

Psychiatry and Political Intervention:
A Case Study from the Asylum Seeker Debate in
Australia

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ABSTRACT¹

Psychiatrists have a long and valuable history of intervention in the political process. The paper will review some contributions to debate over such issues as war, conflict, terrorism, torture, human rights abuse, drug abuse, suicide and other public health issues. However, the competence of specialists in the mental health of individuals to comment on the mental health of collectivities has been questioned, and the philosophical issue of the status of collective mental health is very much an open one.

At the present moment there is an intense debate in Australia over the Government's treatment of asylum seekers, also known as illegal immigrants. The Royal Australian and New Zealand College of Psychiatrists has taken the unusual step of publicly criticising government policy on grounds of its toxicity and depressive effects, particularly among child detainees. The official response has been to deny that collective depression exists and to assert that the concept of such a mental state is meaningless. This contrasts with official recognition of the problem of depression among Australia's young people other than young asylum seekers.

Psychiatry is a branch of medicine dealing with mental disorder, as distinct from psychology, which investigates behaviour, experience and the normal functioning of the mind. While psychiatry is a science, its foundations and methods are far from clearly established, with a minimum of eight distinct models of mental illness accepted by some members of the discipline (Puri, Laking and Treasaden, 1996: 4). As a result, psychiatry is much affected by internal differences and so, when an official body representing psychiatrists decides to take the step of formal intervention in the political process, it is an unusual step, indicating a matter of high significance. The treatment of Australia's child detainees is such an example, but political intervention by psychiatrists is not a new development.

Psychiatrists and Politics

Psychiatrists have a long history of intervention in the political process and have made valuable contributions to debate over such issues as war, conflict, terrorism, torture, human rights abuse, drug abuse, suicide and other public health issues.

Freud, who had trained as a psychiatrist before founding the psychoanalytic school, expressed his concerns about the tragedy of war in his correspondence with Einstein in 1932. In that correspondence, Freud saw the violence of war as a method of

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conflict resolution. This followed from his understanding that within every individual, and group, there exist instincts of two kinds: those that conserve and unify, which can be called erotic (in the sense that Plato gives to Eros in his Symposium), or sexual, and secondly, the instinct to destroy and kill, that is to say, the aggressive or destructive instinct (Freud, in Nathan and Norden, 1960: 7). The two instincts interact and can camouflage each other.

Thus, when a nation is summoned to engage in war, a whole gamut of human motives may respond to this appeal—high and low motives, some openly avowed others slurred over. The lust for aggression and destruction is certainly included; the innumerable cruelties of history and man's daily life confirm its prevalence and strength. The stimulation of these destructive impulses by appeals to idealism and the erotic instinct naturally facilitate their release (Freud in Nathan and Norden, 1960: 8).

As a result of the presence of the instinct for destruction, sometimes called by Freud Thanatos, it is easy to infect humans with war fever, hence the appeal of war as a policy. But Freud did see one certain way to end war, and this was through the establishment by common consent, of a central control body supervised by a supreme court, and possessing adequate force at its disposal (Freud in Nathan and Norden, 1960: 6). (In this proposal, Einstein was in agreement).

During World War II, a team of psychoanalytically trained psychiatrists was set up under the chairmanship of Dr Walter C. Langer, with the purpose of carrying out a psychological analysis of Adolf Hitler. Basing themselves on a detailed analysis of all available documents and interviews with all persons who had had more than a passing contact with Hitler, Langer and his team produced a report for the Office of Strategic Services, which was finally published in 1972. The Langer Report concluded in 1943 that Hitler was in all probability a neurotic psychopath, and went on to consider eight possible scenarios for his future. With what turned out to be great prescience, it declared that the eighth, that Hitler might commit suicide, was the most plausible outcome (Langer, 1973: 211). The implications of the other scenarios, such as mythologising a Hitler killed in battle or incapacitated by schizophrenia, or of assassination, particularly by a person of Jewish background, are spelt out in some detail and would have undoubtedly influenced Allied military planning with a level of appreciation of risks and benefits that are a special product of psychiatric training.

