**Chapter 2**

**Deep Sleep Therapy (aka ‘Prolonged Narcosis’): William Walters Sargant; Cherry Farm Hospital, New Zealand, 1973-78.**

# *Sleep that knits up the ravelled sleave of care, The death of each day's life, sore labor's bath, Balm of hurt minds, great nature's second course, Chief nourisher in life's feast.*

**Introduction:**

Shakespeare’s lines from *MacBeth* on sleep show enormous insight, fully supported by today’s neuroscience. Sleep is not just loss of consciousness, and supposedly - in economic terms - a waste of time. It is an active process, not just for physical restitution, but also to resolve nagging problems in our mind. Modern research makes this ever clearer, and there are strong leads about mechanisms by which this might occur[[1]](#footnote-1).

In the latter half of the nineteenth century, minimal understanding of this may have inspired medical people (first in America, later in Britain and Europe) to recommend affluent patients to submit to ‘rest cures’ (enforced bed rest, sometimes experienced as a brutal imposition). Echoes of this are found in the need for couches on which patients reclined during hypnotism or psychoanalysis. Substituting sedative or hypnotic medicines for natural sleep or bed rest came with advance in anaesthesiology and pharmacology. Volatile anaesthetics, pioneered by Lister in Scotland, were no use here. However, ‘bromides’ (potassium bromide), first used in 1857 as an effective antiepileptic, became widely available as a non-prescription sedative taken by mouth; and chloral hydrate was also used as a sedative from 1869. The assumed equivalence of anaesthesia or drug-induced sedation to natural sleep was always a fallacy.

Sleep as a remedy for mental distress traces back before recorded history. Wilhelm Griesinger may have been the first on record to have used early anaesthetics (ether or chloroform) to induce ‘sleep’ to treat mental disorder (melancholia)[[2]](#footnote-2). In the 1890s in Germany, when many traditions of psychiatry were established, but before there was effective treatment for psychoses or other mental disorders, there was debate over whether exercise or bed-rest were more appropriate for persons admitted to mental hospitals with psychotic disorders. For those in extremes of manic excitement, and/or exhaustion resulting from prolonged psychotic states, prolonged bed rest is not a silly idea – and was an old tradition. The first use of drug-induced sleep for this appears to have been by Neil Macleod, a Scottish physician, working in Shanghai. In 1900, having used prolonged bromide-induced sleep to treat morphine or cocaine addiction, he reported using the same method to treat mania[[3]](#footnote-3). The first barbiturates - anaesthetics to be taken orally, rather than as vapours - were developed in Germany in the first decade of the twentieth century. In 1915, in Turin, an Italian physician, Giuseppe Epifano, administered phenobarbital (‘luminal’) to a young woman admitted with manic-depressive illness. Drug-induced ‘sleep’ was maintained for two weeks, apparently leading to remission of symptoms for over two years[[4]](#footnote-4). Publication in 1915 had little impact, being eclipsed by Italy joining the first World War. In 1911, at the Burghölzli Hospital in Zürich, its director, Eugen Bleuler, developed the ‘schizophrenia’ concept in a monograph. After the war had ended, a psychiatrist there named Jakob Klaesi used a preparation from Roche pharmaceuticals - ‘Somnifen’, a mixture of two barbiturates - to treat persons with this diagnosis[[5]](#footnote-5). By 1930, a more complex mix - the ‘Cloetta combination’ (containing paraldehyde, amylene hydrate, chloral hydrate, alcohol, barbituric acid, digitalin, and ephedrine hydrochloride) was introduced, and used there until at least the mid-1930s.

In this chapter I generally refer to this treatment as ‘deep sleep therapy’, or ‘prolonged narcosis’ but it has other names - ‘narcosis therapy’ ‘prolonged sleep therapy’ or ‘continual sleep’. A major report I quote uses ‘modified narcosis’ (MN), and I often use the abbreviation ‘DST’. Technical details differ between different versions, and rhetoric used by some authors to defend questionable practices sometimes makes an issue of terminology, to distance the author from practice of others. The term ‘coma therapy’ is a confusing usage because ‘coma’ has a precise meaning to specialists, which differs from its use in everyday parlance.

From the late 1920s through the 1930s the method was adopted in other countries, initially Holland, and then the USA. It was used in the Soviet Union, as recommended by Pavlov, but his later work led clinicians there to reject deep narcosis in favour of intermittent deep sleep promoted in other ways. Britain took up the method later than other countries. Many British studies in the 1930s were in the city of Cardiff[[6]](#footnote-6). A similar method (with brief duration of induced sleep, was used in Devon County Mental Hospital from 1934 to the early 1940s. In Australia, DST was used by Reg Ellery from about 1939 (after a trip to Europe) until early 1950s, and was probably carried out at other private clinics (but not well documented)[[7]](#footnote-7). In the USA at the time, psychiatry and neurology were not separated. Short-acting barbiturates were used in aid of psychotherapy to release inhibitions and reveal unconscious processes. This was ‘narco-analysis’. Rudolf Hess, facing trial at Nuremberg, was subjected to narcoanalysis.

*Prolonged* narcosis was also used in USA. whose duration ranged from 16-22 hours per day, over periods lasting up to several weeks. It was used mainly for agitated psychotic states, but also for depressive disorders. Many different sedative or anaesthetic agents were used. A short-acting barbiturate - sodium amytal - developed by pharmaceutical company *Eli Lilly* in the late twenties, was in common use.

It was soon realised that prolonged narcosis had serious risks - pneumonia (mentioned by McLeod), deep vein thrombosis, pulmonary thrombosis, and idiosyncratic responses to specific agents. Lowering of blood pressure was common. A syndrome of barbiturate withdrawal, including convulsions was seen in experimental animals as early as 1931[[8]](#footnote-8). By 1936, it was seen in humans, but the danger was not fully realised until the 1940s[[9]](#footnote-9). It was similar to *Delirium tremens,* on sudden withdrawal in alcohol addicts. In 1937 Palmer wrote a comprehensive iont of the method, commenting that ‘*the treatment is not without danger, but the risk can be effectively safeguarded, and fatalities need not occur. Although serious complications occur which cannot be foreseen, careful nursing, and response to adverse events still make the method worthwhile.[[10]](#footnote-10)*’ Constant nursing care over a long period was needed to avoid the dangers, a serious drawback for routine use[[11]](#footnote-11). At the time, despite inherent dangers, the balance between risks and benefits might favour continued use, provided there was close monitoring of patients, and excellent, possibly intensive nursing care. It was, nonetheless a genuine attempt at therapy, openly published, and its hazards openly discussed.

***William Walters Sargant*:**

In the lead up to the second World War, a psychiatrist of rising importance was William Walters Sargant. At secondary school and university he excelled at sporting activities. He graduated in medicine (St John’s College, Cambridge, and St Mary’s hospital London) in the late 1920s. In 1933 he had something of a nervous breakdown – apparently ‘depression’ - and had to spend a period in a mental hospital. By 1935, he decided to specialise in psychiatry, and by 1936 was one of the first to study psychological effects of amphetamine (benzedrine) and, in 1938, insulin coma therapy. In 1938, he was awarded a Rockefeller Fellowship to spend a year at Harvard Medical School. While there, on a visit to Washington, he visited Chestnut Lodge, Maryland, a clinic where deep sleep therapy was in use.

With outbreak of the war, he returned to Britain, keen to develop methods he had learned in America. He was soon stationed at the Sutton Emergency Service, for receipt of psychological casualties of war. After the Dunkirk evacuations, such casualties were so numerous that usual approaches to psychotherapy were too time-consuming, and - Sargant maintained - ineffective. However, Sargant already knew about narcoanalysis. His objective with Dunkirk evacuees was to reveal memories of trauma for which there was psychogenic amnesia. By chance, he hit on a version of *abreaction therapy*[[12]](#footnote-12): Rather than using hypnotism or free association, as in Freud’s day, he used sub-anaesthetic doses of barbiturates, and sometimes, ether[[13]](#footnote-13) (which had greater excitatory effects). The therapist’s role was to use various means, including verbal interjections, to heighten tension and to bring about maximal emotional climax. He claimed the approach to be very effective, not just by uncovering details of trauma, but by catharsis and emotional release[[14]](#footnote-14). Therapeutic effects, it was claimed[[15]](#footnote-15), depended not just on access to hidden memories, but on discharge of emotion itself. By 1941 or 1942, he was one of the first in Britain to use ECT. Sometimes he combined abreaction with ECT or barbiturates.

More extended barbiturate narcosis was reserved by Sargant for severe cases, ‘not as a rule for more than a week’, according to his 1940 paper in Lancet[[16]](#footnote-16).A more detailed account is given in the 1944 edition of *‘An Introduction to Physical Treatments in Psychiatry’*. We read:

*‘The aim of treatment is to provide twenty hours sleep out of twenty four, for a period which will vary from a few days in the acute anxiety state up to three weeks in the deeply depressed or acutely excited patient.’*

Drugs used included ‘somnifaine’ (a.k.a: aprobarbital, a barbiturate) which in doses for full narcosis, is toxic[[17]](#footnote-17), but was used in smaller doses with ‘something else’ - paraldehyde, sodium amytal, Cloetta’s mixture (as ‘still used on the Continent’). Throughout the war Sargant’s methods were used close to battle fields, in the North African campaign, and, by American forces, in the Battle of the Bulge in winter 1944/45.

All this seems orthodox - if necessarily extreme - wartime psychiatry, but there was an odd feature. Sargant published his method in a three-page article in *British Medical Journal,* in 1942, which would have been subject to peer review. After that, full details and subsequent modifications were never published in peer-reviewed journals. The 1944 edition of Sargant and Slater’s book (*Introduction to physical methods of treatment in Psychiatry*) omits vivid details in the first edition, which nevertheless appear ten years later in *Battle for the Mind,* and in his autobiography. Post war, very little was published by anyone on DST in academic journals.

It is now clear that, during the war, Sargant had been instructed by the War office not to published more on this wartime method. He became an expert on interrogation (which we know because, much later he was invited to write a review of a book on the subject). We now know that he was working with MI5: A publication by Nigel West (‘*Historical Dictionary of British Intelligence’*) writes of a former psychologist advising MI5 (Dr Harold Dearden): ‘*His successor as MI5’s principal psychologist, was Dr William Sargant . . .*’

In 1948, Sargant was appointed as head of the Department of Psychological Medicine, at St Thomas’s Hospital, central London, on the south bank of the Thames. DST was used extensively by Sargant and colleagues, in an annex to St Thomas’s hospital, on the top floor of adjoining Royal Waterloo hospital. He was well aware of the risks; excellent nursing care was possible at St Thomas’s, home of one of the world’s most prestigious nursing schools.

