ABSTRACT: Psychiatrists have a long and highly variable relationship with the political process. They 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. However, they have also been complicit in some 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. 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. A 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.

At the present moment there is a debate in Australia 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 has been to deny that collective depression exists and to assert that the concept of such a mental state is meaningless. The philosophical status of the collective mental state, as accepted by Durkheim, Freud, Jung and many others, is thus a relevant issue to the current debate.

Can this courageous and unusual intervention by psychiatrists be interpreted as a product of earlier political behaviours by psychiatrists? The presence of minority voices within the
Australian psychiatric profession is also noted, as is the growing sense of media awareness among all participants in the debate.

**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 neurologist 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 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.

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 Einstein was in agreement, 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).

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 infamous program of adult euthanasia, known as T4, after the address of its architects' headquarters at Tiergarten 4, Berlin, "involved virtually the entire German psychiatric community and related portions of the general medical community." (Lifton, 1986: 65). As well as the euthanasia program, it was, according to Lifton, a psychiatrist who was the predominant medical presence in the sterilization program (Lifton, 1986: 27), and this same psychiatrist became a significant source of scientific legitimation for the regime's racial policies (Lifton, 1986: 28). The atrocious behaviour of those psychiatrists who originated and implemented Nazi policy continues to resonate through psychiatric thinking to the present day, and it could be argued that an imperative to intervene in contemporary political issues 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 very bad reputation, particularly for the labelling of mentally healthy political dissenterers 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, 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 a 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 significant exceptions, it is fairly unusual for 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 Detainees**

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 1990s and early 2000s, governments decided to take a very restrictive position towards "illegal" arrivals, while the admission of legal immigrants continued at about 150,000 per year. The Migration Act of 1958 was amended by the then Labor government, 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, and nationality and irrespective of whether they are asylum seekers. There are eight 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 (UN, 2002).

Many of the asylum seekers held in detention centres are children. 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, to adequate health care and education, and the centres have 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, posttraumatic stress disorder (PTSD), and various anxiety disorders. (HREOC, 2004:2).

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 did 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, suicides, 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 of their visa application, the 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 children. 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. 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).

A Psychological Explanation of Australia's Mandatory Detention Policy

How can it be that a country, and its elected government, which prides itself on its warmth, generosity and humanity, is prepared to treat asylum seekers and their children with such cruelty and inhumanity?

The answer to this question is multi layered but must start with a concept of doubling, first introduced by the psychoanalysis Otto Rank (1884–1939), and revived by Lifton (1986). Doubling is the division of the personality into two functioning wholes that can operate independently, often serving the need for survival, but also allowing a granting of license to commit evil, as it did for the Nazi doctors. Moreover, doubling can be a collective phenomenon, and here Lifton identifies a "German vulnerability to doubling...intensified by the historical dislocations and fragmentations of cultural symbols following the First World War." (Lifton, 1986: 429). Are there any dislocations and fragmentations present in Australia's past that might be the cause of a collective doubling? (This would require a separate paper but could consider such factors as convict past, isolation, fear of Asia, past victimisation of some ethnic groups, and problems of identity. It would also link the mistreatment of asylum seekers with the mistreatment of Aborigines, the latter policy also being denied by Prime Minister Howard and his government).

A second concept, also introduced by Lifton, is psychic numbing, or a "general category of diminished capacity or inclination to feel." (Lifton, 1986; 442). First applied to Nazi doctors working in concentration camps, it was put forward as a description of the mental state necessary for the continued performance of functions in the basic activity of those places.
In Australia in the last ten years, there is some evidence of psychic numbing, and here the lack of outcry from the Australian public to the treatment of asylum seekers and their children can be referred to. The first of these was the noticeable lack of public outcry over the Tampa affair, when in 2001, several weeks before the September 11 attacks on the World Trade Center and the Pentagon, a ship carrying rescued Afghan refugees to Australia was diverted from Australia to Christmas Island. Shortly after, this incident was followed by the "children overboard affair", in which the government claimed that asylum seekers were cruelly throwing their own children into the sea during interception by the Royal Australian Navy, a claim that was later shown to have been a lie (Senate, 2005: Ch 3-6).

