CORE
Metadata, citation and similar papers at core.ac.uk
Provided by Sydney eScholarship

This is the Accepted Manuscript of an article published in [Health and History]. Available online at http://www.jstor.org/stable/10.5401/healthhist.18.2.0099?seq=1#page_scan_tab_contents

Self-archived in the Sydney eScholarship Repository by the Centre for Values, Ethics and the Law in Medicine (VELiM), University of Sydney, Australia

Please cite as:

Robertson M, Light E, Lipworth W, Walter G. The Contemporary Significance of the Holocaust for Australian Psychiatry. Health and History, 18(2), 99-120. doi:10.5401/healthhist.18.2.0099.

The contemporary significance of the Holocaust for Australian Psychiatry

Robertson M, Light E, Lipworth W, Walter G. (2016)

Primary author: Michael Robertson[1,2], Centre for Values, Ethics and the Law in Medicine, Medical Foundation Building (K25), University of Sydney NSW 2006, michael.robertson@sydney.edu.au, +61 434 952 988

Co-Authors:
Edwina Light[1,2]
Wendy Lipworth[1]
Garry Walter[1,2,3]

Institutional Affiliations

1. Centre for Values, Ethics and the Law in Medicine, School of Public Health, University of Sydney
2. Sydney Jewish Museum
3. Discipline of Psychiatry – Sydney Medical School

Abstract
In this paper we survey briefly the components of the Holocaust directly relevant to the psychiatric profession and identify the main themes of relevance to contemporary psychiatry. The euthanasia program, the persecution of lesbian, gay, bisexual, transgender and intersex (LGBTI) citizens and the complex relationship between the psychiatric profession and Nazi state are the main themes to emerge from this survey. We then compare this period with key themes in the history of Australian psychiatry and link these themes to some of the contemporary ethical challenges the profession faces.

Part 1 – German Psychiatry and the Holocaust

German psychiatry until 1945

Throughout the nineteenth century, German Romanticism dominated the psychiatric profession, although there was a split between those who viewed mental illness as a disease of the soul (*Psychiker)* and those who saw it as a biological phenomenon (*Somatiker*). Arguably, there were two totemic figures in German psychiatry before 1933 – Emil Kraepelin

and Sigmund Freud. Kraepelin's legacy is ostensibly more profound for present-day clinical psychiatry through the various versions of the Diagnostic and Statistical Manual of Mental Disorders[1], although Freud's is better known. Kraepelin's project spanned many lines of enquiry, from classification of psychiatric disorders to biological psychiatry. Towards the end of his career, Kraepelin was drawn to the tenets of social Darwinism, eugenics and racial hygiene. In particular, he was concerned that, by allowing people with intellectual, physical and mental disorders to reproduce, society had gone against natural selection and permitted dysfunctional genetic traits to flourish. As noted by Brüne, Kraepelin was deeply concerned by the number of people with physical, intellectual and psychiatric disabilities reproducing. [2] Kraepelin's acolyte, the Swiss-born psychiatrist Ernst Rüdin, developed these ideas further and ensured that this aspect of Kraepelin's legacy became the dominant paradigm in interwar German psychiatry,[3] ultimately placing Kraepelin's ideas at the service of the National Socialists.[4]

After the assumption of power by the National Socialists in 1933, the entire German population, including the professions, were subject to a process of alignment to the values of the regime.[5] In the case of the medical profession, this alignment (referred to as '*Gleichshaltung')* was orientated around notions of public health and hygiene.[6] Around 50% of German physicians joined the Nazi party, the SS or the National Socialist Doctors Society before the war,[7] and psychiatrists were among the most enthusiastic participants in the Nazi war effort. Many theories have been advanced as to why this was so, including political, economic, ideological, and situational reasons, together with greed and opportunism, and institutional loyalty.[8,9] Perhaps most significantly, psychiatrists were actively involved in the Holocaust, and the remainder of our discussion will focus on this aspect of their involvement in National Socialism.

The meaning of "Holocaust"

For the purposes of this discussion, it is important to define the term 'Holocaust'. The term originated in the thirteenth century, when it was used to denote a 'burnt offering'.[1] The use of the term to define the attempted genocide of European Jewry in the twentieth century is a recent phenomenon, largely attributable to the advocacy of Auschwitz survivor Elie Wiesel, who saw the attempted annihilation of Europe's Jews as a modern incarnation of the sacrificial Biblical figure, Isaac.[10] The full recognition of the suffering of Europe's Jews under the Nazi occupation began to enter collective awareness at the time of the trial of war criminal Adolf Eichmann in 1962. The fate of European Jews under Nazi rule was more fully acknowledged in Western culture from the 1970s, arguably following the release of the graphic and confronting documentary 'The Eighty First Blow' in Israel in 1974 and the TV mini-series 'Holocaust' in the United States (1978) and West Germany (1979).[11] Traditional consideration of the victims of National Socialism included all groups in the concentration camp system, 'only' 10% of whom were Jewish prisoners.[12] Debates over whether or not the use of the term 'Holocaust' should be used to define the persecution by the Nazi regime of all victim groups subsequently became acrimonious and fouled irrevocably the relationship between Wiesel and the equally prominent Holocaust survivor Simon Wiesenthal[13].

Philosopher Zygmunt Bauman's landmark work *Modernity and the Holocaust* (1989)[14] provides us with an approach to this problem of language for the purposes of this discussion. Bauman argued that the Holocaust was both an iconic and central moment in Jewish History and identity, and at the same time the manifestation of a moral failure that exists in modernity more generally. The manner of the systemic elimination of the Jews

[1] The Hebrew term "Shoah" (destruction) was used in some settings during the actual persecution.

utilising technology, science, industry, economics and bureaucracy represented to Bauman a critique of modernity, and the potential that remains in the culture. It is this latter formulation that forms the basis of our use of the term 'Holocaust' and the significance we place upon it in our analysis of the relevance of this period to the Australian psychiatric profession.

A brief history of psychiatry in the Holocaust

Psychiatrists perpetrated egregious crimes under the National Socialist regime in the context of the so-called 'euthanasia program'[15], also referred to in Germany and Austria as '*Krankenmorde'* (the murder of the sick). The history of this period has been extensively narrated in both the English and German literature, and readers are directed to the many excellent historical and theoretical accounts.[15-18] The process that culminated in the murder of hundreds of thousands of Germans with psychiatric, intellectual and physical disabilities began with the 1933 passage of *Law for Prevention of Hereditary Diseased Offspring.* The Law established several hundred 'Hereditary Health Courts' which enforced the sterilisation of adults of child-rearing age deemed by their doctors as having '*Erbkranken*' (hereditary diseases). There followed the murder by overdose of disabled children in various *'Kinderfachabteilung*' (children's wards). The successful experiments with a carbon monoxide gas chamber at Fort VII in Posen (modern day Poznań in western Poland) enabled the centralised process of mass murder of those deemed 'life unworthy of life'. The documentation of victims and the coordination of transportation to a network of dedicated killing centres equipped with carbon monoxide gas chambers throughout Germany and Austria was organised from an address in Berlin, *Tiergartenstraße* 4. This secretive operation was code named '*Aktion* T4'. By late summer 1941, growing public awareness and discontent with the program prompted Hitler to order Aktion T4 to end. However, many German psychiatrists continued to murder patients by deliberate overdose or starvation in a process termed '*wilde Euthanasie'* (decentralised euthanasia)[19]. Many asylum patients were also killed by SS and Wehrmacht soldiers in occupied territories. Not counting the sporadic murder of asylum patients in Nazi-occupied Europe, around 200,000 people with disabilities were killed by the National Socialist regime.