Sargant was a domineering and at times divisive figure. Most persons of importance at this time had recent experience of wartime service, sometimes in frontline or leadership roles. The intensity and style of their commitment had profound impact on their personal style in post-war years, in diverse ways. Try as they might, many could not shed the impact of extreme wartime experiences. In particular, the traditional ethical mandate in health care professions had hardly been a priority during war. After the war, despite weighty pronouncements at the Nuremberg Trial of Doctors, and in the Universal Declaration of Human Rights, doctors often hardly took seriously these ethical requirements, including the need for informed consent.

In 1954 Sargant published a controversial and widely read book - *Battle for the Mind* - on the science behind brain-washing. Its theme is the parallel between three scenarios where attempts are made to change a person’s beliefs: a psychiatrist’s couch (including abreaction), high-pressure religious conversion (familiar to Sargant, from a devout Methodist background), and brain washing/propaganda (important topics, both during the world war and after armistice in the Korean war). Thereafter he was much in demand as a speaker. However, he was under increasing criticism for lack of scientific rigour:

Professional criticism of his practice was well-founded: His ECT regimes were far longer than accepted at the time; poly-pharmacy and other combination treatments went against practice guidelines; use of prolonged narcosis had long been abandoned in psychiatric practice in Britain; and his form of this was never subjected to rigorous clinical trials with control groups. Testimony by his patients was generally scathing in its criticism. Some of his patients *did* die (how many is unknown). Despite lack of proper assessment, DST in one form or another was part of Sargant’s practice, from its inception after the Dunkirk evacuations, up to August 1972, when it stopped suddenly. The context for this is explained later. Few other psychiatrists used the method, and it was completely rejected by professional bodies in Britain from the early 1960s[[18]](#footnote-18). However, we now know that versions of DST occurred not only at St Thomas’s but in at other British centres (see below).

If Sargant’s objective with DST was wholly therapeutic, details of his methods would normally have been published in a peer-reviewed journals. Clinical trials of would have been expected. Sargant published plenty on other topics in medical journals, but details of DST were not published in this way, only in editions of his book with Elliott Slater (‘*An introduction to physical treatments in psychiatry*’; successive editions published in 1944, 1948, 1954, 1963, 1972; the last, after retirement in 1981). Scrutiny by peer reviewers – if there was any at all - would have been less rigorous than in academic journals. Thus, in Sargant’s practice, DST was not only outdated and eventually rejected, but, for a novel medical or psychiatric treatment, was published in unorthodox ways. The exceptions were at the end of his career, in the 1972 edition of his book, and in a long review paper on DST, in the same year, in *British Journal of Psychiatry[[19]](#footnote-19)*.Here, Sargant departs from his usual style, with quantitative detail on medicines used, duration of narcosis, and results for specific diagnoses. The 1972 paper, be it noted, deals with *immediate* outcome. The odd story of the supposed *follow-up study* is told below.

Some details of these publications are germane to my theme. In his 1972 paper, Sargant reports four deaths, out of 679 instances of patients subjected to DST, ‘and no suicides’ (but see a nurse’s comment, below). Medications mentioned in his 1972 publications included the recently introduced benzodiazepines, marketed as ‘anti-anxiety drugs’. This class of drug has a mechanism of action related to, but different in detail from barbiturates. For those habituated to benzodiazepines, withdrawal effects, sometimes serious, are inevitable, as with barbiturates. A long-acting drug in this class mentioned by Sargant was Nitrazepam (aka ‘Mogadon’), with ‘biological half-life’ of about 24 hours, and recommended dose of 5 mg. Sargant’s dose range was ‘5-20 mg six-hourly. Undoubtedly, if sustained over many days, tolerance would develop, and with it, risk of serious complication on withdrawal.

‘Informed consent’ is an important matter in Sargant’s practice. In England, since 1830, physicians had been legally required to obtain informed consent from subjects for medical research. In the urgency of wartime this was hardly a priority. However, nearly 30 years after the war had ended, in the 1972 edition of Sargant and Slater we read:

*‘What is so valuable [about the combined treatment with ECT and narcosis] is that they [the patients] generally have no memory about the actual length of the treatment or the number of ECTs used after the treatment is finished. . . . After 3 or 4 treatments they may ask for ECT to be discontinued because of an increasing dread of further treatments. Combining sleep with ECT avoids this.’*

Implicitly he assumes that, if a patient was unwilling to undergo treatment, their reluctance could be overcome as a result of narcosis. This is explicit in another quotation:-

*‘All sorts of treatment can be given while the patient is kept sleeping, including a variety of drugs and ECT [which] together generally induce considerable memory loss for the period under narcosis. As a rule the patient does not know how long he has been asleep, or what treatment, even including ECT, he has been given. Under sleep . . . one can now give many kinds of physical treatment, necessary, but often not easily tolerated. We may be seeing here a new exciting beginning in psychiatry and the possibility of a treatment era such as followed the introduction of anaesthesia in surgery’*

He seemed completely oblivious to the notion of informed consent.

Sargant’s activities were well known, and his case conferences were open to his colleagues. Critique of his practice must have been well known in medical circles. *He was never called to account.* One may ask why no-one registered serious complaints about his practice, or, if they *did*, why complaints never proved ineffective: It *might* have been because of his domineering character, and, for a time, because of his high reputation. However, two doctors (one of them a young Malcolm Lader later Professor of Pharmacology at the Institute of Psychiatry) were advised that Sargant had ‘friends in high places’. For relatively junior doctors to register complaints would jeopardise their career. *This suggests he* ***was*** *being protected, for reasons which, if true, should have been clarified long ago.*

Over the long period when Sargant used DST, his methods changed. The first antipsychotic drug – chlorpromazine (‘largactil’) - was introduced in the early 1950s. It was not only an antipsychotic agent but also a potent sedative. A point still not fully understood by many who prescribe such medicines is that these two actions are different. Thus, different antipsychotic medicines, equally effective in limiting psychoses, may vary greatly in potency as sedatives. Moreover, the sedation differs from that induced by barbiturates: There are usually no serious problems on sudden withdrawal, as there are with barbiturates. For this reason, around 1960, Sargant switched partly or wholly to using largactil instead of barbiturates for DST. It is clear that the doses of largactil he used were very large. As an antipsychotic, the usual upper limit is 400 mg per day. In Sargant’s practice, doses were 100-400 mg *every six hours.* Clearly, he used it as a sedative, not an anti-psychotic agent, and stated this[[20]](#footnote-20). Anti-psychotic medicines have been called ‘major tranquilizers’, a term which probably originated from the properties of largactil, perhaps from Sargant himself. However, he was not consistent. In *The Unquiet Mind* (p. 182), written while modified narcosis was still proceeding, he writes; ‘*Unlike bromide, the new tranquilizers can be taken in massive doses without clouding he patient’s consciousness’*.

Another important change dates from 1964. In his *Lancet* paper in 1940, most patients were evacuees from Dunkirk, and duration was ‘not as a rule for more than a week’. In editions of Sargant and Slater’s book (1944, 1948, 1954) it was used ‘*for a period which will vary from a few days in the acute anxiety state up to three weeks in the deeply depressed or acutely excited patient’*. However, in a paper in 1966 paper we read: ‘*The duration of the continuous modified narcosis . . .varied between one and seven weeks, the average being 3.9 weeks’*. In the 1972 edition of Sargant & Slater, ‘modified narcosis’ for some diagnoses confined patients to bed for up to three months, and in one case up to five months.Tabulated data gave durations of 4-5 weeks for most diagnoses. In a talk delivered to the Samaritans in Leeds in 1971 he stated[[21]](#footnote-21):

*‘For several years past we have been treating severe resistant depression with long periods of sleep treatment. We can now keep patients asleep or very drowsy for up to 3 months if necessary[[22]](#footnote-22).* No rationale was given for the shift to much longer durations. The year when the shift to the longer duration started – 1964 - assumes importance as I explain in a later chapter.

The change in 1964 was not just in duration. ‘Modified narcosis’ entailed combining DST with ECT given frequently (usually twice per week) over long periods to patients, who - even without premedication, - were unconscious, or semi-conscious. For obsessional neurosis, he states ‘*modified narcosis and ECT may have to be continued for up to three months’.* Overall, ECT was given in 96% of cases, along with various medicines.

To understand this, it should be made clear that Sargant’s fundamental objective had shifted: For Dunkirk evacuees, amytal and similar drugs were used to *restore* memory of traumatic events. He did use ECT, but any amnesia it produced was unwanted, to be avoided if possible. In 1944, he and Slater wrote: ‘*Signs of any gross or continuing memory disturbance or confusion should lead to intermission [of ECT] for a time’*. When ‘modified narcosis’ was started in 1964, his attitude to the amnesia had reversed. In the 1972 edition, ECT-induced amnesia was used so that patients had little awareness of treatment received. In other words, he now used ECT explicitly to erase or obliterate memory.

Some degree of memory loss is well known to occur after ECT, usually quite limited, a price many are willing to pay, given benefits that may come from ECT. I experienced it myself in small degree. It was trivial compared to my overall incapacity. However, some of Sargant’s patients experienced more profound amnesia. In 1951, Erwin Stengel (mentioned in my introductory chapter) wrote on such severe memory loss[[23]](#footnote-23) due to ‘intensive ECT’ – that is, two to four shocks daily, on successive days over a period of a week or two. This appears to have been more intensive than in Sargant’s practice, but not so prolonged. Severe amnesia experienced by some of Sargant’s patients was probably similar to that referred to by Stengel.

Nurses caring for patients undergoing prolonged narcosis found it immensely stressful, although only a small number of nurses were involved: One of them, a student nurse, aged 19 at the time, provided the following description[[24]](#footnote-24):

*I was told I was going to be in the narcosis room for 3 months. Taken into this dark room with four sleeping ladies. And I stayed there for 3 months. I went into there every shift, I put them to sleep, I woke them up, I fed them, I washed them, drugged them, put them back to sleep again, and monitored their sleep patterns It was 4 women in one room, and then we had a smaller ward with 2 men, also asleep. On the whole they came in for about 3 months of narcosis, were periodically taken out to have ECT treatment, and then back to sleep again, and they were allowed a visitor for one afternoon a week.*

*The actual room wasn’t very big. It was a rectangle. Probably about 15 foot by 10 foot wide . . . We were in utter darkness. We had black blinds at the windows so I guess they were disorientated and I guess really it was designed for that reason. . . . .I think all the windows were barred. We had two patients to left and two to the right and we had a tiny little table with an angle-poise lamp that had a black shield to it as well. So that we just had enough light to read a page on a book and to do our monitoring as well. But it was black.*

*. . . There was no night time and day time regime. It was 6 hourly, just the same for the whole time.’*

Q: Did some of them experience memory loss?