Throughout history the treatment of mental illness has been highly variable and often problematic (Foucault, 1988), while psychiatry as a discipline is itself a fairly recent development (Shorter, 1997). Despite the presence of a medical ethic since Hippocrates (470—360 BCE), some psychiatrists have been responsible for gross atrocities, the most infamous of which being during the Nazi regime which has been described as “the all

time low point in the history of psychiatry” and the only documented situation where a body of psychiatrists deliberately set out to exterminate patients (Dudley and Gale, 2002: 586). (The larger picture of the work of the Nazi doctors has been examined in the classic work by Lifton (Lifton, 1986)). The atrocious behaviour of those psychiatrists who implemented Nazi policy continues to resonate through psychiatric thinking to the present day, and it could be argued that intervention in contemporary politics by psychiatrists can be interpreted as a reaction to that shameful episode.

Though not implicated in genocide, psychiatry in the Soviet Union earned itself a particularly bad reputation for the labelling of mentally healthy political dissenters as mentally unwell and in need of compulsory hospitalisation and treatment (Bloch and Reddaway, 1977).

During and after World War II, a group of psychiatrists argued that, from a psychiatric point of view, war was not inevitable. In taking this position, they somewhat distanced themselves from the Freudian view of Thanatos, being rather more influenced by Dollard’s “frustration—aggression thesis” (Dollard, 1939). Here, aggression is seen as a response to frustration caused by interference in the pursuit of goals.

In 1946 these psychiatrists formed the Group for the Advancement of Psychiatry (GAP), with a specific interest in focussing on the problem of war and techniques to avoid it. In 1964 they reported that war is “ a social institution; it is not inevitably rooted in the nature of man” (Rogow, 1968: 213). The organization is still active today and is now concerned with assisting in the process of adapting to terrorist attack (GAP: 2003).

While there are some highly significant exceptions, it is fairly unusual for individual psychiatrists to become involved in political issues; in one view this is because of embarrassment over past “diagnoses”, and also because of a current emphasis on biological factors (Shore, 2001: 195). Another reason is that psychiatry tends to be a rather isolated discipline, while to engage in politics requires joint effort with other disciplines such as sociology and psychology. For example, the study of aggression cannot be isolated from sociological, psychological and developmental perspectives, particularly when occurring in ethnic conflict, blood feuds and wars between nations (Haig, 1991: 204).

Another factor working against political involvement by psychiatrists as individuals and as a group is the presence of many deep divisions within psychiatry itself over concepts and methods, and philosophical and moral issues (McHugh, 1999).

Australia’s Detained Children

Australia's policy on the mandatory detention of asylum seekers provides an example of intervention in the political process by psychiatrists as a profession. Australia is a country made up of indigenous people, immigrants and the descendants of immigrants. In the 1970s and 1980s, over 100,000 "boat people", mainly from Vietnam arrived and were satisfactorily settled. In the 1990's and early 2000's, governments have decided to take a very restrictive position towards illegal arrivals, while the admission of legal immigrants continues at about 150,000 per year. The Migration Act 1958 was amended so that from September 1994, non-citizens found to be unlawfully in Australia, that is, arriving or having arrived without a visa, must be immediately detained in "administrative detention". The detention will continue until a person is determined as having a lawful reason to remain in Australia. The Act applies to all illegal entrants regardless of age, sex, nationality and irrespective of whether they are asylum seekers. The eight existing detention centres are located around Australia, often in desert regions or on islands over 1000 kilometres offshore. In May 2002, the total number of detainees was around 1,500 persons, mostly from Africa, especially the Mahgreb, or Asia (Afghans, Chinese, Iranians, Iraqis, Kurds and Vietnamese). Recently, Australia has made arrangements with two other countries, Papua New Guinea and Nauru, to provide detention camps for Australia-bound asylum seekers: the policy has been called the "Pacific solution" (UN, 2002).