A number of the psychiatrists involved in Aktion T4 later participated in the coordinated killing of sick prisoners in the concentration camp system ('Aktion14f13*')* or the extermination of Europe's Jews and other victims ('Aktion Reinhard'*)*. They also propagated the values of the Nazi state in the so-called 'Göring Institutes' of psychotherapy[20], played key roles in the function of the German military,[21] and participated in the persecution of homosexual victims of the regime.[22]

By regarding homosexuality as a disease,[23] German psychiatry enabled a process of social and political exclusion of this group of citizens on biomedical grounds. Under the *Gleichschaltung*, German medicince repudiated entirely the discipline of sexology, in particular the work of German Jewish physician Dr Magnus Hirschfeld's *Institut für Sexualwissenschaft*, with its focus on homosexual and transgendered patients.[24] Homophobic laws in Germany predated the Nazi Period and were not the prerogative of a particular side of Weimar politics.[25] The persecution of LGBTI people in the Nazi regime was based on draconian extensions of existing laws, although some men were castrated under the 1933 *Law for Prevention of Hereditary Diseased Offspring.*[26] Many LGBTI people were sent to concentration camps – such as Sachsenhausen, Buchenwald or Flössenburg – where they were considered as the lower status of prisoner by both the SS guards and other prisoners[27] and subject to unconsented experimentation to 'treat' their homosexuality.[28]

Part 2 – Australian Psychiatry

Australian psychiatry until 1945

From the mid-1800s until the mid twentieth century, Australian psychiatry existed primarily as an extension of British psychiatry.[29] A local association of psychiatrists did not emerge until 1946 and a specialist college, the Australian and New Zealand College of Psychiatrists ("Royal" was added later) was incorporated only in 1963.

Until the 1950s, psychiatry in Australia was influenced explicitly and implicitly on a principle of alienism. The essence of alienism was attributing an extreme form of "otherness" to people with mental illnesses, manifesting in social exclusion and institutional incarceration. Manning had sought to soften this approach in his reforms. Like many other medical disciplines, psychiatry focused on the hygiene of the European settlement in Australia, which had significant implications for both indigenous and immigrant populations,[30] including their marginalisation and exclusion. In the case of some parts of Aboriginal civilisation, these occurred against the background of attempts at eliminative genocide.[31]

In 1843, the *Dangerous Lunatics Act* was passed in NSW, and similar laws followed in different Australian colonies.[2] In the colonies, asylums were redolent of gaols[32], resembling their counterparts in the northern hemisphere, which predominately functioned as sites of incarceration, seclusion and physical restraint. Australian asylums only evolved into therapeutic institutions in the late nineteenth century under the influence of émigré English pioneer psychiatrists, most notably Dr Frederick Norton Manning, Inspector-General of the Insane in New South Wales. Apart from institutional reforms, Manning was among the first to note the implications of European settlement on the mental health of indigenous Australians.[33]

Following the influx of a large number of Chinese workers to the colonies in the late nineteenth century, the presence of a growing Chinese asylum population raised anxiety within the white community—in particular the fear of importing madness, criminality and heredity deficiency.[34] Coleborne and McKinnon have argued that asylum annual reports for Australia and New Zealand from the latter part of the nineteenth-century indicated Australian psychiatrists feared importing madness and mental deficiency into the colonies. [33] This anxiety yoked immigration and public policy with discourses of eugenics and mental hygiene. Following Federation, the 1901 *Immigration Restriction Act* ("White Australia policy") referred specifically to 'insanity' and 'mental defect'[35] as grounds for exclusion.

In the first half of the twentieth century, Australian psychiatrists, like their German and American colleagues, became actively involved in eugenic movements.[36] As the temporary capital of the Commonwealth, Melbourne was the epicenter of Australian eugenics.[37] Repeated attempts to introduce eugenic legislation ultimately led to the passage of the *Mental Deficiency Bill* in 1939 in Victoria. This law was similar to laws in Germany and the USA at the time, and included provisions for compulsory sterilisation of those thought to carry inferior genetic stock. A Commonwealth Survey of Mental Deficiency in 1928 recommended a program of mass sterilisation, which was perhaps only averted by the paralysing effects of the Great Depression on government policy.[38]
In the period of following the Second World War, Australian psychiatry's dominant paradigms in illness and treatment shifted under the influence of psychoanalytic thinking in

---

[2] This patchwork of mental health legislation has persisted and is evident in the variety of state and territory mental health laws in place today.

the 1950s, the social psychiatry movement and its emphasis on social environment and inequalities in the 1960s, and a re-balancing of biological and social determinist views of mental illness from the 1970s onwards.[39] The apparent 'success' of antipsychotic drugs, such as chlorpromazine, heralded an era of 'biological psychiatry'.[40]This modern era of psychiatric treatment in Australia emphasised biological and genetic models of illness and therapy. This period was characterised by a shift away from institutional to community mental health care.[41,42]

Scrutiny of deinstitutionalisation in Australia by a number of independent and parliamentary commissions of inquiry revealed major failures, due to the unsuccessful implementation of deinstitutionalisation and other mental health policies as well as instances of scandalous abuse and neglect of people living with mental illness. The Human Rights and Equal Opportunity Commission's National Inquiry into Human Rights of People with a Mental Illness (1990-1993) drew attention to earlier inquiries into allegations of cruelty and misconduct at psychiatric facilities in NSW, Queensland and Victoria and made its own findings that services for people living with mental illness were 'disgraceful'.[43] Although Australian Health Ministers committed to correct the 'decades of neglect in mental health' with the commencement in 1992 of a national mental health strategy,[44] subsequent independent and parliamentary inquiries found ongoing mental health system failings and mistreatment and neglect of people living with mental illnesses.[44-46]

People living with severe and persistent mental illnesses continue to face significant challenges. People with a severe and enduring mental illness are often isolated by the symptoms of their illness,[47] confront stigma and discrimination,[47,48] homelessness, neglect, isolation, poverty, unemployment or underemployment, and violent victimisation.[47,49-51] Only a third of this group access the mental health care they need.[52] In the homeless population in Australia, around 75% have a mental illness.[53] As with the broader population of people with mental illness, only a small proportion of people with intellectual disabilities are able access the mental health care they need.[54] In addition, people with intellectual and psychiatric disability are amongst the most vulnerable to physical and sexual abuse in the community.[55]