*That is dreadful! . . . .These poor ladies, they were literally like zombies. Really. They hardly knew their names. They did not know who they were, they forgot their families. That is very impressionable for a 19 year old nurse. I***still** *don’t approve of it at all. It’s made me very wary of dealing with mental illness at all. I still back off. I very nearly gave up nursing because of it*

Q: What drugs were administered? What was the regime?

*I certainly remember Largactil, and I have a horrible idea it was something like 400 mg. they were given the same drugs every 6 hours and I’m sure there was nitrazepan [Nitrazepa****m]****, Largactil and certainly another two. It was a lot of drugs.. . . .So if my memory serves me correctly and they were on these sleeping pills, then they would be getting 4 times the recommended dose because they would be having it every 6 hours.*

An odd feature of Sargant’s career is that, despite being a high-profile psychiatrist, much in the public eye, he was never made full professor at St Thomas’s. In 1971 he put his name forward as contender to be first president of the College of Psychiatrists, as it acquired ‘Royal College’ status. Thus, when he was drafting his 1972 publications, he was hoping to become first president of this new Royal College. The unusual (for him) degree of quantitative detail - on numbers of patients, response to treatment (etc) - might be seen as a response to criticism. However, publishing in such detail in the college’s own journal on ‘modified narcosis’ may have had other motives - to fulfil his career ambitions, as head of the new Royal College. The college acquired its Royal status in 1971, with Sir Martin Roth elected as first president, before Sargant’s book and paper appeared. He never became president.

As mentioned, the 1972 edition of Sargant & Slater gave a clear indication that a paper dealing with follow-up results for modified narcosis would be published later that year (or perhaps early in 1973); but it was never published. Granted, it is not rare in academic life for a researcher to give advance publicity to papers that are never published, especially when applying for a job (or in Sargant’s case, a high position in a to-be-established Royal College). Nonetheless, for one with such a high profile, the failure to publish the second paper is strange. It can hardly have been that it *was* written and submitted, but not accepted.

At the end of Sargant’s public career lies an enigma: He reached retirement age of 65 years in 1972, and lived another 16 years. In a letter in BMJ letter (23 June, 1973) he almost boasted of the several thousand patients since 1940s who had undergone sleep therapy[[25]](#footnote-25). In another (*Prescribing Mandrax;* 25 August 1973) he wrote: *‘There are hundreds of narcosis records at St Thomas’s and Belmont Hospital* [formerly Sutton Emergency Centre where Sargant worked during the war], *and nurses treating such patients could also be consulted’*. Probably, therefore, he was busy using such methods, with no sign of an end, until half way through August 1973. However, late in 1973, the narcosis ward at St. Thomas’s was closed with precipitate haste[[26]](#footnote-26). This might have been expected when he retired, but Sargant claimed it was the Royal College of Nursing which closed the ward. Case records at St Thomas’s on narcosis therapy seem to have disappeared. Enquiries produced the reply: ‘*We don’t keep records for more that 10 years, except in some situations*’[[27]](#footnote-27) an odd response, given St. Thomas’s long and proud history in health care. It *could* have been a response designed to hide an embarrassing secret.

After retirement, he identified himself as ‘Honorary Consultant Psychiatrist at St. Thomas’s Hospital, London’[[28]](#footnote-28), continuing in private practise; but he published nothing more in academic journals, apart from a few letters in BMJ. In one such (8 June 1974) he wrote:

*‘I was able to re-establish a narcosis ward in a psychiatric nursing home and today, among other patients, 25 often considered “chronic” schizophrenics have had full combined narcosis and ECT treatment with additional insulin sopr when needed.’*

He also wrote the popular book *The Mind Possessed* (1975), and the last (6th) edition of *An introduction to physical treatments in psychiatry* (1981). His reticence regarding publication after 1972 is odd for one who had published regularly and was such a dominant figure in psychiatry. It is unlikely to have been because he was piqued at not becoming the first president of RCP: That occurred in 1971, yet, as late as mid-1973, he hinted at much unpublished material in clinical records. Something seems to have happened in August or September 1973, which discouraged him from major publication.

Sargant died in 1988. Obituaries in *BMJ* and *Lancet[[29]](#footnote-29)*, never mention his use of DST, nor is it mentioned in the obituary of his colleague at Royal Waterloo Hospital, Dr John Pollitt[[30]](#footnote-30). A shorter obituary of Sargant in *Lancet* a month later[[31]](#footnote-31), praises his persistence with the most difficult cases, and does mention his use of continuous narcosis. An obituary in *Psychiatric Bulletin[[32]](#footnote-32)* comments that ‘it was a pity’ that he did not become the college’s first president. Clearly, controversy about Sargent continued after his death. Abundant information on him is archived in the Wellcome library in London, much of it is embargoed for a long time, some for 100 years after his death, the year 2088.

In my investigations into DST, I have identified other sites where versions of DST occurred, usually at hospitals in smaller centres within easy reach of London (not cities with medical schools). These include The Priory Hospital, Roehamptom; Stonehouse in Dartford; Park Prewett in Basingstoke; St. John’s in Aylesbury; and St Augustine’s hospital, Chartham, Kent. As far as I know DST in such centres did not continue after 1973. Information came in part from the anonymous investigator mentioned below, subjected to DST in Royal Waterloo hospital. Duration of narcosis varied greatly across locations. Later versions of DST occurred in more remote places - Royal Dundee Hospital, Scotland[[33]](#footnote-33) (1975-77) and St John of God’s Hospital Dublin, Ireland (1976-77), where a patient received ECT 34 times in a 3-month period.

I was in contact with one of Sargant’s former patients at Royal Waterloo. She used a pseudonym, and I never had a video conversation when I could see her face. Clearly, she felt vulnerable and afraid to enter public discussion. She said she was uneducated. Such belittling comments mean nothing to me: She has been a determined, systematic researcher, aware of prevailing criticism of conspiracy theorists, and therefore cautious in drawing conclusions that go beyond the evidence. I learned useful detail from her. She was admitted to the ward at age 22 in 1973, apparently one of the last of Sargant’s DST patients at St. Thomas’s. Some records of DST *did* still exist about Sargant’s practice, from the out-patient department not the ward. She was also very persistent at the Wellcome library asking the same question in different ways at different times. She never found psychiatrist’s records, but obtained some nursing notes. How much of such records still exist is not clear.

She made a few other points to add to my story: Although Sargant signed himself in letters to BMJ in 1973 and 1974 from an address in ‘London W1’ (presumably his office in Harley street) she told me that this was not where narcosis treatment was continued. His private clinic for narcosis was somewhere south of the river ‘or somewhere in Kent’.

My informant also confirmed what I had learned of the use of DST at a site in Ireland and gave me location and dates of its use there. One of her contacts claimed to have been kidnapped in a street in Folkestone, prior to receiving DST at Stonehouse hospital, Dartford. My informant was sceptical of this, as I would have been; but credibility of strange stories depends on what one assumes as possible. Natural assumptions on the implausibility of this story should perhaps be set aside, after hearing the testimony of Rosemary Thompson, cited in the previous chapter.

A comment of special importance is that, with all the repetitious defensive lines we hear about ‘conspiracy theories’, it was hard to get the topic of DST ever raised in public. Nonetheless, she states *‘I think it was far too important not to have been officially investigated’*. In that respect New Zealand, with its Royal Commission has gone further than the UK in investigating past psychiatric abuse, despite its ‘getting cold feet’ about follow-up investigations to identify the ultimate locus of responsibility.

***Personality of William Sargant*:** From early years, with success on the sports field, Sargant seems to have been a man of action rather than deep thought. Wartime medicine in extreme conditions, may have favoured ones with this trait. According to Ann Dally[[34]](#footnote-34), Sargant had no time for self-analysis by either himself or his patients. Hyperactive and domineering, he seemed to lack the capacity for introspection, which might have led him to present himself, as far as possible, in consistent fashion; but he quickly adapted to prevailing circumstance in how he presented himself. He thus gave inconsistent accounts of his practise in different publications. In a book review on psychotherapy for schizophrenia[[35]](#footnote-35) he castigates the authors for ‘marking long-term psychotherapy look suspiciously like brain-washing’; and yet in ‘*Battle for the Mind’* this was how he validated his version of therapy. His reports of abreaction therapy varied according to likely readership, sometimes emphasising, sometimes minimising the extent to which he deliberately enhanced emotional outbursts. Often he relied on ‘clinical intuition’ rather than statistical analysis, yet sometimes berated others for not providing such analyses. In some details, what he describes differs from independent testimony, for instance, in his claim that there were no suicides related to modified narcosis. My informant, and the nurse quoted above considered that a three-month duration of prolonged narcosis was the norm, but Sargant’s 1972 publications gave no impression of this. His autobiography *The Unquiet Mind* claims that Ward 5 was unlocked, but first hand testimony from patients says otherwise.

Two persons who later became prominent made comments on his practice. One of these – Malcom Lederer was mentioned above. The other - David Owen (later Sir David Owen, and then Lord Owen) - become a politician for the Liberal party, and also Foreign Secretary for a while. He claims that Sargant understood his patients well (especially regarding depression which Sargant had himself experienced). Of course, psychological understanding *does* often come from a person’s introspection, and ability to project their experience, and recognise it in other people. However, Sargant never appears to have written of his own depression*.* He may have avoided mention of his time in a psychiatric ward because it would have jeopardised his professional standing (an attitude which still prevails in professional psychiatry).

There may have been good reason to reject the types of psychotherapy promulgated at the time. However, in a less specific sense, psychotherapy is at the heart of good doctoring in any specialty; yet Sargant, at least in the later days at St Thomas’s, seemed to have been blind to the need to develop a therapeutic relationship based on trust. Thus David Owen’s claim that he had deep understanding of his patients does not ring true. In *The Unquiet Mind,* there are other important, more controversial aspects of his life which are not mentioned. Like many autobiographies, itoften reads like at attempt at self-justification.