A third incident occurred when a boat carrying asylum seekers, the "Suspected Illegal Entry Vessel X" or "SIEV-X", sank within the Australian surveillance zone with the loss of 353 lives, while attempting to enter Australian waters. An Australian Senate enquiry concluded that "...it is extraordinary that major human disaster could occur in the vicinity of a theatre of intensive Australian operations and remain undetected until three days after the event, without any concern being raised within intelligence and decision making circles." (Senate, 2005: Ch 9).

The evidence of psychic numbing is the electoral success of Mr Howard and his Coalition parties in the election of 2001, following these events, and including the lack of major outcry by the Labor Opposition, which, it will be recalled, was itself the originator of the mandatory detention policy.

Despite overwhelming endorsement by the Australian general electorate, the policy of mandatory detention has received much criticism and condemnation from private citizens, students and school children, 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 was "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). In addition, a committee of the United Nation’s Commission on 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 the experience of witnessing several suicides of adult detainees in the same Australian centres cannot be underestimated.

An important component in the process of psychic numbing is the use of euphemism, as practised by many regimes of different ideological nature, as they have gone about the business of disguising the true nature of their policies (Young, 1991). The most sinister example of the euphemism is the term Final Solution (Endlösung). Apparently unaware of its most sinister linguistic association, Mr Howard forthrightly described his government's detention of asylum seekers to Australia in special facilities on the island state of Nauru and In Papua New Guinea as a "truly Pacific solution", after which the term Pacific Solution became used widely in official and public circles (Clyne, 2005: 180). In addition, the policy of returning asylum seekers to the country of origin became known as "border protection". Yet another use of euphemism was the official title of the Australian Senate's enquiry into the sinking of the SIEV-X as a "Senate Select
Committee for an enquiry into a certain maritime incident" (Senate, 2005). The certain unnamed "maritime incident" referred to was, in fact, the greatest maritime disaster in or near to Australian waters since World War 2.

Another mechanism for discriminatory policy identified by Lifton is collective diagnosis, by which is meant that mere membership of a group is sufficient evidence to ensure a medical-type diagnosis requiring a certain regime of treatment, as part of a larger scheme of policy based on a biomedical approach to policy. This was clearly demonstrated when, during the 2001 election campaign, the Prime Minister, Mr Howard, stated that

"Our nation must be protected from the activities of people smugglers, drug traffickers and the introduction of diseases and dangerous goods." (Clyne, 2005: 184).

Psychologists and psychiatrists who have studied human cruelty, such as notably Staub or Lifton, have concluded that after all of the relevant psychological, social and political mechanisms are explained, there remains a choice to commit evil, that is, not only to kill, but to create conditions that materially or psychologically damage people (Staub, 1992: 25). Lifton observes that this is a Faustian choice, whereby certain acts are committed for personal or collective gain, in exchange for spiritual values, or as in the Faustian legend, where the cost of Dr Faust's gain in power was his soul.

The explanation of the Australian government's cruel and inhuman policy towards asylum seekers and their children is therefore one of a Faustian choice: to sacrifice conscience and decency by targeting a group for the purposes of electoral gain, in the name of leadership. Writing of the Prime Minister, Mr Howard, it has been stated that

"One of the greatest opportunities of his political career came his way a few months before the 2001 election. He could show leadership in protecting Australia from asylum seekers." (Clyne, 2005: 180).

The RANZCP and the Minister’s Response

Of special interest is the intervention in the political process concerning the mandatory detention of children by the Royal Australian and New Zealand College of Psychiatrists (RANZCP), 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 of Psychiatrists noted that the length of the appeals process leads to a collective depression syndrome at some of the detention centres (HEROC, 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 Phillip Ruddock, (until October 7, 2003), was 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.

The Nature of Childhood Depression

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 could be expected to be much higher.