A 2015 Senate inquiry found that violence, abuse and neglect of people with psychiatric disability 'is both widespread and takes many forms', reporting that a root cause begins with the de-valuing of people with disability.[56] This devaluing, it was argued, 'permeates the attitudes of individual disability workers, service delivery organisations and, most disturbingly, government systems designed to protect the rights of individuals' (page xxvi).[56] The inquiry also drew attention to instances where, 'under the guise of 'therapeutic treatment', people with disability can be subjected to forcible actions that could be considered assault in any other context. They are often detained arbitrarily and indefinitely, sometimes being held in prisons without being convicted of any offence'.[56] Nearly half of the prison population have mental health problems, and around 20% of prisoners taken into custody are taking prescribed psychotropic medication.[57] The recent work of Baldry and colleagues draws attention to the fact that 'thousands of people with mental and cognitive disability are being "managed" by [Australian] criminal justice systems rather than being supported in the community, a disproportionate number of them Indigenous' (page 19).[58] Due to co-morbid physical illness, the life expectancy of people with severe and persistent mental illness is shorter compared to the general population.[59,60] Nearly 80% of men and women with serious mental illness who die before average life expectancies do so due to physical health conditions, losing anywhere between 10 and 36 years of expected life[61], creating a situation of what one advocate described as a form of 'creeping euthanasia'.[62]

The RANZCP has tasked itself with advocacy for appropriate mental health services and continued engagement in questions of ethical practice and human rights.[63] It is reasonable to conclude that the gross social exclusion, disadvantage and adversity faced by people living with severe and persistent mental illness is an ongoing challenge for Australian psychiatry.
Against the backdrop of this general evolution of Australian psychiatry, specific groups have been of particular interest to the psychiatric profession, most notably Indigenous Australians, people living with disabilities in Australia, Lesbian, gay, bisexual, transgender and intersex (LGBTI) people, and asylum seekers in the first decades of the twenty-first century. In the remainder of our survey of Australian psychiatric history, we will focus on four key themes – the traumatic displacement and attempted genocide of Aboriginal Australia, the challenges facing people living with disabilities in Australia, the treatment of LGBTI people, and the difficulties of working under public policies affecting asylum seekers in the first decades of the twenty-first century.

Australian psychiatry and the indigenous population

Australian psychiatry's engagement with Aboriginal Australia was limited until the arrival of Norton Manning in the late nineteenth century. Manning noted that among the small number of predominately male Aboriginal patients in asylums, the dominant theme in their clinical presentations was 'the loss of contact with their tribes, and their closer proximity to European modes of social control, including police, through the effects of legislation "protecting" Aboriginal people and separating them from whites in designated mission stations' (p373).[33] This was not surprising given that a dominant theme in the Aboriginal experience of white European colonisation had been forced displacement from traditional lands, which had catastrophic consequences for Aboriginal civilization.[64] The pretext of the forced dispossession was the impression that the Aboriginal people were not utilising their land for agriculture, and that their 'perceived inability to value the land and mix their labour with the soil … put them beyond civilization' (p 252).[65] Dispossession was the first of two phases of the putative genocide of Aboriginal Australia, followed by the 'cleansing' or obliteration of those remaining.[66]

Two world wars and an economic depression disrupted psychiatry's already limited interest in Aboriginal Australia until the 1950s, when NSW psychiatrist John Cawte began his landmark work,[67,68] in which he further developed Manning's observations about the effects of cultural alienation on Aboriginal patients. Cawte noted that many such patients in asylums, diagnosed with severe mental illness, were likely demonstrating the psychological consequences of cultural forced integration with white Australia and loss of connection with traditional Aboriginal culture and their interpersonal networks.[67,69]

While Cawte's *ouvre* developed over many decades, it remained obscure in mainstream psychiatric discourse, perhaps paralleling the general lack of interest shown by Australian society to Aboriginal affairs until the post-Whitlam era in the 1970's. Indeed, only in the 1990s did Australian psychiatry become actively engaged in the specific enterprise of indigenous mental health . The legacy of Cawte's work was realised by the subsequent work of many of his mentees within the profession.

Since the 1990s there has been progress in the field of indigenous mental health. The area is now a substantive component of psychiatric training in Australia and New Zealand, and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) has been vocal in a sophisticated and non-partisan way in attempting to promote the field, disseminate the necessary skills and knowledge among its members[70] and influence public policy.[71]

Australian psychiatry and contemporary immigration dilemmas

In 1938, the Intergovernmental Committee on Refugees (Evian conference) convened to address the international response to the migration crisis posed by Jewish people fleeing Germany after the Kristallnacht pogrom. Australia's delegate, Federal Minister for Trade and Customs Thomas White, argued that Australia's immigration rate was comparable to that of any other nation. He argued that Australia's reluctance to accept Jewish refugees on a large-scale arose from the fear of importing of 'foreigners' and racial problems.[72] White's remarks are depicted at the Yad Vashem Holocaust memorial as the symbol of the world's indifference to the unfolding disaster facing Europe's Jews. Historian Suzanne Rutland points out that, even following the revelation of the full scale of the Holocaust, the Australian Consul in Shanghai highlighted that Australia had no interest in a further influx of Jewish Refugees, issuing only a few visas as a token gesture.[73]

These openly racist and xenophobic sentiments persisted until the process of dismantling the 'white Australia policy' unfolded from the mid-1960s through to its final abandonment by the Whitlam government in 1973. With the exception of the policy of allowing in non-Anglo-Celtic skilled migrants from southern Europe to work on the Snowy Mountains Hydro-electric Scheme in the 1950s, the first waves of non-White migrants, from Vietnam, Cambodian, Timor and other sites of geo-political turmoil, only began to arrive from the mid-1970s onwards. In general, the recent experience of migration from South East Asia has been considered successful, the foundation of what many argue is a generally well-structured immigration policy.[74] However, the collapse of world order in the late twentieth and earlier twenty-first centuries, particularly in the Middle East, has created a global refugee problem rivaling that of the 1930s in Europe and has raised questions about whether Australia's immigration policy is, in fact, as well-structured as previously thought.

In this regard, it is noteworthy that, in 1992, the Keating government introduced the *Australian Migration Act* which directed the mandatory detention of asylum seekers. The initial legislation within the *Australian Migration Act* disallowed judicial review of detention—a violation of human rights that was allegedly balanced by having a 273-day limit on detention. By 1994 the time limit had been removed. The Howard government brought in further changes to the legislation in 2001, designed both to excise Australian migration zones and to escalate the deterrent effect of indefinite mandatory detention through the designation of several offshore detention sites in the Pacific. This so-called Pacific Solution proved popular with the electorate[75] but has also raised profound questions about Australia's commitment to human rights. Writing as a prisoner in the Manus Island detention centre, Kurdish journalist Behrouz Boochani wrote of camp life in a manner that is reminiscent of Primo Levi's notion of the 'spiritual shipwreck' outlined in *Se questo è un uomo:*[76]

> We still have to live tomorrow but life in Manus prison is limited to the constant repetition of the past three years. Repetition of nightmares, repetition of agonies, vain hopes, little happiness and the repetition of conversations with no novelty. Further away, a skinny man, while leaning his back against a coconut tree in an outlying corner, deeply smokes, deeply suffers and deeply lives.[77]

In addition to highlighting major problems with Australia's immigration policies, the twenty-first century refugee crisis has also brought the Australian psychiatric profession into an uneasy proximity with the dilemmas arising from immigration. In questioning whether it should collude with a xenophobic immigration policy qua alienists, the Australian psychiatric

profession faces a moral dilemma that questions the very foundation of the professional social contract.