He probablylearned at an early age that, by charm and force of personality, he could evade criticism. This is a personality flaw in one aspiring to be a leading psychiatrist. It would make Sargant not just flawed, but dangerous, because he could get away with practices by claiming them to be genuinely therapeutic, when the real motive was quite different. However it is hard to claim that he was deliberately deceptive: To repeat a truism, ‘the best liars believe what they say’. The psychology of persons who at once deceive others and themselves is inevitably complex. Sargant may have been driven by several motives inconsistent with each other, yet unaware of their contradictions. This comment may be specially relevant for persons trying to make their way in peacetime medicine, with its need for open transparent publication and peer review, after wartime service, particularly in is more secretive areas. This may account for the sharp divergence of opinions about him. In hindsight, one might say that there had been an error of judgment in those who appointed him to the position at St. Thomas’s. However, we cannot know what considerations, beyond psychiatry, led to this decision in 1948.

***Harry Bailey and the Chelmsford Scandal***

In New South Wales, a high-flying, big-spending Australian psychiatrist, Harry Bailey used a version of DST, in the 1960s and 1970s in a private clinic at Chelmsford. He started work at this clinic in 1963, combining DST with ECT, but had little experience of the drugs he used. Being a private clinic, it had none of the back-up facilities for emergencies, available in a major hospital. Nursing care was grossly inadequate, and about 25 people died. A monograph on the scandal by lawyer Brian Bromberger and journalist Janet Fife-Yeomans is not strong on clinical detail, especially durations of DST for patients. However, between November 1965 and 1978, 1127 patients underwent DST in Bailey’s clinic. These (and others) were private patients, and Bailey made big money, sometimes for treatments that were never given. Admission to Chelmsford and use of DST seems to have been haphazard with respect to diagnosis.

Several deaths occurred within a week or two of admission. The monograph never mentions Sargant’s term ‘*modified* narcosis therapy’ adopted after 1964 but rather ‘Deep Sleep’ or ‘Coma Therapy’. Bailey regarded depth of narcosis as critical for treatment. Barbiturates in large doses were amongst medicines used. With such doses, complications abounded, such as failure of the reflexes that clear the lungs, and also, depression of breathing. One can infer that deaths were often a direct or indirect consequence of excess of barbiturates. The first documented deaths occurred in 1964 – five occurred between July and the end of that year – amongst the 150 patients treated at the clinic.

A friend of mine who trained as an intensive care nurse in the late 1960s worked at the Chelmsford as an agency nurse on night shifts, for about 6 months in 1973. She remembers unconscious patients there with urinary catheters and nasal tubes. In the middle of the night unconscious patients were taken somewhere else for ECT. She recalls that the usual duration of DST regimes was 6 to 8 weeks. At the time, adverse publicity about Chelmsford had hardly started, and she was not alerted to anything sinister.

Litigation against Bailey intensified in the 1980s. Sargant was asked to testify, and he spoke *against* Bailey. Soon after, Bailey committed suicide. His practice at Chelmsford was inexpert, dangerous and idiosyncratic. He seems to have been an overconfident rogue psychiatrist with an inflated ego, and utterly reckless. I see no rationale to his methods, other than to make money, and in the end fame, such as might have a bearing on the rest of my story. However, at the end of this chapter I trace his links to other players in my story, as told so far

**Deep Sleep Therapy in New Zealand.**

A version of DST was used in New Zealand in the 1970s, especially at Cherry Farm hospital, 25 miles north of Dunedin. Nothing was published about its use at the time in medical journals. It was the Citizen’s Commission for Human Rights, profiled in the last chapter, which brought Deep Sleep Therapy in New Zealand to public attention. Questions were raised in parliament in June 1989. In 1990 there was press coverage in several articles, especially the Sunday News written (sometimes in sensational style) by Peter Richardson. Most or all facts in the articles appear to have come from CCHR. On 26 September 1990, Minister of Health Helen Clark commissioned psychiatrist Graham Mellsop and lawyer Michael Radford to conduct an inquiry into the practice in New Zealand. Their report was released in January 1991 (‘Mellsop-Radford report’, easily accessible on the internet). It is a primary source about DST in New Zealand with much useful clinical detail and sharp criticism and recommendations; but it stops short of identifying the chain of responsibility which led to use of DST (since this was not included in its ‘Terms of Reference’). I also learned about DST in New Zealand from other sources:

* The doctor immediately responsible for DST at Cherry Farm, Dr HDG Martinus, was interviewed on Radio NZ by Cecily McNeil[[36]](#footnote-36) on 19 February 1991, one month after release of the Mellsop-Radford report.
* A senior journalist with New Zealand Herald, Fran O’Sullivan was a student nurse, age 20, at Cherry Farm in the early 1970s, when DST was taking place. She has written about the topic recently[[37]](#footnote-37); I met her once to discuss my concerns.
* I met one person subjected to DST in Cherry Farm in the 1970s, who gave me a few details. I should not name her.
* In late 2019, I was approached by journalist/lawyer, Mike Wesley-Smith, regarding Cherry Farm (although his focus then was mainly on Lake Alice). I shared with him what I knew, and he helped me by giving details of the press reports about DST from 1989 and 1990.
* At New Year 2020/2021 I had a conversation with a psychiatrist in her retirement home, who had been superintendent at Cherry Farm in the 1980s, shortly before it closed down and some years after the period of concern about DST.
* I also received relevant information in conversation with a person who knew about hospital administration in Otago and elsewhere in New Zealand in the 1970s. He is Warwick Brunton, who has written knowledgeably about the history of mental health care in New Zealand. I have not followed up most of the leads he suggested, because they would be documents archived – somewhere! - in Otago, and I rarely get to Dunedin these days. However, in relevant sections I give relevant detail of what might be available, and where to look, for those with the time and inclination to dig deeper.

***Times, Locations, and Numbers of Patients Subjected to DST in New Zealand****.*

At Cherry Farm, the first genuine instance of DST, as defined by Mellsop and Radford seems to have occurred in October 1973[[38]](#footnote-38), the last sometime in 1978. There may have been earlier patients on which no information is available (to me). The number of patients so treated is unknown, but in a single year, (1973-4) it totalled 52. The total number is therefore likely to been a few hundred. DST was practised on smaller numbers, at Kew hospital Invercargill, at Sunnyside hospital Christchurch, and in New Plymouth. The account of patient Joyce (*Sunday news*, 22 July, 1990), and the published dispensary table about prescription of Hemineurin is compelling evidence that something like DST was going on in Wellington hospital in 1979. In other places, Mellsop and Radford conclude that procedures did not constitute DST, as otherwise understood. The main focus of their report (as here) is DST at Cherry Farm.

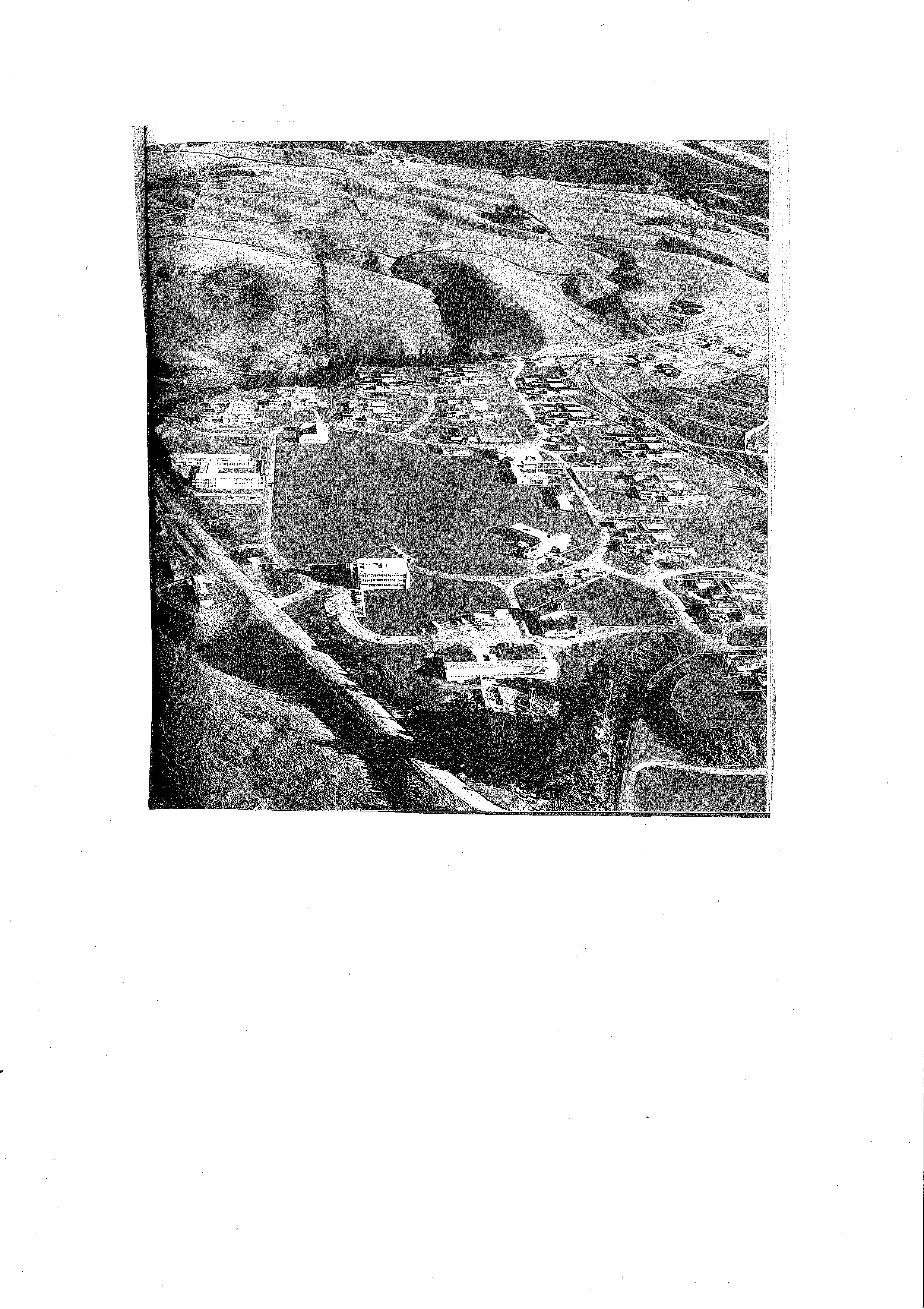
When Mike Wesley-Smith joined the Royal Commission on Abuse in Care, of necessity, he could no longer share with me all he knew, now presumably somewhere in the state archives. He did tell me that the Commission the names of patients who were subjected to DST at Cherry Farm, but I received nothing in return about who they were, despite my specific mention of one person, a friend of mine before his premature death in 2005, who might have been one such. Apart from the one person with whom I have spoken about her experiences in the Cherry Farm Narcosis Unit, I know no other names.

