health workers are subjected to the type of racism that reflect the 'no-win' contradictory nature of Australian racism toward Aboriginal people: too much like Anglo-Australians, therefore not authentically Aboriginal; too little like Anglo-Australians, therefore sub-standard human beings. The complexity of Aboriginality is either denied or simplified, in line with the widespread ignorance in Australian society generally, namely that the basis of Aboriginality, like all kinds of human identity, is social and cultural with shared histories(Cowlishaw, 1988: 282; Schab, 1988: 79; Hemming, 1996: 30-31). Alarmingly, certain educated non-Aboriginal educators share this ignorance:

> Mainstream academics at _____ University School of Nursing in midwifery asked, 'You don't look Aboriginal. What part of Aboriginal are you?' It concerns me greatly. (Aboriginal man, project officer, Drugs and Rehabilitation, Adelaide)

> To them the only real Aboriginal is the ones in the bush with tribal scars, whereas us mob are just gammon (pretending). (Aboriginal man, manager, drugs and alcohol, Adelaide)

At other times, lighter-skinned Aboriginal people could be accepted as 'equals' by non-Aboriginal people but then are forced to witness racism toward their darker-skinned colleagues, or deliberately confronted with racist remarks about the latter. An Aboriginal health worker in an Adelaide health centre described the racism of workers in government and private agencies he liaised with:

> It's a bit different for me, my mum's light too, my dad's black and I'm light coloured so I don't have a problem with people seeing me as an Aboriginal worker because I can walk into a place and get treated fairly because of my light coloured skin, but what I do hear is behind closed doors, racism towards the rest of the crew. I know the difference between walking into a place with an Aboriginal worker who is darker skin than me. I get them to come along with me and straight away the service is different. Whereas if I walk in by myself, it's to my advantage I can do that sort of stuff. The hardest part for me is hearing all this stuff and hearing white fellas put down black fellas in front of my face and that's where its stressful for me because I'm always in a situation where I have to challenge that and I've just learnt over the years.

Aboriginal people themselves could reflect the racism of the dominant society although markedly less so. One Aboriginal health manager in a rural area thought so many employees and people in the health centre were judgemental when she first arrived there that she initiated cultural awareness for all staff 'so that people truly understand why we are in the situation we are today'.

Importance of Aboriginal Ways

There is something familiar and comforting about being with other Aboriginal people particularly after working with non-Aboriginal people all day. Some of those special qualities include the fellowship, and 'the easy speak', an acceptance of the way other Aboriginal people are, and speak. It is being accepted as Aboriginal and listening to each other.

> Getting together. It's sort of like, you work with a lot of white people and you go home and see your family and sort of relax, you've got time for them, they want to do things with them. It's a great thing for me to go home from work after 5.00pm. It's good. (Man Adelaide)

> Contact, fellowship, the easy speak.(Woman rural area)
>
> Maintaining our culture; being accepted as Aboriginal. Communication, keeping in touch to find out what's going on. Encourage them to sort of deal with issues to look after themselves to extend themselves, to challenge, don't give up.(Man Adelaide)

A common way to talk about their Aboriginality was with the words ‘closeness, caring and sharing’. This could mean closeness in a family unit; it could mean mutual support in the community and this could even extend to giving food if neighbours didn’t have sufficient.

> Being part of the family is really important. There is not one of us singled out or anything and my immediate family are number one. It’s really important just keeping in contact with everybody. You just have to connect with them all and then there is no jealousy. (Woman, environs of Adelaide)
>
> Being there for each other. Supporting each other. We haven't lost that culture that's just the way Nunga fellas are. They care for themselves and their own community.(Woman environs of Adelaide)
>
> The extended family and the support. There are a lot of community members here in (rural area) we're underneath their wing and vice-versa. The people that you never met before in your life and you connect. They might need to go shopping or something and you automatically ring up and say I'm going shopping. It’s like the extended family. Sometimes you might get people that just wanna ring up to yarn.(Woman rural area)
>
> Colour of our skin, we've got our culture. We used to go out hunting, gathering bush tucker, go out camping. Aboriginal culture has got to do with caring and sharing. That's what our family is about. Even our neighbours, if they run out of meat or bread, we can borrow chops and a loaf of bread from another Aboriginal family. (Woman rural area)

This last woman included a range of features also included by others that were part of her recognition of Aboriginality including skin colour, also hunting and gathering and bush tucker. Particularly in the far west, the diet of kangaroo, wombat and sleepy lizards was mentioned.

There was also a strong meaning to reciprocity, give and take and obligation but there was no choice in the matter of obligation; once those relations came into force, ‘we know we just got to do it’.

> Our culture is based in reciprocity, give and take - obligation – the word used also have negative feeling about it. You do something for me, I'll do something for you. We know we have just got to do it.(Woman rural area)

Family units were seen to pull together and no member of the family is ever excluded.