Psychiatrists have long recognised the plight of refugees when it comes to mental health. Along with the Vietnam War, the experience of the Holocaust resuscitated discourses of traumatic stress as a factor in mental health and mental illness.[78] Psychiatric disorders were described in Holocaust survivors,[79] although these were neither inevitable nor uniform in nature.[80] Building on these observations of the mental health problems of those fleeing or surviving persecution, Australian psychiatrists are currently acutely aware that Australia's policies of indefinite or open ended detention and uncertainty over current and future statelessness are profoundly injurious to mental health.[81-83] In February 2012, the RANZCP provided a series of recommendations that asserted that the detention of children was a human rights violation, that detention should not be conducted off-shore, that asylum claims should be processed promptly, and that specialised mental health services should be provided for asylum seekers.[84] Four years later, the RANZCP released guidelines for clinicians working in the detention centres, advocating principles of 'proper use of professional knowledge and skills', responsibility to the patient, clinical independence, advocacy, and confidentiality.[85]

This turn of events seems to have reversed much of the alienism that characterized Australian psychiatry in the twentieth century. What is perhaps most significant about the RANZCP's approach to the asylum seeker issue was that it located the profession as an independent social actor, with an independent voice, instead of as an agent of the state. Indeed, the conduct of the RANZCP over the public policy dilemmas of contemporary immigration policy has placed it, in some respects, in direct conflict with the state. As Dudley has highlighted, the historical parallels with the National Socialist period is evident,[86] and arguments about the moral resemblance of Australian medical profession compliance with asylum seeker policy and collusion of German doctors with Nazis have appeared in the Australian psychiatric literature.[86]

Australian psychiatry and the LGBTI community

> homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function, produced by a certain arrest of sexual development (Freud, 1935)[∞]

The first medicalised accounts of sexual 'deviance', and in particular homosexuality and transgender, are attributed to the work of English physician Havelock Ellis in the Nineteenth Century,[87] although there is some evidence of earlier discourses on the pathology of sexuality.[88] Since Ellis's time, psychiatry, particularly British psychiatry in the late nineteenth and early twentieth centuries, colluded with this view.[89] Numerous, ultimately flawed attempts at biological[90] and psychoanalytic[91] explanations of the 'disease' of homosexuality followed. In the final analysis, these represented a means of exclusion of a particular group through a medical discourse, comparable to discourses in eugenics, racial hygiene or alienism. Until 1973, when the American Psychiatric Association voted on the issue, 'homosexuality' was considered a mental illness in the United States, Britain and elsewhere.[92] King and Bartlett observed of the British profession that although many professionals may have been well intentioned in helping a disadvantaged group of patients towards what they regarded as a better adjustment to life, very few seem to have later questioned the wisdom of their work noting few psychiatrists had repented[89].

[∞] Freud, S. (1935) Anonymous (letter to an American mother). Reprinted in *The Letters of Sigmund Freud* (ed. E. Freud), 1960. New York: Basic Books.

Australian psychiatry followed British psychiatry in its approach to LGBTI patients, and the contemporary Australian psychiatric profession remains, arguably, unengaged in this regard.[93] In the early 2000s, eminent Australian jurist Michael Kirby reflected on this history on the then 30th anniversary of the American Psychiatric Association's demedicalization of homosexuality in the psychiatric literature.[92,94,95] Kirby paid particular attention to the work of Australian psychiatrist Neil McConaghy, who had offered and researched aversive therapy 'treatments' for homosexual men in the 1970s.[96] In his response to Kirby, McConaghy argued that the men seeking treatment had been genuinely distressed by their sexual orientation as it was then framed by the socio-cultural context, and that it was society that had been ultimately in need of treatment.[97] In 2015 the RANZCP stated publicly its repudiation of 'Sexual Orientation Change Efforts' and asserted its position on the rights of LGBTI community members[98]. The RANZCP has, on occasion, also distanced itself from organisations with an arguably homophobic agenda, such as 'Doctors for the Family', of which some RANZCP Fellows have been members.[99]

Despite these efforts on the part of the RANZCP, it is evident that both homophobic and transphobic attitudes persist in contemporary mental health professions,[100,101] and excess psychiatric morbidity within the LGBTI community remains a major concern.[102] Compared to the sophisticated engagement of the Australian psychiatric profession with other disadvantaged groups, this arguably represents a major failing, and one which may be linked to the ambivalence of the broader Australian community to the LGBTI community. It cannot be persuasively argued that the RANZCP failed to engage with its troubled history with this group, or to respond to particularly egregious statements that have implications for the profession. However, compared to efforts at service delivery and public advocacy on behalf of other groups such as xxx, the RANZCP has been somewhat sedate on the issue of LGBTI patients. As the public discourse in Australia on questions of marriage equality has become increasingly febrile, particularly from the political right and sections of the media sympathetic to Conservative views on social equality, this is emerging as a challenge for the RANZCP.

Part 3 - The contemporary relevance of the Holocaust to Australian psychiatry

In the previous sections, we provided parallel narratives of the Australian and German psychiatric professions. In this section, we will consider the ways in which an understanding of the history of German psychiatry—particularly during the Holocaust—can shed light on the four themes we saw as most significant for the contemporary psychiatric profession in Australia: its engagement with indigenous Australia, the LGBTI and refugee populations, and the more general gross social deprivation faced by people living with severe and persistent mental illness

If one accepts the premise that the Holocaust represented the greatest moral crisis in the history of Western culture, then it behooves us to both explore the historical significance of this event to Australian psychiatry and to interrogate the parallels with the psychiatric profession in Germany at that time. Rather than argue that the moral psychology of contemporary Australian psychiatrists is analogous to that of the their National Socialist counterparts, we will argue that both Australian psychiatric ethics and National Socialist psychiatric ethics can be understood as manifestations of a 'contractarian professional ethics', which assumes the existence of a social contract between a profession and society

or the state. A profession is a group possessed of a particular expertise and set of skills that are privileged within the community in exchange for the beneficent application of their craft.[103,104] This represents a social contract of sorts. The notion of a professional social contract brings to the fore the close relationship between political, cultural and historical context of any profession, and its ethics.

Some of the most fundamental dilemmas in the history of medical ethics have emerged when the concept of the greater good has been used to justify public policy that is persecutory or destructive to a particular group.[105] As argued elsewhere,[106] most dilemmas in psychiatric ethics can be argued to be manifestations of the 'dual role dilemma' –the concept of professional ethics constantly challenges psychiatrists to weigh the common good against the good of the individual patient. In the remainder of our analysis, we will reframe other aspects of the history of Australian psychiatry in terms of the dual role dilemma in the light of the Holocaust, and, where relevant, make note of the contemporary significance of our analysis.