***Villas in Cherry Farm where DST Occurred*:**

According to Mellsop and Radford, DST took place in three villas at Cherry Farm. Two of them can be identified as ‘Villa H’ and ‘Villa D’, most remote of all from the main road which ran alongside the hospital complex (uppermost right, in illustration below). There were other patients in the same villas who were not subjected to DST.

***Psychiatrist(s) with Immediate Responsibility at Cherry Farm*:**

The name of the person directly responsible for DST in all three villas at Cherry Farm is redacted in copies of the Mellsop-Radford report as now available. However, it is well known that he was Dr Hettiarachchige Don George Martinus. He was Sri-Lankan, born 9 July 1927,



at Hewagama (near Colombo) and had been in New Zealand since 1970, possibly a little earlier. He died in 2017. Affidavits in the Mellsop-Radford report indicate that at least one other psychiatrist was involved, but their identity(ies) are unknown. An article in *Sunday star* (29 July 1990) refers to ‘four psychiatrists’ being involved. Warwick Brunton told me that the Archives of Otago DHB, available in Dunedin, but requiring permission might give more details on Martinus, and – who knows? – identities of other psychiatrists in the DST units. However, at the time of his appointment (i.e. before 22 March 1972), Cherry Farm would have been administered by Ministry of Health, not the local Health Board. Details might therefor be available in Wellington.

***Nursing Staff and Quality of Nursing Care*:**

I was told that in the early 1970s in-patient nurses in mental hospitals were not the most able of nurses trained at that time. Cherry Farm had on-going problems recruiting staff, probably more severe than in most New Zealand asylums, as a result of the institution’s isolation from any urban centre. As a result, many nurses there were short-term or itinerant, and some were probably ‘hereditary’. Warwick Brunton told me that the Archives of Otago DHB, available in Dunedin, but requiring permission, might give details of nursing staff numbers, qualifications and identities.

An article in *Sunday news* (22 July, 1990) quotes one nurse (Pearl Bennett)(referred to below). I have been unable to identify her, and I do not know if she is still alive, and able to respond to questions.

The Mellsop-Radford report makes it clear that *general* nursing care on the DST units was good. No-one died in the ward; there was expertise and equipment (oxygen, hydrocortisone, intravenous valium, dextrose drip) to cope with emergencies. Despite high quality general nursing, records available suggest that there was little expertise in mental health nursing. There is little sign of detailed – or any - psychological assessment, or professional standards of psychiatric nursing.

A comment from my contact subjected to DST is that the main body of nurses were not at all sympathetic in their approach, with few psychological skills, whereas community-based nurses were more considerate. The two types of nurses wore different uniforms, with different lapel badges. This might suggest that specialist nurses were recruited for a special purpose, perhaps related to the physical nursing care needed for DST. In this context, I have heard from two sources that, much later, in the 1990s some staff in a mental hospital in the North Island were British military physicians. I have wondered whether the non-community nurses at Cherry Farm were also in part military.

***Diagnosis of patients subjected to DST*:**

The Mellsop/Radford report states that patients had a wide range of diagnoses, often multiple for one patient. Some patients had not been in hospital long-enough for accurate diagnosis – or even any diagnosis - to have been determined. ‘*In many, the diagnosis . . .appears not to have stood the test of time.* Use of DST seems to have been haphazard with respect to diagnosis.’ Mellsop and Radford identified this as a point for criticism. However, it may not be so remarkable: I heard from another source that scant attention to diagnosis was fairly normal in mental health services in the 1970s in New Zealand. There was little need for diagnoses in asylums in some English-speaking countries until the American Psychiatric Association brought in its third edition of Diagnostic and Statistical Manual (DSMIII) in 1980. DSMIII was more of an administrative than a clinical document but became widely used for clinical purposes. Administratively, it was important that mental health patients had formal diagnoses, whatever their validity, both for purposes of financing, and to refute charges of unnecessary confinement in mental hospitals.

***Source of Referral*:**

The Mellsop-Radford report does not give a full breakdown of the sources of referral, but affidavits therein mention referral from:

* other villas at Cherry Farm;
* Ashburn Hall (a private psychiatric clinic on the outskirts of Dunedin);
* directly from an un-named GP;
* from ‘Ward 10’ at Wakari Hospital, in a Dunedin suburb. The University Department of Psychological Medicine was located at Wakari, a stone’s throw from Ward 10.

One affidavit mentions that the writer came from a Borstal in the Invercargill A letter is included in the Mellsop-Radford report from the superintendent at the Invercargill borstal. The superintendent of Cherry Farm[[39]](#footnote-39) visited and persuaded him to come to Cherry Farm for a ‘rest’; but later, when transferred to the DST unit, this ‘patient’ realised he had made a mistake. When I met the person, who, in 1980s directed Cherry Farm, I was told that, in the previous decade, it was a quite open strategy, to offer young people with disturbed backgrounds, and who had run foul of the law, ‘a better alternative’. As described in the previous chapter, criticism was raised by the Royal Commission of using psychiatric facilities to treat behavioural problems in young people. Journalist Fran O’Sullivan claims that those submitted to deep sleep therapy included not only psychiatric patients, but also women prisoners within the corrections system. She did not question use of DST on psychiatric patients (although she was troubled by having to administer deep narcosis medications to patients while she was a student nurse there). The most troubling matter for her was use of DST on prisoners. I understand that she brought complaints against Dr Martinus at the time (probably ~1974).

A newspaper report (*Sunday news,* 29 July, 1990) stated that ‘*Some patients were sent to Cherry Farm’s narcosis unit by then head of Psychological Medicine, at Otago university, Professor Basil James*.’ This fact was probably discovered by CCHR investigators. Professor James is important in my story, and I have more detail on him in a later chapter. The significance here is that, despite being local to the region, and one of the more important psychiatrists in the country both in the 1970s, and when CCHR did its investigations, his name was never mentioned in the Mellsop-Radford report. This is quite odd. It seems that authors of the report deliberately avoided mentioning him.

In October 2012, I was in correspondence with Graham Mellsop. I quote a key sentence from his message: *‘One of the sad things about the Cherry Farm deep sleep, I think, was that while a particular psychiatrist there was blamed* [I assume, Martinus]*, many of the patients were referred by one of the country’s most highly regarded psychiatrists!’*. [Mellsop’s exclamation mark, not mine]. Professor Mellsop was being deliberately vague and knew more than he was prepared to tell me. He hinted that Dr Martinus was not the real driver of the DST project: Someone else may have been ‘pulling the strings’. He may have been referring to Professor Basil James, then head of the Department of Psychological Medicine at Otago University, who had a high public profile at the time. I was on the staff of Otago Medical School as a recent immigrant from the UK, and keenly followed news about psychiatry. I can think of no-one else to whom he could have been referring. On 29 March 2019, in the context of the present Royal Commission, I wrote to Professor Mellsop, giving the name of the person to whom I had assumed he was referring in his message to me in 2012. In his reply he was unwilling to confirm or deny what I suggested.

***The DST Regime*:**

The Mellsop-Radford report states that the usual duration of the ‘Modified Narcosis’ was around six weeks. No detailed protocol of treatment is not described, but excerpts from the various affidavits give an idea of the regime:

* ‘Sedated more or less all the time’;
* ‘Just endless days of pills, sleep . . .drowsiness, vaguely awake’;
* ‘Average sleep over this period 17 hours per day’;
* ‘I recall being constantly drugged and taking vast amount of pills’;
* ‘I was so heavily drugged as to have no real recollection of what was happening during that period’;
* ‘I was told that I would sleep 18 out of the 24 hours, per day, and would be improved following a 6-week period of this treatment’;
* ‘. . .she was kept asleep all of the time. She was sat up to have her meals, bathed etc. I remember every four hours she would be given injections and hand fulls of pills to keep her unconscious.’
* Through most of the five weeks the patient slept for 17 hours daily.

Nurse Pearl Bennett (quoted in *Sunday news*, 22 July, 1990) worked the night shift in Villa H, one of the narcosis units. She said it was run under heavy security, and that ‘*she has never felt happy with the goings-on at Cherry Farm in those two years and “it was about time the truth came out”’*. She ‘*It was a strange place. . . All the patients were under heavy sedation. . .They were kept in this sort of state for up to two weeks at a time – I never found out why – it was just my job to look after them*.’

***Medicines Used, Doses and Polypharmacy*:**

Several classes of medicine were used in DST units, including short-acting barbiturates (sodium amytal, and pentobarbitone); Nitrazepam (‘mogadon’) - a long acting benzodiazepine; antipsychotics (chlorpromazine, haloperidol); Promazine (a low potency antipsychotic agent, more a sedative than antipsychotic agent); antidepressants (tofranil [imipramine] is mentioned in one affidavit); hemineurin (aka Clomethiazole) a sedative/hypnotic which acts in a manner similar to barbiturates; and anticonvulsants (sulthiame is mentioned, used against partial seizures). Other agents used were generally given to counteract motor side effects of antipsychotic drugs (eg benzhexol), and to prevent constipation (coloxyl, danthron).

In one case, for which detailed psychiatric progress notes were provided over five weeks, initial doses of chlorpromazine was 300 mg three times daily, and 700 mg at night (total 1600 mg daily) and sodium amytal (100 mg three times daily). Over the first week chlorpromazine was increased to 1900 mg daily, but on the fourth day, sodium amytal was reduced to 100 mg twice daily. Obviously it was used as a potent sedative rather than an antipsychotic agent.

Barbiturates, benzodiazepines and hemineurin are all known to be associated with rapid development of tolerance and dependence if taken for more than a few weeks, and withdrawal symptoms if terminated suddenly. Towards the end of the five week period, promazine was substituted for chlorpromazine, and doses of nitrazepam were tailed off. This made sense, given the risk of serious withdrawal effects after habituation to nitrazepam.