This policy of mandatory detention has received much criticism and condemnation from private citizens, health care professionals including individual psychiatrists, organizations and official bodies. A former Governor-General of Australia, Sir William Deane, stated that the detention of children was a "challenge to justice and truth" (Shanahan, 2003: 10), and a clinical psychologist who has worked with asylum seekers for 10 years stated that mandatory detention is worse than torture (Steel, 2002). A psychiatrist concluded that a sustained effort will be needed to alter an entrenched policy of exclusion that is producing acts of desperation (Silove, 2002). A committee of the United Nation's Commission of Human Rights raised concerns about the policy's automatic and indiscriminate nature, the absence of juridical control and its psychologically damaging impact, particularly on children (United Nations, 2002: 1). The impact on child detainees of several suicides of adult detainees in the same Australian centres cannot be underestimated.

The Human Rights and Equal Opportunity Commission

In its National Inquiry into Children in Immigration Detention Report - A Last Resort?, tabled in Federal Parliament in May 2004, the Human Rights and Equal Opportunity Commission (HREOC), a body established and financed under federal law, found that Australia's immigration detention policy had failed to protect children in Australian immigration detention centres. These children have suffered numerous and

repeated breaches of their human rights, to mental health of children, to adequate health care and education, and that the centres had failed to protect unaccompanied children and those with disabilities.

The Commission's two-year Inquiry also found that the mandatory detention system breached the UN Convention on the Rights of the Child.

Under the Convention on the Rights of the Child, all children living in Australia - including children held in immigration detention - have a right to the 'highest attainable standard of health'. The Convention also states that children escaping conflict, torture or trauma have a right to special help to recover 'in an environment which fosters the health, self-respect and dignity of the child. (HREOC, 2004:7).

In failing to make detention a measure of "last resort", for the "shortest appropriate period of time" and subject to independent review, the Australian Government has been in breach of the Convention.

In preparing its report, the Inquiry received a wide range of evidence as to the highly harmful effect of detention upon the mental health of some children. The Inquiry was advised by many expert witnesses that whilst the children in detention received some support from mental health professionals, the detention environment was itself the source of many of the problems, with the result that child detainees had experienced, amongst other things, clinical depression, post traumatic stress disorder (PTSD), and various anxiety disorders. (HREOC, 2004:2).

The Inquiry heard numerous examples where State mental health and child protection agencies, as well as independent experts, repeatedly recommended that children be removed from detention to protect their mental health. By April 2002 most unaccompanied children were removed from detention centres following these recommendations - but the recommendations were not implemented for children in detention with their parents.

The child detainees presented a variety of symptoms ranging from bed wetting, sleep walking and night terrors, to the more serious disturbances of mutism, refusal to eat and drink, suicide attempts and self-harm, such as by mutilation. Some children also revealed developmental disorders.

More than 92% of children in detention were found to be refugees, with the implication that most, if not all, of the detained children are likely to have been affected by significant traumatic episodes before they arrived in Australia. However, the Inquiry received evidence that the trauma children experienced before they arrived in

Australia does not account for the extent of mental health problems they demonstrated in detention. In fact, the evidence was clear that immigration detention centres were not an environment which would be conducive to their recovery from the trauma of their past experience including persecution. (HREOC, 2004:7).

Reporting to the Inquiry, many psychiatrists observed that children were deeply affected by witnessing violence in the detention centres, such as riots, fires, suicide attempts, incidents of self-harm and hunger strikes. The atmosphere of violence was compounded by other factors such as living in a closed environment and the uncertainty and sense of hopelessness concerning the future, in particular the applications for visas. As months passed without any news on their visa application, or if the application had been rejected, detainees grew more depressed and fearful.

An additional factor in provoking depression among the child detainees was the strain on the family, and the fact that being in detention severely undermined the ability of parents to care for their child. The Inquiry heard that parents in detention became depressed themselves, which meant their parenting skills were severely impaired such that they were unable to play with their children, read to them, supervise them or look after their safety. In some cases, parents also found it difficult to manage their children's behaviour in the detention environment.

A parent's depression caused some children to take on an 'adult' role of caring for a parent or younger siblings and acting as an intermediary with detention centre staff because they had better English language skills than their parents.