> Closeness. Even though we might sort of all fight and carry on, but in actual fact we do pull together. My family will ring for money to help with phone etc., but they will help me as well. Even though they might not have much, they will do what they can. I like all that sort of stuff. I like the fact that when I go to …… I'll can go to my sister's place and there might be 14 people there who are all related to you. They never kick anyone out. (Man, Adelaide)

Language was also talked about as a central cultural feature, and it was also part of Aboriginal history and identification to know that it had been obliterated in some cases, but people also talked about reclaiming it, and that was part of Aboriginality too (Gale, 1991).

> Language – Pitjantjatjara (traditional man)
>
> It's very important (Aboriginal ways). Being together, and expressing that Aboriginal language, we talk a lot of our language (Yunktjatjara). We don't speak fluently, but we speak some.
> I'm from Oodnadatta which is outback, but I got taken away when I nine years old. They took us fair one's away. Oodnadatta's traditional people there. All us fair one's were taken away. *That was a stressful time. I remember everything.* There was 12 of us and only 9 are alive. Mother was Indulka and father was Irish, Australian born though. They took us to the Oodnadatta Children's Home when I was about 4 years old. Most of the kids put into the home and then they find families here in Adelaide to send them down. So they're in and out all the time at Oodnadatta. (Emphasis added)(Woman, Adelaide)

Other people also referred to the importance of history and memory in forming Aboriginal identity:

> Aboriginal ways are important to me and my family. Our history, our culture comes from Ngarrindjeri and how it was before white invasion. A lot of elders talk about the past and what it was like when they were children. (Man rural area)

Mostly people talked with a great deal of positive feeling and attachment to their conception of Aboriginal ways. Occasionally people would say that assimilation had been successful:

> Being a family unit. We used to have a lot of sharing when I was a kid on the mission we used to have family things. Everyone cared for each other, not like that now. Society has caught up with us Nungás and we want more material things than we did in the old days. We didn't care about that sort of stuff. Assimilation stuffed us. We had our language taken away from us too. They took our language, they took our culture and our hearts and everything.(Woman environs of Adelaide) 119

But as a direct result of the history of this dispossession and the racism which is so strong and ongoing, Aboriginality is also forged in this very political opposition behind this woman's strong sentiments. The words, 'respect' and 'mutual respect' were often used to express this aspect of Aboriginality, and this meant respect for other Aboriginal people wherever they were located, something frequently not accorded them by non-Aboriginal Australians.

> Respect more or less covers everything about being Aboriginal. Like your Aboriginality. The majority of Aboriginal people, like I can go down to Adelaide and I could be sitting in the pub, like somebody will look at me, and Aboriginal person, and say: 'How ya going brother?'. You can sit there and have a yarn with them. It's sort of like a mutual respect and pride is a very strong thing with Aboriginal people.(Man, rural area)

It is clear from these sentiments about identification that Aboriginal people have strong ideas of who they are socially in this land of their birth, and it is certainly understandably more complex and multi-faceted than earlier anthropologists, like spencer and Gillen (Mulvaney, 1985: 41) would allow. The latter had a static and essentialist view of culture that does not allow for legitimate change. Such a perspective which is still around and now unfortunately helps form Australian 'common sense' on who is a 'real' Aboriginal person. It is one of the elements in the deep-seated cultural racism against Aboriginal people especially in the long settled parts of Australia. Cultural essentialism expects them to still be standing on a rock with a spear circa 1788. The French in France or Australia are not expected to speak like, dress and have the values of Louis XIV's court. The Dutch are not expected to still wear clogs to be authenticated by anthropologists as 'Dutch' (Rintoul, 2002). The Women's Liberation Movement affected French culture in France, as it did most cultures in the world including Italian, Greek, Croatian and Moslem cultures where we are witnessing reactions to it in fundamentalism. There are Islamic feminist organizations in countries like Malaysia eg 'Sisters in Islam'. This kind of cultural essentialism can cause conflicts between parents and children of Australian migrants. The parents sometimes hold versions of the culture they left, but a culture frozen in time in their minds. They can experience shock if they visit their former homeland and find the culture has changed. Almost no cultures on the globe would be in a position to have no cultural reaction to the 20th century revolutions on gender and sexuality. No one questions that modern French culture post the Women's

Liberation Movement and changes in sexuality is not genuinely 'French'. French culture is allowed to change and develop, and even be different in other parts of the world such as French Canada. Yet according to static, cultural essentialism, Women's Liberation values would be a sign of assimilation. In some quarters, patriarchal values circa 1788 are defended as a sign of 'true Aboriginality'.