Like many first nation peoples, Aboriginal Australia's experience of European colonisation was of traumatic dispossession of traditional lands and decimation of culture and identity. John Cawte's original work on indigenous mental health in many ways parallels that of Franz Fanon in post-colonial Algeria and enables understanding of the process of colonization. In Fanon's core thesis, psychiatric power denies the colonized their identity and legitimacy of their culture through the prism of psychiatric power and the medicalized 'Otherness' forced upon them. Fanon utilized Lacan's notion of *'*méconnaissance',[107] to argue that psychiatric power, as an extension of colonial power, alienates and weakens the colonized by forcing their constant questioning of 'Who am I?'. Fanon ultimately argued that psychiatry in Algeria was Eurocentric and contributed to institutionalized racism.[108] Beyond Fanon, Littlewood has averred that 'racism and psychiatry have developed as particularly White cultural and political enterprises'.[109] It is argued that in present day psychiatric practice, over-diagnosis of mental illness, and higher levels of coercion and medicating of ethnic and cultural 'Others' is an ongoing manifestation of institutionalized racism in the exercise of psychiatric power.[110] The institutionalisation of Aboriginal patients in asylums in Australia parallels the coercive exercise of psychiatric power by the coloniser over the colonised in all post-Colonial societies.

While dispossession and colonization obviously had profound existential and cultural effects on Aboriginal civilization,[64] the question of 'genocide' in discussing the history of Aboriginal Australia (as against massacre) is as contentious a use of the term as it is in the context of the Armenian genocide. In this regard, it is significant that Australia, like many countries confronting genocidal narratives, lacks an equivalent of modern Germany's 'Aufarbeitung der Vergangenheit,' literally 'working the past'.[111] Australian Holocaust scholar Colin Tatz argues there are many parallels between the Holocaust and the plight of Aboriginal Australia after the arrival of Europeans, including aspirations of ethnic cleansing and a form of racism manifest in an attempt at eliminative genocide.[31] Kiernan has described several common themes in history's genocides. On the specific question of the Aboriginal experience, he argues that the state's efforts at exterminating or 'breeding out' the indigenous population arose from an obsession with agricultural land. This had been argued as being a clear parallel to the attempted extermination of Europe's Jews by the Nazis and their collaborators.[66] Australian society and political discourse remains polarised on questions of Aboriginal history, with the political far right arguing for repudiation of any notion of genocide in Australian history, the so-called 'black armband view' of Australian history.[112] While Australian psychiatry has made great progress in indigenous mental health, it is best placed

in its ongoing engagement with the area by reflecting constantly on this aspect of its history with Aboriginal Australia.

By contrast, the Australian psychiatry's history with the LGBTI community is, arguably, less evolved. The RANZCP's acknowledgement and repudiation of previous abuses of LGBTI patients by the psychiatric profession is recent, despite the fact that the challenge of social inequality faced by LGBTI people remains a major determinant of the mental health of this part of the community. As we have noted, LGBTI people encounter stigma within the health system and lack access to mental health care sensitive to their particular needs. In general, there is broad support in the Australian community for social equality for LGBTI people,[113] yet the political class are significantly divided on LGBTI rights, particularly marriage equality and culturally sensitive education programs in schools. Within this complex sociocultural environment, the RANZCP needs to balance the need for advocacy for this group and their particular needs, while not politicising the profession and entering a partisan social and political debate.

The social adversity faced by people living with intellectual, physical or psychiatric disability (often in combination) is in large measure a product of social policy failure under the influence of neo-liberal economic influences. As has been argued elsewhere,[114] neoliberalism is a pervasive moral and economic philosophy that now dominates post-industrial Western cultures, yet is insensitive to the needs of people with enduring disabilities, particularly psychiatric disabilities. Neoliberal influence introduces a primarily economic framing of questions of social justice, arguing for a form of indifference on the part of the state in lieu of the notion of individual responsibility. The result has seen the kind of social deprivation that has resulted in a person with schizophrenia in 2016 having a comparable life expectancy to someone born in 1901.[115] While it is inappropriate to compare the abjection of patient languishing in an asylum in Nazi Germany with a person with schizophrenia languishing on the street in a major Australian city, the critical consideration is the commonality of economic forces influencing the health of people living with disabilities. In particular, the issue of advocacy for and against public policies that may disadvantage those with serious and persistent disabilities – in areas such as welfare and health and social service funding – places psychiatrists potentially at odds with the state and in a tension with their contractarian ethics. The Holocaust provides Australian psychiatrists a clear picture of the endgame of indulging a purely economic consideration of the plight of people living with severe disabilities.

The lessons of the Holocaust are perhaps most vividly evident in the challenges Australian psychiatrists face today in dealing with asylum seekers in detention facilities, particularly those located offshore. To any observer, vulnerable adults placed in such camps is abhorrent and inconsistent with the values of an enlightened civil society. Published research indicates that about a third of the electorate support harsh policies towards asylum seekers with a fifth opposed, and the remainder indifferent.[116] Asylum seeker policy debates have dominated Australian politics since 2000 and the political class has drifted to a hard right-wing position on the topic of 'border protection'. In this regard, Australia seems to be revisiting its xenophobic past, and this represents one of the most significant instances of the overt exclusion of a group in Australian post war history.

Australian psychiatrists have been brought into this situation both through direct clinical involvement with asylum seekers in detention settings and in their contributions to public discourse over public policy. The Australian Human Rights Commission explicitly advocates that the specific needs of children in detention centres be addressed (and ideally removed

from these settings to the community), that asylum claims be processed promptly and the off-shore detention centres be closed.[117,118] There has emerged an extensive body of literature in Australian psychiatry in this area, offering clear moral arguments in direct opposition to such policies.[119] Psychiatrists have also emphasised their obligation to advocate and participate in public debate,[120] and have argued for the need for public reporting of health data of asylum seekers in detention to inform public debate.[86,121] In some circumstances, this may involve 'subversive research' that is conducted without oversight that may identify the psychiatric impact of these immigration policies,[122] although this particular approach does not have the sanction of the Australian psychiatric profession.[123]

In this context, Australian psychiatry has perhaps drawn the most explicit lessons from the Holocaust. Comparisons of 'detainees' in offshore detention centres and prisoners in Nazi concentration camps are inflammatory. However, in taking a stand on behalf of this group in the face of public policy that 80% of the Australian population either supports or is unmoved by, the Australian psychiatric profession seems to be doing what Nazi psychiatrists could (or would) not do This places Australian psychiatrists at odds with both public policy and public sentiment. Under the *Australian Border Force Act*,[124] it is illegal to speak out against conditions in Australian run detention facilities and there have been several instances of medical practitioners acting, quite publically, in contravention of this law. While psychiatrists who choose to breach what many regard as an unjust law do not face the same risk as a psychiatrist in Nazi Germany speaking out against the T4 program, the perceived need to sometimes act unlawfully in response to what is unethical appears to be a key lesson of the Holocaust. It was left to the Catholic Church among others to foment opposition to the T4 program in National Socialist Germany, forcing the murder of the disabled further underground. The opposition of more German psychiatrists may have prevented many more deaths. Perhaps Australian psychiatrists have heeded this lesson?