The children who had been detained for lengthy periods presented significant mental health problems. A report on 20 children from a remote detention centre who had been detained for an average of 28 months found that: all but one child received a diagnosis of major depressive disorder and half were diagnosed with PTSD. The symptoms of PTSD experienced by the children were considered to be almost entirely related to experience of trauma in detention (HREOC, 2004:11).

In April 2002, the South Australian child welfare authority made the following report on a 13-year-old boy who had been detained for 455 days:

[He] is very withdrawn and lethargic. Since entering Woomera he has been suicidal and very sad. He reports nightmares nightly, seeing himself dead, or unable to move with people carrying his body. He reports waking screaming and finds trouble falling to sleep. He reports a diminished appetite. He has little memory of past events and no hope for the future. He refuses to make new friends because he believes they will be released but not him. He engages in

constructive daytime activities but spends hours sitting staring vacantly (HREOC, 2004:12).

Children in detention also self-harmed - they have sewn their lips together, attempted to hang themselves, swallowed shampoo and detergents and have cut themselves. Between April and July 2002, one child detained at Woomera made four attempts to hang himself, climbed into the razor wire four times, went on hunger strike twice and slashed his arm twice. Records from April 2002 report this boy saying:

If I go back to camp I have every intention of killing myself. I'll do it again and again. We came for support and it seems we're being tortured. It doesn't matter where you keep me - I'm going to hang myself. (HREOC, 2004:12).

The RANZCP and the Minister's Response

Of special interest is the intervention of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in the political process concerning the mandatory detention of children, which has been joined in its intervention by the Paediatric and Child Health Division of the Royal Australasian College of Physicians (RACP). These bodies have called for an immediate review of the health needs of children in Australia's detention centres, in the light of evidence that the prolonged detention of children is harmful to their physical and mental health. The Colleges referred to examples of nations that have developed appropriate and humane ways to manage asylum seekers, referring in particular to Sweden which has only a brief period of detention and does not impound children (RANZCP, 2001).

In a later statement, the chairperson of the RANZCP went on to state:

The policy of mandatory detention in Australia contributes to the ongoing traumatisation of detainees. There is clear evidence that detention is toxic for people and that mental health services cannot be delivered in these environments. The emotional and psychological damage being done to people in detention will leave them with scars which will be difficult and costly to treat. (RANZCP. 2002: 1).

The call for the immediate release of children and adults who pose no immediate security risk to Australia was reiterated (RANZCP, 2003: 1). The College noted that the length of the appeals process leads to a collective depression syndrome at some of the detention centres (AHRC, 2002: 1). The College did not elaborate on the symptoms of this syndrome but the UN Working Group on Arbitrary Detention indicated the

following symptomatology: suicide, parasuicide, self-mutilation, aggression, affective aggression and autistic reaction (UN, 2002: 4-5).

The response of the Minister for Immigration, Multicultural and Indigenous Affairs, Mr P. Ruddock, (until October 7, 2003), has been to deny that depression is widespread within the detention centres and to question the validity of the concept of collective depression

I don't know what you mean by collective depression but...there are very few people (in detention centres) who have depression...The number of opportunities that people have to try and impress their claims whereby they then seek to self-harm and exhibit what some people call collective depression, has increased significantly with the number of visits (to detention centres)...When you've had periods in which there have been fewer visits, the general condition improves. (Ruddock, 2002: 4).

The Minister's statement has not been contradicted by the Prime Minister or any other Minister, and so it can be assumed to be a statement of official policy on the mental condition of Australia's detainees including the child detainees.

Childhood Depression: the Scientific View?

Depressive disorder in children is not uncommon before puberty and is much more common after, occurring in 0.5 to 8% of 14-15 year-olds, with some significant risk of suicide (Puri, Laking and Treasaden, 1996:298). In conditions of stress or trauma, such as those experienced by Australia's detained children, both before and after arrival in Australia, these figures would be much higher.