***Adverse Effects of Medicines*:**

The most serious side effect appears to have been *Delirium tremens* (although not named as such)*.* In regular practise thisoccurs most often in those who have abused alcohol and become dependent on it, during withdrawal. It can occur on withdrawal from both benzodiazepines and barbiturates, for which drugs tolerance and dependence develop quite rapidly (within a few weeks) even at normal doses. Clearly, for such medications to be prescribed in those who were already alcohol dependent and tolerant (as some were in the DST unit) is problematic. Mellsop and Radford write: ‘*Despite some of the patients being regarded as “dependent on” or as abusers of alcohol, they appear to have been prescribed barbiturate and/or benzodiazepines.*’

In one typed affidavit the dose of 55 mg Nitrazepam is mentioned. The usual dose is 5 mg. This *might* be a mis-typing, but it is hard to believe that there had been no cross-checking of this detail. If correct, it implies that either a massive excess dose was prescribed, and/or that a high degree of tolerance had already developed. In another affidavit, a patient describes great difficulty in stopping prescription medications, after discharge from the unit. Statements in the report, and affidavits suggest that *Delirium tremens* **did** occur from time to time: In one affidavit, the author writes ‘*I saw a patient having a fit on the floor. I was told she was withdrawing from narcosis drugs, and the process was too fast’*. This patient herself experienced something similar, according to her affidavit. Mellsop and Radford comment that *‘the amount, nature and varieties of drugs used in our opinion were not consistent with sound clinical practice’; ‘the degree of polypharmacy is viewed by us with concern’*; and ‘*of additional concern was the use of drugs known to be dependency-producing [barbiturates and to a lesser extent benzodiazepines] as a core pharmacological tool.*’

Other serious side effects were:-

* postural hypotension or ‘hypotensive crises’ (BP: 86/60 in clinical notes in one case). This was understandable after prolonged treatment with benzodiazepines, and a similar problem was well known as early as the 1930s when DST was in use.
* suspected deep vein thrombosis (mentioned in one affidavit: *‘leg continued to cause pain, and mild DVT was suspected’*);
* loss of the ability to walk (and not just due to hypotension) such that retraining was required;
* inability to speak;
* impaired vision;
* inability to swallow (These last four complaints are possible motor side effect, including effects on eye movements, of antipsychotic medications, in which case they are temporary);
* incontinence.
* My contact who had been subjected to DST says that, on release from Cherry Farm she had gained massively in weight, a disturbing symptom which she could not explain. Exactly the same was reported by the person I corresponded with, who had been in Sargant’s ward at Royal Waterloo.
* Although no deaths were reported in the DST units (unlike at Chelmsford), there is mention of a suicide eight days after discharge from villa H.

The report in *Sunday news* (29th July, 1990) quotes Professor Ralph Edwards, at the time Director of the National Toxicology Group, and associate professor in clinical pharmacology at Otago University. After reviewing the case records of one patient he stated: ‘*It is apparent that some weird things were happening at Cherry Farm’. He says that only a full inquiry will allow the full truth to be known*.’ It is not clear whether he saw the case records as part of the Mellsop-Radford enquiry, or as a result of enquiries by CCHR or the journalist.

***Record keeping*:**

Mellsop and Radford write in their summary: *‘Hospital record keeping leaves a lot to be desired, resulting in difficulties in deciding why certain treatments were given, and what the results of those treatments were.’*

In addition:

* *‘In no files could we find detailed progress notes over the MN period from a doctor. In approximately half of the files the nursing notes for the MN period were missing. In the others there were daily reports available for inspection.*
* *‘It was often difficult to follow in a logical way what diagnoses had been made, the reasons certain treatments were given and the results achieved.’*
* *‘There was insufficient evidence on the file that their assessment had been thorough.’*
* *‘There was no evidence in the patient files of systematic monitoring of the therapeutic effectiveness of MN.’*
* *‘In most cases there was evidence of careful physical monitoring recording of drugs given, and of drug prescription including vitamins.’*
* *‘Where patients suffered from complications, the nursing staff appear to have recorded these and dealt with the problems in an acceptable manner.’*

***Was Informed Consent Given by Patients to the DST?***

A dissertation of Dr Tafuna’i (‘*On the Efficacy of Modified Narcosis Therapy’*) is quoted by Mellsop and Radford, stating that consent was obtained from all patients or their relatives. The authors comment suggest *‘we think it is possible that most patients did have the procedure of MN discussed with them prior to entering the unit, and that they gave at least tacit consent’*. However:

* Nurse Pearl Bennett is quoted (*Sunday news,* 22nd July, 1990): ‘*The poor patients had no idea what they were doing or what was being done to them.’*
* In *Dominion,* 24 July 1990, a Mrs Mason is quoted as saying ‘*Dr Martinus talked it over with me and said that he had a new experiment he would like to try on my son’*
* For at least one patient at Cherry Farm, there is no record of consent.
* An Affidavit states: ‘*I do not recall signing any consent forms’*.
* Another Affidavit states: ‘*I did not sign any consent forms to have sleep therapy or ECT*.’
* An Affidavit from a Wellington patient states: ‘*The psychiatrist told me I was physically and emotionally exhausted and offered me help in the form of “sleep treatment”. He explained that this would give me the rest I needed*.’
* An Affidavit from a New Plymouth patient states: ‘*Nobody ever advised me what was going to happen. . .I was never asked about my consent to the treatment’*

As mentioned earlier in this chapter, emphasis on the ethical principle of informed consent grew after the Nuremberg ‘Trial of Doctors’ in 1946/47. Initially it referred to research studies, but was later held to apply to most medical treatments and interventions. Development of operational procedures to obtain legally-valid informed consent did not occur until after ~1979. Regardless of this physicians throughout the 1960s and 1970s should have been aware of the need to obtain informed consent. At that time, this probably did not apply to most nurses whose professional role was highly subservient to medical professionals. Nonetheless, some nurses were obviously keenly aware of the principle, albeit with little power to insist it be followed.

***Dr Martinus’s Accounts of DST*:**

On 28 July 1990, an article by Fran O’Sullivan (which newspaper is not clear) quote Dr Martinus stating *‘“Deep Sleep” therapy was never used at the unit he supervised. It was a modified narcosis – a very mild sleep therapy which was intensively monitored’*. Dr Martinus said that it was used for depressed patients, kept “lightly” sedated for a period of time.’

On 29 July 1990, an article in *Sunday news* quotes Dr Martinus saying: ‘*The unit was used as a last-ditch “treatment” for unruly and troublesome patients sent from all over the country.’ ‘and full records were kept on every patient who visited the unit.*’ ‘*Dr Martinus was spoken to by senior members of the Otago Area Health Board about the narcosis unit on Thursday* [26 July]*, where he put exactly the same claims to them.*’

After release of the Mellsop-Radford report, Dr Martinus was interviewed briefly for Radio New Zealand by Cecily McNeil. He insisted that he had a clear conscience. He admitted that this manner of treatment was no longer (i.e. in 1991) used anywhere in the world. Most patients (he said) were suffering from severe depression or anxiety. Many came to Cherry Farm as a last resort, already having gone through antidepressant therapy or ECT. No-one died, but some became incontinent, or suffered DVT.’

There are inconsistencies between what Dr Martinus claims and other evidence:

* The claim that DST was used only for severe depression or anxiety conflicts with what Mellsop and Radford reported.
* The claim that DST was ‘intensively monitored’ might well have been correct, given that equipment and other preparations for adverse events were available; yet there is no evidence in the records to substantiate the claim.
* The claim that full records were kept is at odds with the Mellsop-Radford report, unless they *were* kept, but were subsequently lost, destroyed or sent and housed elsewhere.
* It can be questioned whether all patients came to the DST unit ‘as a last resort’ given that Mellsop and Radford found that only one was a candidate for leucotomy, and many patients had not been examined thoroughly enough to make such a call, or even obtain a reliable diagnosis.

***Apparent Secrecy*:**

Cherry Farm was itself an isolated institution. Villas ‘H’ and ‘D’ were in part of the hospital complex most remote from the main highway. Even within Villa H, the narcosis unit was a little apart, segregated from the rest of the villa.

Most patients were vulnerable young persons, possibly selected because they would never be believed if they were to speak out. My contact who had been in a DST unit eventually gained access to her case notes, which, apparently estimated her to be a hopeless case, consigned to an asylum for the rest of her days. *Little did they know*!

One affidavit mentions a teenage girl’s parents being prevented several times from seeing her when she was in Cherry Farm. Another states that ‘*I was moved to Villa A, because I was asking too many questions about what was going in Villa H’*. A third reports a patient being told she ‘*had no rights, that I could not vote, and that I would never be able to stand on a jury if I ever got out of Cherry farm*.’ Since patients would never be full citizens, any stories they told would never be believed. Thus the DST units seemed to be operating in a clandestine manner. Their location, the selection of patients therein, and the way the program was run seemed to be designed to avoid knowledge reaching the public.

In 2012, I tried to obtain the diploma dissertation of Dr Tafuna’I, in Otago University Library. It was not available. This need not arouse suspicion, because, unlike Masters or Doctoral theses, diploma dissertations may not be archived in university libraries. However, the dissertation was not to be found in the Department of Psychological Medicine (where it should have been held), although Mellsop and Radford obviously read it in 1990. Regardless of this, the fact that a dissertation was written, implies that, in some sense DST at Cherry Farm was some sort of research project, not regular treatment.

***Systematic Cover-up?*:**

There were many open publications in academic journals on DST in the 1920s and 1930s, often reporting serious dangers to physical health. After the second World War, there were few publications on this, and none from Bailey about practice at Chelmsford, nor about DST at Cherry Farm (apart from the Tafuna’i diploma dissertation). Nor, to the best of my knowledge was there any report to the Ministry of Health when the program ended.