References

1. Decker H. How Kraepelinian was Kraepelin? How Kraepelinian are the neo-Kraepelinians?—from Emil Kraepelin to DSM-III *History of Psychiatry* 2007; **18**: 337360.

2. Brüne M. On human self-domestication, psychiatry, and eugenics. *Philosophy, Ethics, and Humanities in Medicine* 2007; **2**.

3. Weber M. Ernst Rüdin, 1874-1952: A German psychiatrist and geneticist. *American Journal of Medical Genetics* 1996; **67**: 323-31.

4. Engstrom E, Weber M, Burgmair W. Emil Wilhelm Magnus Georg Kraepelin (1856-1926). *The American Journal of Psychiatry* 2006; **163**: 1710.

5. Koonz C. The Nazi Conscience. Cambridge, Mass: Bellknap; 2003.

6. Lifton R. The Nazi Doctors: Medical Killing and the Psychology of Genocide. New York: Basic Books; 2000.

7. Haque O, De Freitas J, Viani I, Niederschulte B, Bursztajn H. Why did so many German doctors join the Nazi Party early? *Int J Law Psychiatry* 2012; **35**: 473-9.

8. Freidlander H. Physicians as killers in Nazi Germany. In: Nicosia F, Huener J, eds. Medicine and Medical Ethics in Nazi Germany. New York: Berghahn Books; 2002: 59-76.

9. Dudley M, Gale F. Psychiatrists as a moral community? Psychiatry under the Nazis and its contemporary relevance. *The Australian and New Zealand journal of psychiatry* 2002; **36**(5): 585-94.

10. Garber Z, Zuckerman B. Double Takes: Thinking and Rethinking Issues of Modern Judaism in Ancient Contexts. Lanham, MD: University Press of America, Inc; 2004.

11. Magilow D, Silverman L. Holocaust Representations in History: An Introduction. New York: Bloomsbury; 2015.

12. Wachsmann N. KL - A History of the Nazi Concentration Camps. London: Little Brown; 2015.

13. Spurlin W, . Lost Intimacies: Rethinking Homosexuality under National Socialism. New York: Peter Lang Publishing; 2009.

14. Bauman Z. Modernity and The Holocaust. Ithaca, N.Y: Cornell University Press; 1989.

15. Freidlander H. The Origins of Nazi Genocide: From Euthanasia to the Final Solution Chapel Hill: University of Noth Carolina Press; 1995.

16. Klee E. "Euthanasie" im NS-Staat: Die "Vernichtung lebensunwerten Lebens". Frankfurt-am-Main: S. Fischer Verlag; 1983.

17. Lifton R. *The Nazi Doctors*. New York: Basic Books; 1986.

18. Burleigh M. Death and Deliverance - euthanasia in Germany 1900-1945. London: Pan; 2002.

19. Schmidt G. Selektion in der Heilanstalt, 1939-1945 - 2nd Ed. Frankfurt-am-Main: Edition Suhrkamp; 1983.

20. Cocks G. Psychotherapy in the Third Reich: The Göring Institute. New York: Oxford; 1997.

21. Reidesser P, Verderber A. Aufrüstung der Seelen. Militärpsychiatrie und Militärpsychologie in Deutschland und Amerika Freiburg im Breisgau Dreisam; 1985.

22. Oosterhuis H. Medicine, Male Bonding and Homosexuality in Nazi Germany. *Journal of Contemporary History* 1997; **32**(2): 187-205.

23. Mildenberger F. Kraepelin and the 'urnings': male homosexuality in psychiatric discourse. *History of psychiatry* 2007; **18**(71 Pt 3): 321-35.

24. Haeberle EJ. Swastika, Pink Triangle and Yellow Star: The Destruction of Sexology and the Persecution of Homosexuals in Nazi Germany. *The Journal of Sex Research* 1981; **17**(3): 270-87.

25. Herzer M. Communists, Social Democrats, and the Homosexual Movement in the Weimar Republic. *Journal of Homosexuality* 1995; **29**(2-3): 197-226.

26. Giles GJ. 'The Most Unkindest Cut of All': Castration, Homosexuality and Nazi Justice. *Journal of Contemporary History* 1992; **27**(1): 41-61.

27. Lautmann R. The Pink Triangle. *Journal of Homosexuality* 1981; **6**(1-2): 141-60.

28. Röll W. Homosexual Inmates in the Buchenwald Concentration Camp. *Journal of Homosexuality* 1996; **31**(4): 1-28.

29. Kirkby K. History of psychiatry in Australia, pre-1960. *History of Psychiatry* 1999; **10**: 191-204.

30. Anderson W. Postcolonial histories of medicine. In: Huisman F, Warner J, eds. Locating medical history: The stories and their meanings. Baltimore: Johns Hopkins University Press; 2004: 285–306.

31. Tatz C. Confronting Australian genocide. *Aboriginal history* 2001; **25**: 16-36.

32. Lewis M. Managing madness: Psychiatry and society in Australia 1788–1980. Canberra: Australian Government Publishing Service; 1988.

33. Coleborne C, MacKinnon D. Psychiatry and its institutions in Australia and New Zealand: An overview. *International Review of Psychiatry* 2006; **18**(4): 371-80.

34. Coleborne C. Making 'mad' populations in settler colonies: The work of law and medicine in the creation of the colonial asylum. In: Kirkby D, Coleborne C, eds. Law, history, colonialism: The reach of empire. New York: Manchester University Press.; 2001: 106–22.

35. Bashford A, Howard S. Immigration and health: Law and regulation in Australia, 1901–1958. *Health and history* 2004; **6**: 97-112.

36. Garton S. Medicine and madness: A social history of insanity in New South Wales 1880–1940. Sydney: UNSW Press; 1988.

37. Jones R. Eugenics in Australia: The secret of Melbourne's elite. 2011. http://theconversation.com/eugenics-in-australia-the-secret-of-melbournes-elite-3350 (accessed 22 February 2016).

38. Jones R. Removing Some of the Dust from the Wheels of Civilization: William Ernest Jones and the 1928 Commonwealth Survey of Mental Deficiency. *Australian historical studies* 2009; **40**(1): 63-78.

39. Acting Justice JP Slattery. Report of the Royal Commission into Deep Sleep Therapy. Sydney: New South Wales Royal Commission into Deep Sleep Therapy, 1990.

40. Ban TA. Fifty years of chlorpramazine: a historical perspective *Neuropsychiatric Disease and Treatment* 2007; **3**(4): 495-500.

41. Gray D. The social experience of health, illness and disability Frenchs Forest Pearson Education Australia; 2006.

42. Health Commission of New South Wales. Psychiatric Statistics: Part 1 Notes towards a history of public psychiatry in New South Wales. Sydney, 1979.

43. Burdekin B, Guilfoyle M, Hall D. Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness. Canberra: Human Rights and Equal Opportunity Commission 1993.