Individual depression in children and adults can be successfully treated by a range of therapies but when it is affecting a large number of people simultaneously, it needs to be recognised as being caused by the social or political environment. The normal lowering of spirits in response to life's events used to be called reactive depression, and the depression with no apparent precipitant was formerly called endogenous depression (Reber, 1995: 198), but this distinction can now be supplemented with a classification of (1) mild, moderate or severe (2) with or without biological features (3) with or without delusions or hallucinations (4) with or without manic episodes (bipolar/unipolar) (Collier, Longmore and Harvey, 1991: 338).

Major depression, which can occur in children, is a very serious condition that can cause an inability to function or even suicide but can remain undiagnosed. Its

aetiology is not fully known but could be (1) biochemical (2) endocrinological (Collier, Longmore and Harvey, 1991: 336) or (3) psychodynamic: often actuated by the death of someone close or other forms of profound loss including loss of freedom and is therefore a product of grief (Haig, 1990: 7-11). In the Freudian view, depression mirrors bereavement, but the loss can be an object and not simply a person (Collier, Longmore and Harvey, 1991: 336). Another view is that learned helplessness, the hallmark of depression, results when punishment is received without being contingent upon the actions of the individual (Collier, Longmore and Harvey, 1991: 336). Depression can also be related to illness, pain, prolonged fatigue, and lack of human contact: deep areas of causality often described by the term melancholia. The condition of Australia's detained children would appear to be a clear cause of melancholia, primarily environmental in causation. This said, it is important to note that psychiatrists themselves remain divided: some assert the over diagnosing of post traumatic stress disorder as an example of the medicalising of human conditions (McHugh, 1999).

Depression among individual children is thus a major problem but it is not untreatable. The major treatments include pharmaceutical drugs administered by physicians and also many proven psychological techniques, from counselling to different types of psychotherapy, psychodrama, and psychoanalysis though this is strictly contraindicated if psychosis is suspected (Gillett, 1988: 148), but it is fundamental to try to overcome disruption to family life coming from the environment (Puri, Laking and Treasaden, 1996:298), which in the case of Australia's detained children, is one of extreme hostility.

Collective Depression

The concept of collective depression is much vaguer and is the subject of conjecture because of its association with the concept of a collective mind, as proposed by Le Bon in 1895 (LeBon, 1960), and developed by Durkheim as collective consciousness, (Durkheim 1964:103n). Le Bon advanced a contagion theory that crowd behaviour takes over from individual behaviour through the infectious spread of emotion and action. This view has been contested by those who argue for an emergent-norms theory that sees group unanimity as an illusion created by common action based on prevailing norms (Robertson, 1987: 358-359). The methodological difficulty of assessing any concept of group mind has meant that it has fallen outside mainstream social science discussion, with the result that there is very little research currently being undertaken (Varvoglis, 1997: 1).

Medical scientists tend to leave open the question of collective mental states: for example Cawte states that a sick society is one with a high amount of psychiatric illness (Cawte, 1973: 365-379). Without assuming the concept of a group mind, it is possible to

state that collective depression can exist: it is when a large proportion of the members of a society are depressed, that is, are displaying signs of inadequacy, despondency, lack of vitality, pessimism, sadness and dependency upon substance ingestion and calls for help through self-mutilation and suicide attempts.

beyondblue

In 2000, the Australian Government in conjunction with the Victorian Government now supported by other State and Territory governments, private companies and community-based organizations, created beyondblue, a national program to treat depression, which was seen as reaching epidemic proportions among the Australian population (beyondblue, 2004). The program has been led by the former premier of the State of Victoria, Jeff Kennett, and initially provoked discussion of whether the condition should be treated biologically or socially, but left open the question of its collective nature (Busch, 2000).

This program is based on an official acknowledgement that around one million Australian adults and 100,000 young people live with depression each year. Depression is estimated to cost the Australian community over \$600 million each year and is currently the leading cause of non-fatal disability in Australia. Depression will be second only to heart disease as the leading medical cause of death and disability within 20 years (beyondblue, 2004). To the present, beyondblue seems to be concentrating on individual depression, by promoting awareness of the condition and urging individual sufferers to seek medical treatment.