Martinus’ name is redacted in the copy of the Mellsop/Radford report now available. At about the time of release of the Mellsop-Radford report, the Medical Council of New Zealand (MCNZ) conducted its enquiry into Martinus and DST at Cherry Farm. Georgina Jones, who was Chief Executive of MCNZ at that time wrote in her report of those years as follows:

*‘In 1992-1993 the PPC was faced with a complex investigation when complaints of malpractice came in, alleging that psychiatrists had been using “deep sleep therapy” at Cherry Farm near Dunedin in the 1970s. The investigating committee finally determined that there was no case to answer. A detailed press release was made when the complainants were informed, as the issue had sparked considerable public debate. It is interesting to note that, more recently, forensic psychiatric practice in that era has again been under the spotlight over the use of drastic measures to modify the behaviour of “uncooperative inmates” at Lake Alice Hospital near Marton. In the latter case, the allegations were proven, leading to compensation payments and charges being brought against the chief medical officer of the institution, now in Australia.*’[[40]](#footnote-40)

The former-patient in the DST unit at Cherry Farm to whom I spoke referred to ‘hush money’ being paid to two patients there (about $10,000). I do not know when it was paid, by whom, or whether it was the same as the ACC payment referred to in the ODT article. A report in Otago Daily Times[[41]](#footnote-41) gives a different slant:

*‘A two-year Medical Council investigation subsequently cleared the Cherry Farm psychiatrist of misconduct, saying the patients had not received deep sleep therapy but modified narcosis, which induced light sleep for up to 18 hours a day, allowing patients to get up, eat and exercise. The treatment was not improper or unreasonable at the time, the council said. The Accident Compensation Corporation paid compensation to at least one of the former patients who had modified narcosis therapy.’*

The last sentence contradicts the penultimate one, which itself contradicts Mellsop and Radford who had greater expertise. In August 2012, I asked the Medical Council about Dr Martinus. They had never heard of him.

***Hints of Concealment of Professor James’s knowledge of DST at Cherry Farm***:

Two months before Helen Clark ordered the inquiry into Deep Sleep Therapy and appointed Mellsop and Radford to conduct their inquiry, contradictory reports appeared about Professor James’s awareness of DST at Cherry Farm. An article in *Sunday star* (29 July 1990) claimed that he ‘knew about and supported’ the DST unit at Cherry Farm. A month later, another article (*Dominion*, 27 August 1990) quotes him saying ‘*I had no responsibility for what occurred in Cherry Farm at any point and, to the best of my knowledge, never referred anyone for the treatment’*. Note that in he did not say he did not know about it, but perhaps implied that he did not. At the time, he was Director of Mental Health in Wellington; but by the end of the year, he had resigned his position to relocate to a position in Queensland, Australia.

Professor Mellsop’s phrase in his message to me in October 2012 referred to ‘*one of the country’s most highly regarded psychiatrists’*. This seems to refer to Professor James: He had a high public profile at the time. I was on the staff of Otago Medical School at the time, a recent immigrant, and keenly followed news about psychiatry. I can think of no-one else to whom he could have been referring; but he was being vague, signifying that he knew more than he could say. On 29 March 2019, I wrote to him, naming Professor James as the person he appeared unwilling to name in his message to me in 2012. In his reply he was unwilling to confirm or deny what I suggested. He was hiding what he knew. It is hard to believe that Professor James was not the person referred to. It is also hard to believe that Professor James did not refer patients to the narcosis unit. Given this, it would have been obvious for Mellsop and Radford to have sought to interview him regarding DST at Cherry farm, but there is no hint of this and no mention of his name, in their report. This is extraordinary. However, by 26 September 1990, when Helen Clark commissioned Mellsop and Radford to conduct their enquiry, Professor James was already in Australia. A phone conversation would have been easy, but there is no suggestion that such contact was made. This is again strange.

In 1975, in the middle of the period when DST was carried out at Cherry Farm, Dr Martinus became a fellow of the Australian and New Zealand College of Psychiatry (not yet *Royal* College). In addition, the Mellsop-Radford report cites the dissertation by S.S.Tafuna’i, for Diploma in Psychological Medicine at University of Otago (*‘On the efficacy of modified narcosis therapy’*). Professor James was head of the Department of Psychological Medicine in Otago University and soon to be President of the bi-national Royal Australian and New Zealand College of Psychiatrists when (mid-1977) it acquired ‘***Royal*** College’ status. Both Dr Martinus and Dr Tafuna’i would have been under authority or supervision of this professional body and/or the Department of Psychological Medicine in Otago. Given this, and the fact that some referrals were from Ward 10 (a venue for clinical teaching in Otago University Medical Faculty), as well as from Ashburn Hall, one is forced to conclude that Professor James *must* have known about DST at Cherry Farm.

In my introductory chapter I described how I sat on committees of RANZCP for five years, and explained how I was driven to say farewell in a dramatic and challenging manner; yet that ending was enigmatic to those who witnessed it because I had not yet gained a clear view of the roots of my evident disquiet. One representative on the committee was another New Zealander who I had known for thirty years. He had been closer to the action in Otago mental health politics than ever I was (though not in the 1970s), had much wider experience of such politics at a national level than I when Basil James was Director of Mental Health, and he had much longer and closer association with RANZCP than I. Before he died I had two useful conversations with him via Skype. Like me, he could remember Basil James twenty years earlier and more, when he was active in New Zealand. On the subject of Deep Sleep at Cherry Farm, he said ‘*Basil must have known what was going on at Cherry Farm’*. That was an important statement; but I am sorry he had never said this in committee. Basil James died in 2017. No-one ever tried to call him to account. This is disturbing. There are serious, dark secrets hidden in this story.

***Who Was ‘In the Know’? Who Turned a Blind Eye?***

Nothing was made publicabout DST at the time, and no scientific or medical publications resulted from its use at Cherry Farm. Mellsop and Radford concluded that the superintendent of Cherry Farm at the time knew of its use; this is supported by an affidavit. The superintendent at the time was Dr James Hannah (who I did meet in the late 1970s), but articles in *Sunday news* refer to Dr Charles Moore, who was replaced by Dr Hannah in 1970. Both of these were listed as staff members in the Department of Psychological Medicine of Otago University. Both must have been in the know.

The Otago Area Health Board’s ‘consumer information and complaints committee’ made a comment (*Dominion*, 14 September 1990) that the treatment was ‘*at its worst, a somewhat idiosyncratic treatment regime’*, although one committee member challenged the statement, claiming that drug doses were at such levels as to appear experimental. Given this, and the comment of the toxicology professor Ralph Edwards, quoted above, there does seem to have been a striking lack of curiosity.

In later chapters I present evidence of at least three persons at high levels of administration or politics at the time, knew of an important visit from overseas, which could have had a direct bearing on what went on both at Cherry Farm, and at the Lake Alice Child & Adolescent Unit in the same period. They kept knowledge of this secret, and one of them appears to have deceived parliament in August 1972, thus concealing details of the visit.

***Did the DST program at Cherry Farm really have Therapeutic Objectives?***

Several points mentioned above are consistent with the notion that *DST in New Zealand in the 1970s, especially at Cherry Farm was carried out for purposes that were* ***not*** *therapeutic.*

* Carrying out unorthodox, outdated and dangerous procedures in an isolated institution, on vulnerable patients, who, it might be thought, were unlikely ever to be believed, if they were to report what they experienced.
* Lack of open publication of results
* Lack of logical relation between diagnosis and treatment
* Absent recording of therapeutic effectiveness of the DST regime
* Use of medications in doses, durations and combinations known to have serious risks
* Prescription of medications known to pre-dispose to addiction and tolerance, with potentially serious side effects on withdrawal, to patients already addicted to alcohol, and at risk of similar complications.
* Poor diagnostic assessment, or none
* Poor medical record keeping in terms of standard medical expectations
* Scant regard for principles of medical ethics accepted at the time.
* Unexpectedly high-quality *general* nursing (as also stated by Dr Martinus), apparently with expectation of known physical problems in managing patients, combined with poor quality psychiatric nursing. This is surprising for an isolated institution such as Cherry Farm. It suggests some forward planning.

***Comparisons, Contrasts, Motives***

In my introductory chapter and in the last two chapters I surveyed first, a phoney inquest, then horrific abuse and torture in an isolated rural mental hospital ward, and in this chapter various versions of a less horrific but still very disturbing type of mental health treatment in centres in both Britain and New Zealand. Despite differences there were *common threads*.

The victims in all these situations were vulnerable young people, minor youth offenders, those with troubled backgrounds, young people from racially disadvantaged groups and sometimes with disabilities or difficulties in communication. They would rarely tell their stories in coherent fashion, and if they did, were unlikely to be believed.

An affidavit from a Cherry Farm patient, had a telling line. She was told she ‘*had no rights, . . .could not vote, and . . .would never be able to stand on a jury if . . ever got out of Cherry farm*.’ One of the most important of citizen’s rights is the right to vote in General Elections. Relevant legislation, the Electoral Act 1893, much vaunted because it gave women the vote before any other country, included the following clause:

*8. No alien, lunatic, or person of unsound mind, nor any person attainted or convicted of any treason felony, or of any offence punishable by imprisonment for one year or upwards within any part of Her Majesty's dominions, or convicted within the colony as a public defaulter, or under "The Police Offences Act, 18B4," as an idle and disorderly person or as a rogue and vagabond, unless such person shall have received a free pardon, or shall have undergone the sentence or punishment to which he shall have been adjudged for such offence, shall be entitled to be registered.* Current legislation (Electoral Act 1993) still has a similar clause(*80. Disqualification for registration*), but is more precise in its application, and less sweeping in its reach. Nonetheless, the line from the nurse at Cherry farm to this patient was probably the ungarnished truth. Some might have tried to use this clause in the Act to justify the abuses they perpetrated, on the grounds that the victims were essentially ‘non-citizens’ with no rights.

In all scenarios so far considered, procedures for admission to hospital were questionable; behavioural problems were mistakenly treated as psychiatric issues, often with minimal attention to formal diagnosis and informed consent. Record keeping was generally inadequate.. However, there were *differences* between the different scenarios, which lead me to consider driving motives.

What occurred at LACAU caused severe pain and profound fear. It was torture by any definition, and was deliberately cruel. It may indeed have been *intended* to have lifelong adverse impact on those young people.

Deep Sleep Therapy, as it occurred under Sargant Bailey and at Cherry Farm was very different. However, medicines used in Sargant’s practise and at Cherry Farm were similar – especially barbiturates and benzodiazepines (nitrazepam) - in similar doses, and with similar side effect, including side effect of withdrawal. There were also differences between these two scenarios: ‘Prolonged narcosis’ in Sargant’s regime after 1964 combined drug-induced sedation/light anaesthesia with frequent ECT. It seemed designed to obliterate memory, and was often quite effective in this respect. This was probably also the rationale in the more remote locations of Dundee and Dublin after 1972. At Cherry Farm ECT was not used so often. There were no prominent or repeated reports of severe memory loss. The rationale appeared to be different from that in Sargant’s procedures. What the rationale might have been is discussed in a later chapter. However, at another site in New Zealand - Ngawhatu hospital near Nelson - more intensive use of ECT did occur, which led to major memory loss and related disablement. This was conducted by Dr Rina Moore, mainly in the 1950s. I comment on this in Chapter 5.