Modern Australian Aboriginality is culturally diverse but usually with strong links to the Aboriginal family which has endured. People talked about 'being around your mob you know who you are'. But not only do they know who they are, in terms of history and culture, but they have some of the strongest social bonds in Australian society, bonds that should be the envy of other social groups not the source of disrespect.

These social bonds relate to family and the way they live in family relationships which still retain distinctive aspects. Health workers households are very similar to the general pattern in the study as a whole which will be set forth. The total sample have many more children: 46% have more than two children. They have adapted the concept of husband/wife to fit in with the extended family. Even when they may appear to be living in a nuclear type household of husband and wife relationship although commonly it is defacto, most are supporting the children of other family members. Thus 47% (61) are economically supporting children beyond nuclear family borders. They live in a range of household types. This includes husband wife, defacto, two same sex adults, more than two adults, single parent and individuals living alone. Forty four per cent (58) have an extended family visit more than once a month, while a further 17% (23) have such a visit once a month. A similar number have one about every 2months or once every 6 months. Only one person in the study 'never' had an extended family visit, and only 6% (8) less than once a year and usually such people were living away, and kept in touch by phone. Health workers had this to say about their extended family connections and visits:

> Everyday. Family come and go. I've a nephew who comes down from Darwin. Sometimes they can stay for up to a year.
>
> Living with my man (defacto relationship) my 23 year old son and his partner, my daughter and her partner and one grand-daughter. 118
>
> (More than 2 adults) three – 81 year old elder and 10 year old grand-daughter going on 21. Extended family visit about every 2 months and stay a couple of nights.72
>
> Single parent – myself, I'm a single parent with two adult children. I've got my grandson and eldest daughter and younger son living with me. Extended family visits were 'all the time' and they stayed 'about a week'.56

Divorced single parent who had an extended family visit once every 6 months ‘Sometimes hard to get rid of them, so up to 3 months sometimes’. She was supporting ‘Three foster kids that stay with me’. 05

A traditional man was in a defacto relationship. He had two children and was supporting a niece. Extended family visits occurred once a month and lasted a couple of days to a week.

A divorced parent lived in a 2 adult household, had five children and now had 20 grandchildren who she helped support; she had extended family visits more than once a month and they stayed over the weekend.119

Even a young married man in a formally married husband/wife relationship with two small children had extended family visits more often than once a month and they stayed a couple of days. He and his wife had ‘looked after two teenage girls from the Aboriginal Family Support Services’ for 3 months.

A further development of these Aboriginal values and life style issues is presented in chapter 7.

Conclusion

The workers in this chapter enter a cultural borderland between western medicine and the Aboriginal community (Moreton-Robinson and Runciman n.d.). This is difficult for them because western medicine is based on a set of largely hidden cultural values which fragment human experience and deny the presence of legitimate emotions. Patients are separated from their diseases (Baker, Yoels & Claire, 1996) and it is unusual for the body and disease to be located in its social context. Doctors and physicians are actually trained to eliminate their emotions but this merely camouflages and manipulates them under what has been called a cloak of competence ((Smith & Kleinman, 1977). These cultural values of science are possibly at the extreme end of the way non-Aboriginal society is different to Aboriginal society. Not many non-Aboriginal professionals and workers in the mainstream health system enter the cultural borderland.

Aboriginal primary health care workers are crucial in mediating these two cultural worlds to make it possible for Aboriginal people to participate in the mainstream health system, however minimally, in ways that make them feel safe. They understand and use the appropriate emotions in relation to other Aboriginal people (in terms of Aboriginal culture and history which dominant Australian society has little knowledge or appreciation of). Emotional labour as a concept enables us to grasp the highly specific variant of the emotional labour AHWs do. In their case, it is inextricably linked to values of care, reciprocity and respect,

and obligations to carry out cultural practices in terms of Aboriginal identity such as attendance at funerals. These essential duties are analysed through a new and related concept, obligatory community labour. Acknowledging the emotional labour and its relationship to obligatory community labour and the way these practices do not fit readily into western concepts of 'work', 'non-work' and 'voluntary work', is part of the process of fully including Aboriginal workers as a group in the OHS system from which they have long been marginalised.

This chapter intoduces a sociological reading of emotional exhaustion measures to examine possible OHS costs from the complex use of emotions and Aboriginal identity as part of successfully carrying out a human service health job. Aboriginal primary health care workers (particularly women) had the second highest levels of emotional exhaustion after Aboriginal managers. The levels were sufficiently high to cause real concern. Usually emotional exhaustion is an extreme feelings state and is considered the first stage of burnout. It can also be also a precursor to physical ill health (Gaines & Jermier, 1983). But, in this case, the situation is more serious because it is often interacting with pre-existing physical ill health which is much more likely to be present than in the non-Aboriginal workforce.