44. Groom G, Hickie I, Davenport T. Out of Hospital, Out of Mind! A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-2008. Canberra: Mental Health Council of Australia, 2003.

45. Senate Select Committee on Mental Health. A national approach to mental health - from crisis to community: First report. Canberra: Commonwealth of Australia; 2006.

46. National Mental Health Commission. Report of the National review of Mental Health Programmes and Services: Summary. Canberra: National Mental Health Commission, 2014.

47. Australian Institute of Health and Welfare. Australia's health 2014. Canberra AIHW, 2014.

48. Reavley N, Jorm A. Strengthening Community Understanding of Mental Health: A Literature Review: Melbourne School of Population and Global Health, University of Melbourne 2013.

49. Wilkinson J. The politics of risk and trust in mental health *Critical Quarterly* 2004; **46**(3): 82-102.

50. Choe JY, Teplin LA, Abram KM. Perpetration of violence, violent victimization, and severe mental illness: balancing public health concerns. *Psychiatric Services* 2008; **59**(2): 153-64.

51. Australian Institute of Health and Welfare. Mental health services in Australia. Canberra: AIHW, 2014.

52. Australian Bureau of Statistics (ABS). National Survey of Mental Health and Wellbeing: Summary of Results, Australia, 2007. Canberra: ABS, 2008.

53. Hodder T, Teesson M, Buhrich N. Down and Out in Sydney: Prevalence of Mental Disorders, Disability and Health Service Use among Homeless People in Inner Sydney. Sydney: Sydney City Mission, 1998.

54. AIHW. Access to health services by Australians with disability 2012. Canberra: AIHW, 2015.

55. Ammerman R, Hersen M, Van Hasselt V, McGonigle J, Lubetsky M. Abuse and neglect in psychiatrically hospitalized multihandicapped children. *Child Abuse and Neglect* 1989; **13**: 335-43.

56. Senate Community Affairs References Committee. Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait

Islander people with disability, and culturally and linguistically diverse people with disability. Canberra Commonwealth of Australia, 2015.

57. AIHW. The health of Australia's prisoners 2012. Canberra: Australian Institute of Health and Welfare, 2013.

58. Baldry E, McCausland R, Dowse L, McEntyre E. A predictable and preventable path: Aboriginal people with mental and cognitive disabilities in the criminal justice system: UNSW, 2015.

59. De Hert M, Correll CU, Bobes J, et al. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry* 2011; **10**(1): 52-77.

60. Kisely S, Preston N, Xiao J, Lawrence D, Louise S, Crowe E. Reducing all-cause mortality among patients with psychiatric disorders: a population-based study *CMAJ: Canadian Medical Association Journal* 2013; **185**: E50-E6.

61. Royal Australian and New Zealand College of Psychiatrists. The economic cost of serious mental illness and comorbidities in Australia and New Zealand. Melbourne: RANZCP, 2016.

62. Armitage C. A kind of creeping euthanasia': Needless early deaths among mentally ill cost the economy $15 billion a year. *Sydney Morning Herald*, 10 April 2016, 2016. http://www.smh.com.au/national/health/a-kind-of-creeping-euthanasia-needless-early-deaths-among-mentally-ill-cost-the-economy-15-billion-a-year-20160408-go1nnc.html (accessed 11 April 2016).

63. RANZCP. Position Statement #37 - Policy on Mental Health Services. 2010. https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/ps37-pdf.aspx (accessed 16 April 2016).

64. Lindqvist S. Terra Nullius - A Journey Through No One's Land. London: Granta; 2007.

65. Kiernan B. Blood and Soil: A World History of Genocide from Sparta to Darfur. New Haven: Yale University Press; 2007.

66. Markus A. Genocide in Australia. *Aboriginal history* 2001; **25**: 57-69.

67. McMahon E. Psychiatry at the Frontier: Surveying Aboriginal Mental Health in the Era of Assimilation. *Health & History: Journal of the Australian & New Zealand Society for the History of Medicine* 2007; **9**(2): 22-47.

68. Cawte JE. Australian Ethnopsychiatry in the Field: A sampling in north Kimberley. *Medical Journal of Australia* 1964; **1**(13): 467-72.

69. Cawte JE. Australian Aborigines in Mental Hospitals, Part II: Patterns of Transitional Psychosis. *Oceania* 1966; **36**: 264-82.

70. RANZCP. Aboriginal and Torres Strait Islander mental health. 2015. https://www.ranzcp.org/Publications/Indigenous-mental-health/Aboriginal-Torres-Strait-Islander-mental-health.aspx (accessed 22 February 2016).

71. RANZCP. College joins Recognise Campaign 2015. https://www.ranzcp.org/News-policy/News/College-joins-Recognise-Campaign.aspx (accessed 22 February 2016).

72. Bartrop PR. The Australian Government's 'Liberalisation' of Refugee Immigration Policy in 1938: Fact or Myth? *Menorah* 1998; **2**: 70.

73. Rutland S. Jewish Immigration after the Second World War- "The transformation of a community". 2006. http://www.ijs.org.au/Jewish-Immigration-after-the-Second-World-War/default.aspx (accessed 1 February 2016).

74. Nguyen V, Ho M. Families and cultural diversity in Australia 1995. https://aifs.gov.au/publications/families-and-cultural-diversity-australia (accessed 1 February 2016).

75. Marr D, Wilkinson M. Dark Victory. Sydney: Allen & Unwin; 2003.

76. Levi P. *If this is a Man and The Truce*. London: Abacus; 1995.

77. Boochani B. Life on Manus: island of the damned. *The Saturday Paper*, 27 Feb 2016, 2016. https://www.thesaturdaypaper.com.au/opinion/topic/2016/02/27/life-manus-island-the-damned/14564916002937 (accessed 27 Feb 2016).

78. Herman J. Trauma and Recovery: The Aftermath of Violence--from Domestic Abuse to Political Terror. New York: Basic Books; 1992.

79. Sharon A, Levav I, Brodsky J, Shemesh AA, Kohn R. Psychiatric disorders and other health dimensions among Holocaust survivors 6 decades later. *The British Journal of Psychiatry* 2009; **195**(4): 331-5.

80. Weinfeld M, Sigal JJ, Eaton WW. Long-Term Effects of the Holocaust on Selected Social Attitudes and Behaviors of Survivors: A Cautionary Note. *Social Forces* 1981; **60**(1): 1-19.

81. Steel Z, Momartin S, Bateman C, Hafshejani A. Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia. *Australian and New Zealand Journal of Public Health* 2004; **28**: 527-36.

82. Steel Z, Silove D, Brooks R, S O. Impact of immigration detention and temporary protection on the mental health of refugees. *British Journal of Psychiatry* 2006; **188**: 58-64.

83. Newman L. Seeking asylum-trauma, mental health, and human rights: an Australian perspective. *Journal of trauma & dissociation : the official journal of the International Society for the Study of Dissociation (ISSD)* 2013; **14**(2): 213-23.