Treating Collective Depression

It has been asserted that collective depression can be related to national trauma, as in a shock felt by a very high percentage of a population. One such recent event was the death of Princess Diana in 1997 (Lincoln, 1997). Other causes of collective trauma are political assassinations, unprovoked acts of terrorism or war, economic depression, and technological disaster (Neal, 1996); or specifically, the 9/11 attack (Mandel, 2002). All of these events can trigger collective depression, either in a direct way, or by a more gradual process of incremental accretion which can be transmitted by contagion. Depression is therefore accepted to be a collective phenomenon, passed by contagion by negative multiplier effect. The contagion with emotions can also occur in many domains of behaviour. Kiev hypothesised a collective anxiety neurosis (Kiev, 1973) and collective fear has been isolated as a causal factor in extreme political behaviour (Lake and Rothchild, 1996).

It would seem comprehensible that depression can be passed between individuals by contagion, but does research give any confirmation? Forsyth reviewed the literature and concluded that "the bridge between social psychology and mental health can still not be traversed" (Forsyth, 1996: 5), but suggested some areas of enquiry, such as the causal power of the group to change individuals when they become part of a group. Some of the group processes that require research are leadership, group development, social learning, self-insight, social influence and social provisions (Forsyth, 1996: 5).

Individual depression can be successfully treated, as already noted, but collective depression, being a different order of problem, cannot be treated by therapies for individuals but can be treated by leadership, as observed by Forsyth (1996: 5). Vigil also notes that although the Latin American continent has a state of collective depression, there are individuals standing outside this mental state and therefore are in a position to assist in its removal. Vigil refers those who remain firm, and impervious to dismay and depression "...our Latin American prophets, anonymous, hidden in the barrios, in the countryside, in the popular, feminist, indigenous, black, and labour movements ... "(Vigil, 1996: 3).

The function of leadership in treating collective depression is thus to assess the obvious causes of the depression, and then to demonstrate that the situational factors can be changed, starting with small symbolic ways, if only with those few that are possible, and to show a leadership role by speaking out as a bystander.

As with individual depression, positive practical actions, encouraged by indications of support from outside, no matter how seemingly small in comparison with the magnitude of the task, can lead to a lifting of the condition, as shown with the work of some members of a Peace Institute in a village in war torn Georgia (Rueffler, M., 2000). This linking process could be called "positive contagion", while attitudinal changes, including the use of humour, is another rich field of collective therapeutic action.

The use by the RANZCP of the concept of toxicity is interesting. The term has long been used in relation to the physical toxicity of drugs and other chemical and physical agents but only rarely in relation to the behavioural effects of influence by agents (Saxena, 1974). Psychiatrists are now drawing upon the work of organizational theorists who have labelled certain harmful effects of organizational operation, such as poor leadership, as toxic, in other words, poisonous in effect (Hirschhorn, 1990: 533). In proposing the approach of detoxication of the psychological environment, organisational theory has relevance in the case of the children and adults held in Australia's detention centres.

Conclusion

Psychiatrists have had a long but intermittent and sometimes valuable history of intervention in the political process, without diminishing the existence of several infamous examples of group malpractice on a huge scale. They have made contributions to debate over such issues as war, conflict, terrorism, torture, human rights abuse, drug abuse, suicide and other public health issues. However, the competence of specialists in the mental health of individuals to comment on the mental health of collectivities has been questioned by some Australian politicians (and some psychiatric theorists) so that there is an open philosophical issue of the status of collective mental health.

At the present moment there is an intense debate in the Australian community over the Government's treatment of asylum seekers, also known as illegal immigrants, and the Royal Australian and New Zealand College of Psychiatrists has taken the unusual step of publicly criticising government policy on grounds of its toxicity and depressive effects, particularly among child detainees. The official response of denial that collective depression exists and assertion that the concept of such a mental state is meaningless has created an unresolved tension between psychiatrists and politicians. The fact that the Australian Government has seen fit to acknowledge and fund a program for the treatment of depression among a large percentage of the non asylum-seeking population, including 100,000 young people (other than the child detainees), is a major inconsistency.

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