Extra pressure is also placed on Aboriginal primary health care workers. First, their job involves much more than similar non-Aboriginal jobs. It is common for them to be approached by clients about their health at community social events -- and they therefore find it difficult to separate work and community life, and have the necessary breaks. Second, AHWs regularly do related extra tasks in the community in their non-work time. Third, additional pressure is also created for them because of the low levels of professionalism toward cultural difference and racism experienced from non-Aboriginal health-care professionals and related workers. While Aboriginal primary health care workers are already experts on cultural sensitivity, (the basis of their job), many non-Aboriginal managers, professionals, nurses, security guards are not and even blatantly racist.

Moreover, almost the entire workload in relation to cultural sensitivity is falling on the shoulders of Aboriginal primary health care workers. Non-Aboriginal health professionals and workers able to abdicate the responsibility (sometimes entirely) of engaging with Aboriginal clients, or of learning about Aboriginal history and contemporary cultural values which would allow them to better meet the health needs of this group of clients. This, together with abuse from clients, colleagues, and related agencies adds to the potential for emotional exhaustion in Aboriginal health workers. The images of being 'meat in the sandwich' and 'caught in a vice' exemplify their location between groups who do not understand or appreciate their job function.

What changes are Aboriginal primary health care workers themselves seeking to improve this situation? As is commonly expressed in the book, most of them are labouring under situations where there is a shortage of staff, resources and

actual physical space. Sometimes they were the only full time employee. In some cases, the employment of someone else in an administrative role would help. There were comments that the Aboriginal community expected them to do a good job for the community and as one said ironically, 'work for 75 hours a week'. Often they would like their own unit. This meant they could have an Aboriginal identity: 'a separate unit within the hospital, an area where Aboriginal patients could come and talk and things' and more responsibility so they could solve more readily common problems presented by clients:

> What we need is a bigger office, our own budget, easy access for funding for our clients. They come from the community; they got no money. If we got a budget say for $320 and they've got a cheque coming down for $320, what we do is sort of give them the $320 and keep their cheques. More responsibility.(ALO hospital Adelaide)

On a related issue, one woman talked about better access to related services so they could really help clients in desperate need but not within the present hand-to-mouth charity framework:

> It's not the job; it's about access. Having access to services properly, that sort of thing. I think we can improve that. And I know we need to improve that. One thing that I do really hate is taking families to places like Anglicare for food vouchers; it's like a begging system. You have to stand out the front. You have to be there by 8:00am in the morning, stand in a line and hope to god that you get seen to. If you don't get seen to you miss out. We had a family ring up last Thursday. There was mum, dad, her mother and those kids and we could see over the long week-end they wouldn't have anything to eat. That's the part of it I hate. (Health worker environs of Adelaide)

This could be linked to issues of cultural appropriateness and cultural sensitivity for example 'like when you have got really specific women's issues and specific men's issues' so they and their clients did not feel 'intimidated by white people'.

They would like 'recognition of the importance of the work we do and ongoing support'.

> When they see us as an independent department. Not looking at us like social worker assistants.(AHW hospital Adelaide)

They wanted management to understand and accept the diversity within Aboriginal communities and not dissolve all Aboriginal client/patient problems into 'Aboriginal problems' and immediately made their responsibility:

> Proper space for workers. Clarification in jobs and what's expected of them. A duty statement would be helpful. We're counsellor's; we're

> nurses. Management to respect and accept the diversity within Aboriginal communities. We've got job specs. But we would like job duty statements. Because we are classified much lower than mainstream.(Woman coordinator rural area)

A health worker in another rural area wished she could speak the local Aboriginal language fluently rather than 'just bits and pieces' that would make her job easier.

Greater cultural sensitivity and cultural awareness was mentioned. One woman in a rural area articulates the way obligations from the Aboriginal community and from the Aboriginal family cannot be fitted into the 9-5 working day which this book is arguing is modelled on the non-Aboriginal family structure which is naturalised as 'the Australian family structure':

> Management to realise that it is a 24 hour job not 9 to 5. It could be funerals, community meetings, expecting to just drop everything and attend. I've got a telephone call right now saying my father-in-law, because he is dying from prostrate cancer, so I just drop it and go.

Finally one health worker in the rural area thought his community run organization was 'pretty good; most of their supervisors supported them all of the time'. But he was resigned to the fact that the stereotyping and racism were unlikely to change, so 'you just get on with your job and what you get paid for'.

(***CHAPTER 3 ABORIGINAL WORKERS AND MANAGERS, HISTORY, EMOTIONAL AND COMMUNITY LABOUR AND OCCUPATIONAL HEALTH AND SAFETY IN SOUTH AUSTRALIA (2003) Claire Williams and Bill Thorpe with Carolyn Chapman, Henley Beach, Seaview Press.***
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