84. RANZCP. Position Statement 46 - The provision of mental health services to asylum seekers and refugees. 2012. https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/ps46-pdf.aspx (accessed 1 February 2016).

85. RANZCP. PPG12- PPP - Guidance for psychiatrists working in Australian immigration detention centres. 2016.

https://www.ranzcp.org/Files/Resources/College_Statements/Practice_Guidelines/PPG-12-Guidance-for-psychiatrists-working-in-Austr.aspx (accessed 21 Feb 2016).

86. Dudley M. Helping professionals and Border Force secrecy: effective asylum-seeker healthcare requires independence from callous policies. *Australasian psychiatry : bulletin of Royal Australian and New Zealand College of Psychiatrists* 2016.

87. Ellis H, Symonds J. Sexual Inversion. London: Wilson and Macmillan; 1897.

88. Crozier I. Nineteenth-Century British Psychiatric Writing about Homosexuality before Havelock Ellis: The Missing Story. *Journal of the History of Medicine and Allied Sciences* 2008; **63**(1): 65-102.

89. King M, Bartlett A. British psychiatry and homosexuality. *The British journal of psychiatry : the journal of mental science* 1999; **175**: 106-13.

90. Herrn R. On the history of biological theories of homosexuality. *Journal of homosexuality* 1995; **28**(1-2): 31-56.

91. Friedman RC, Downey J. Psychoanalysis, psychobiology, and homosexuality. *Journal of the American Psychoanalytic Association* 1993; **41**(4): 1159-98.

92. Kirby M. The 1973 deletion of homosexuality as a psychiatric disorder: 30 years on. *The Australian and New Zealand journal of psychiatry* 2003; **37**(6): 674-7.

93. Kirby M. Psychiatry, Psychology, Law and Homosexuality - Uncomfortable Bedfellows. R G Myers Memorial Lecture 2000 Melbourne: Monash University and Australia and New Zealand Association of Psychiatry, Psychology and Law (Victoria); 2000.

94. Kirby M. Psychiatry, psychology, law and homosexuality — uncomfortable bedfellows. *Psychiatry, Psychology and Law* 2000; **7**(2): 139-49.

95. Kirby M. Remaining Sceptical - Lessons from psychiatry's treatment of homosexual patients. Quadrant. 2000 2000/01//:48.

96. McConaghy N. Is a homosexual orientation irreversible? *The British journal of psychiatry : the journal of mental science* 1976; **129**: 556-63.

97. McConaghy N. Australian psychiatry and homosexuality. [online]. *Quadrant* 2000; **44**(5): 46-50.

98. RANZCP. Position Statement 60 - Sexual Orientation Change Efforts. 2015. https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-60-PS-Sexual-Orientation-Change-Efforts-%28Ju-%281%29.aspx (accessed 29 February 2016).

99. RANZCP. Statement from the President – 15 May 2012 Melbourne: RANZCP; 2012.

100. Drescher J. Ethical issues in treating gay and lesbian patients. *Psychiatr Clin North Am* 2002; **25**(3): 605-21.

101. Irwin L. Homophobia and heterosexism: implications for nursing and nursing practice. *Australian Journal of Advanced Nursing* 2007; **25**: 70-6.

102. King M, Semlyen J, Tai SS, et al. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry* 2008; **8**: 70.

103. Cruess S, Johnston S, Cruess R. Professionalism for medicine: opportunities and obligations. *Medical Journal of Australia* 2002; (177): 208- 11.

104. ABIM Foundation, ACP-ASIM Foundation, EFIM. Medical Professionalism in the New Millennium: A Physician Charter

. *Annals of Internal Medicine* 2002; **136**: 243-6.

105. Robertson M, Walter G. Psychiatric Ethics and the 'New Professionalism'. In: Bhugra D, Malik A, Ikkos G, eds. Psychiatry's contract with society - Concepts, controversies, and consequences. London: Oxford University Press; 2010: 221-40.

106. Robertson M, Walter G. The many faces of the dual-role dilemma in psychiatric ethics. *Australian and New Zealand Journal of Psychiatry* 2008; **42**: 228-35.

107. Lacan J. Écrits. Paris: Seuil; 1966.

108. Fanon F. *The wretched of the earth*. New York: Grove; 1963.

109. Littlewood R. Ideology, Camouflage or Contingency? Racism in British Psychiatry. *Transcultural Psychiatry* 1993; **30**(3): 243-90.

110. Bhugra D, Bhui K. Racism in Psychiatry: paradigm lost - paradigm regained. *International Review of Psychiatry* 1999; **11**: 236-43.

111. Moses AD. Coming to terms with genocidal pasts in comparative perspective: Germany and Australia. *Aboriginal history* 2001; **25**: 91-115.

112. Blainey G. Drawing up a Balance Sheet of Our History. *Quadrant* 1993; **37**(7-8 (July-August)): 10-5.

113. Galaxy Research. Religion and Same- Sex Marriage 2012. http://www.australianmarriageequality.org/wp-content/uploads/2012/03/REPORT-Religion-And-Same-Sex-Marriage-Feb-2012.pdf (accessed 11 April 2016).

114. Robertson M, Walter G. Ethics and Mental Health - the Patient, Profession and Community. Boca Raton, Fl: CRC Press; 2013.

115. Laursen TM, Nordentoft M, Mortensen PB. Excess early mortality in schizophrenia. *Annual review of clinical psychology* 2014; **10**: 425-48.

116. Markus A. What does the Australian public really think about asylum seekers? . July 30 2012. http://theconversation.com/what-does-the-australian-public-really-think-about-asylum-seekers-8522 (accessed 11 April 2016).

117. Australian Human Rights Commission. The Forgotten Children: National Inquiry into Children in Immigration Detention 20142014. http://www.humanrights.gov.au/publications-home/all. (accessed 1 Feb 2016).

118. Australian Human Rights Commission. Australian Human Rights Commission 2014-15 Annual Report2015. https://www.humanrights.gov.au/our-work/commission-general/publications/annual-reports (accessed 1 Feb 2016).

119. Dudley M, Steel Z, Mares S, Newman L. Children and young people in immigration detention. *Curr Opin Psychiatry* 2012; **25**(4): 285-92.

120. Newman L, Proctor N, Dudley M. Seeking asylum in Australia: immigration detention, human rights and mental health care. *Australasian psychiatry : bulletin of Royal Australian and New Zealand College of Psychiatrists* 2013; **21**(4): 315-20.

121. Young P, Gordon MS. Mental health screening in immigration detention: A fresh look at Australian government data. *Australasian psychiatry : bulletin of Royal Australian and New Zealand College of Psychiatrists* 2016.

122. Kirmayer LJ, Rousseau C, Crepeau F. Research ethics and the plight of refugees in detention. *Monash bioethics review* 2004; **23**(4): 85-92.

123. Minas IH. Detention and deception: limits of ethical acceptability in detention research. *Monash bioethics review* 2004; **23**(4): 69-77.

124. Austalian Government. Australian Border Force Act 2015 https://www.comlaw.gov.au/Series/C2015A00040 (accessed 3 September 2015). Canberra; 2015.