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 leaving a condition often described by lay people with the term melancholia. The condition of Australia’s detained children would appear to be a clear cause of melancholia, and primarily environmental in causation. But even here, it is important to note that psychiatrists themselves are
philosophically divided: some assert the over diagnosing of posttraumatic 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).

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. Thus while government denies that any depression exist in detention centres, other than that caused by the visits of
psychiatrists and other health care professionals, it is acknowledging the prevalence of widespread depression in the general community.

Treating Collective Depression

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). The function of leadership in treating collective depression is 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.

The Australian psychiatric profession has accepted this role with its clear statement that "detention is toxic". Here the use by the RANZCP of the concept of toxicity is noteworthy. 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, it can also be noted that organizational theory has relevance in the case of the children and adults held in Australia’s detention centres.

The quest for a leadership role by the RANZCP has not been without its internal critics from among psychiatrists and members of other branches of the medical profession. In an article in Australian Psychiatry, Dr Doron Samuell has made the following statement:

We have gone from being concerned about children in detention centres to being active opponents of the centres and direct opponents of the government.... Is the evidence for inadequate health facilities to detainees convincing? Do we blame the parents for protracted appeals that keep the children in detention? Should we be worried about the way that children are being manipulated into violent demonstrations in the detention centres or more worried about how they have been used in school-based campaigns against government policy? Do we have a uniform and homogeneous view within the College about how government should protect its borders? (Samuell, 2003; 122).

Writing in the Medical Journal of Australia, Dr Debra Graves expressed opposition to the publication of an article written by a medical doctor who was himself a detainee, on the grounds that the detained doctor had a "potential bias" concerning his treatment by the "democratically elected government of this country." (Graves, 2002: 8).

Conclusion: The Quest for Leadership

The relationship between leadership and politics is implicit rather than explicit (Kets de Vries, 1990). Leadership, from the old English laeden, is to direct by going forward, and occurs at a minimum of two levels, the conscious and the unconscious, requiring an interaction between the two levels. Leadership at one level requires decisions and actions based on strategy, to
achieve desired results. At the unconscious level, where dreams, emotions and subconscious states such as elation, depression and fear occur, another type of leadership is required.

A major conceptual distinction in leadership types is between transformational and transactional types (Burns, 1978). Another key concept is the legitimacy to lead (Walters, 1999: 27), which can also be seen from the obverse face as leadership without authority (Heifetz, 1994). These four concepts of leadership type--transformational, transactional, legitimate and non-legitimate--are of great value in understanding the roles of the two types of leadership shown in the matter of Australia's treatment of its asylum seekers.

The asylum seeker debate can be interpreted as a struggle for leadership. The Prime Minister of Australia, Mr Howard, and his government, have effectively demonstrated transactional leadership by offering the Australian people security from their fear of the perceived threat of terrorism, drug importation, disease and cruelty (such as alleged infanticide by throwing off boats). The Australian people have accepted this transaction, with the aid of extensive collective doubling, which has made it possible for a country which sees itself as warm and caring, to embrace at the same time cruelty and mistreatment towards adults and children. The process of psychic numbing has made possible the denial of all evidence of collective depression and other suffering. At the same time, there is evidence of selective acceptance by the Australian government of the existence of a collective mental state of fear and depression. 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.

In contrast, there is another contender for leadership, this time by a group officially representing a profession which is itself deeply divided over philosophical issues and tainted by past behaviour of tragic nature. The psychiatrists of Australia are claiming collective leadership in their appeals to the Australian community to recognize and rectify the mistreatment of adults and children by government acting in their name. This leadership is transformational, in that it seeks to transform Australia from one kind of community into another, but their actions have provoked internal tensions.

Both leadership contenders, the transactional political leadership of Australia, and the transformational leadership of the Australian psychiatric profession, are in contest, seeking to undermine the legitimacy to lead of each other, either as moral legitimacy or as scientific, philosophical and professional legitimacy. That this leadership contest is necessary is a result of dislocations and fragmentations in Australia's past.

References


Senate (Parliament of Australia), 2005. *Senate Select Committee for an enquiry into a certain maritime incident*.