***Questions*:**

As I wind up this chapter, as in the last, I leave the reader not with conclusion, but with questions. My account of Sargant and his use of Deep Sleep Therapy is clearly incomplete, leaving numerous questions unanswered. I have selected material to portray him as a somewhat unorthodox, radical psychiatrist, but beyond that, possibly a genuine health care professional – but that account was hardly convincing. The most important remaining questions were:

***How did he get away with practicing the way he did, with all its shortcomings?***

***Who was protecting him?***

***Who was funding him?***

***What was the real objective of those who funded him?*** The only information I have on this is from a paper of his in BMJ in 1966: *‘Valuable help was obtained from the endowment fund of St Thomas’s and gifts of money from private lay persons’*.

***Did no-one ever ask for further details?***

Sargant’s full story is so complicated that I deliberately present Sargant first in this way. To convey the darker side of his work in a way that makes sense, I need to prepare the ground with more material on historical context. In this framework some of the questions *do* have answers.

At Cherry Farm, a puzzling aspect of the DST regime is that, despite poor quality mental health nursing, there were clearly good preparations for physical care, including equipment and drugs to cope with anticipated emergencies, There may have been specialist nursing staff for physical care. In any case, there are suggestion of advance planning, and therefore possibly special financial arrangements, as needed for something that was not routine, and possibly classed as research; but there is no evidence of any research proposal. Warwick Brunton told me that all money transactions for Cherry Farm would have gone through that hospital’s administration. However, given the signs of secrecy about the narcosis units, assumptions about ‘normal procedures’ should perhaps be set aside. In any case, up to 22 March 1972, Cherry Farm was administered from the Ministry of Health. Financial records related to appointment of Martius, and possibly planning of the DST program might not therefore be in Otago.

Professor James, of undoubted importance in my story, appears to have been ‘air-brushed’ out of history.

***What DID Professor James know about DST?***

***What part did he play in its planning?***

***Who - or which agency - was really behind this ‘research’ program?***

***Who - if anyone – coordinated the cover-up?***

***. . .and Why?***

***Why did Professor James also relocate, when DST started to receive press coverage?***

***What was the real objective of DST at Cherry Farm?***

The Mellsop-Radford inquiry and report also leaves us with unanswered questions:

***How, and by whom, were the Terms of Reference decided?***

***Why did the ToR not ask that the Chain of Responsibility for DST be Examined?***

***What was Graham Mellsop hiding:***

***What does Mellsop know that he will not or cannot share?***

***For those in the know, how wide did the network spread?***

***Cross Links? Sargant, Bailey, Martinus, James. . . .and even Leeks?***

My descriptions so far - of a crooked inquest, of torture and abuse, and of DST in different centres in several countries – has so far kept these episodes separate from each other. This also is how they were dealt with in the various enquires generated by these episodes. But were they *really* separate from each other? Many strands of evidence suggest that they were not.

Concerning Dr Martinus, in *Sunday News,* 29th July 1990, we read:- ‘*It was as a teacher in the late 1950s at the Institute of Psychology in London, that Dr Sargant met young Sri Lankan doctor Martinus. Sargant not only taught Martinus but also took him for his final exams.*’ This is intriguing and potentially important, but not accurate in detail. I never heard of an ‘Institute of Psychology’: It must be ‘Institute of Psychiatry’ in Camberwell, London (well south of the Thames). It is unlikely that Sargant taught Martinus at the Institute of Psychiatry, because by the late 1950s Sargant had been head of Department of Psychological Medicine at St Thomas’s for nearly ten years, and, I understand, his relations with the Institute of Psychiatry were far from cordial. However, the statement that Martinus had been one of Sargant’s students (at St Thomas’s) is likely to be correct. The same *Sunday News* article, quotes Martinus saying that ‘*he learned his trade under William Sargant’*; and in his interview for Radio New Zealand in 1991, he stated that ‘*what he was doing was similar to what William Sargant had done at St Thomas’s’*. This was reiterated in the interview with Cecily McNeil. Given similarities between Martinus’s and Sargent’s version of modified narcosis, there is no doubt that he really did train as a psychiatrist under Sargant[[42]](#footnote-42).

In the interview with Cecily McNeil, he also claimed that what he was doing at Cherry Farm was different from what was going on at Chelmsford (i.e. ‘*modified* narcosis therapy’) and that, like Sargant’s practice, it was only ‘mild’ narcosis. In one sense this was correct, but in another was deceptive. Sargant’s procedures after 1964 was not ‘mild’. Martinus’s statement implied that the practice at Chelmsford was ‘unmodified’ narcosis (presumably similar to what Sargant had been doing prior to 1964). This is incorrect. It was an undisciplined exaggeration of what Sargant was doing at the same time.

With regard to Bailey himself, he certainly learnt about DST from Sargant in the mid-1950s, and his practice at Chelmsford certainly grew out of Sargant’s. Sargant was well aware of inherent risks and had access to excellent nursing care to avoid the hazards. Bailey did not. One witness against Bailey was a nurse who worked briefly at Chelmsford in 1972, and was so alarmed by what she saw, that she eventually obtained employment there, to collect further evidence. Through the 1970s, so she reported, Bailey was in regular contact with Sargant. They seemed to compete with each other to see who could keep patients under deep sleep for longest. While this may have reflected a flippant off-the-cuff remark made periodically by Bailey, it suggests that longer duration DST which Sargant had started at St Thomas’s in 1964, continued not only in the clinic Sargant used after he had abandoned his practice at St Thomas’s, but also, after his own fashion, in Australia at the Chelmsford clinic.

There were also links across the Tasman, through the College of Psychiatry, between attempts to forestall Bailey being held to account in New South Wales, and what was unfolding in 1977 regarding Lake Alice Child & Adolescent Unit. CCHR members in Australia played a major part in collecting the evidence about Bailey and Chelmsford and in exposing it. The public image of CCHR was worse in Australia than in New Zealand: Scientology was banned in the state of Victoria. When the new President of the British Royal college, Sir Martin Roth was asked about Bailey and Chelmsford, he warned the Australian psychiatrist who sought his advice, ‘proceed with caution’, because adverse conclusions would leave the profession vulnerable to further criticism from ‘scientologists’. This line is remarkably similar to that from Dr Dobson, for the New Zealand branch of the college at the same time. In reality, regardless of scientology, the college *was* indeed vulnerable until a serious issue was addressed.

Not only did Dr Martinus have links with William Sargant*: So did Professor James*: I have no evidence that Basil James ever met Sargant. However, at the time of appointment in Otago there is much evidence that he was strongly influenced by Sargant. The three papers (all single case studies) he had published at the time of appointment all cite Sargant’s writings, including *Battle for the Mind.* One of these publications was on abreaction therapy for a patient with long-standing war-related trauma – a method promoted much earlier by Sargant. The other implicitly drew on the concept of abreaction. Sargant’s version of Pavlov’s psychology was evident in these publications, as it was in a published lecture he gave in Otago in 1967. I go into more detail on Pavlov later. It all gains significance from the fact that Sargant’s practice was mainly rejected in Britain at the time of appointment. I infer that practice in psychiatry by both James and Martinus was strongly influenced, indirectly, and perhaps directly, by William Sargant, although, by the 1970s, use of DST had long been abandoned by most psychiatrists in Britain and elsewhere.

There were also links between Dr Leeks and Professor James. Before he went to Britain for training in child psychiatry, Leeks had been a member of the same department where Dr James had been appointed (although not yet head of that department). In the Royal Commission hearings, one CCHR witness stated that in 1973, when Martinus was carrying out DST, Leeks visited Cherry Farm. My enquiries with today’s District Health Board in Otago, produced the reply that they had nothing in their archives to indicate that they had organised the visit. They suggested it was probably organised from the Department of Psychological Medicine.

A curious coincidence links what went on at LACAU with Martinus’s practice at Cherry Farm. In 1978, after much adverse publicity in newspapers about Lake Alice Child & Adolescent Unit, Dr Leeks ended his employment there, and relocated to a position in Victoria. In the same period, there had been no publicity about DST at Cherry Farm. That came a decade later. On 25 May 1978, after the DST program there ended, Dr Martinus took out New Zealand citizenship, as if now committing to spending many untroubled years in the country; but within a year, he had uprooted himself again, to take up a position at Callan Park ospital, , Sydney, across the Tasman. This odd coincidence suggests ‘pressure’ or ‘enticement’, in common with that which led Leeks to relocate at about the same time. After arrival in New South Wales, he is known to have started a company of some sort, but its objectives were not clear, and was eventually wound up[[43]](#footnote-43).

***Why did Dr Martinus leave the country soon after DST ended at Cherry Farm?***

***Did he go voluntarily, or was he pushed? Was he escaping something?***

***Did he receive payment, to encourage him to relocate, enabling him to start his company?***

Complaints were made about inadequacy of record keeping in testimony to the Royal Commission about Lake Alice Child & Adolescent Unit, and also by Mellsop and Radford about the narcosis units at Cherry Farm. It is hardly remarkable and may have been typical of mental hospitals throughout the country at the time. However, in *Sunday news* (22 July, 1990) Mellsop is quoted as saying that he had heard of deep sleep treatment in Australia, but had never encountered it personally. That was a huge understatement. A Royal Commission in New South Wales about the Chelmsford scandal had been running since 1988, with hundreds of witnesses (victims, staff etc) called to testify and be cross-examined. Mellsop must have been keenly aware of this. He hid what he knew. ***Why was Mellsop one of the two investigators assigned the task of enquiring into Deep Sleep Therapy?***

***Reason versus Rhetoric; Socrates versus the Sophists.***

In stories recounted thus far I discern another unifying thread of great interest. Consider the following:

* In the inquest in which I had been involved, the eventual bland outcome was shaped long in advance by the simple device of ruling that evidence prior to the young man’s last admission to hospital was ‘out of scope’.
* In administration of the Royal Commission by Department of Internal Affairs, a late change in Terms of Reference ensured that state servants at high levels, could never be held to account, nor, probably, could their agencies, department, or directorates be disbanded on receipt of recommendations from the Royal Commission.
* In the present chapter, I have just pointed out numerous commonalities, and numerous direct or indirect links between the different scenarios I considered, where institutional abuse within mental health services occurred, and indeed, where institutional structures were themselves abused. Yet the various enquiries, despite escalating levels of prestige, always considered the different scenarios isolation, never together, to highlight these commonalities, and links. This sophisticated strategy ensures that systemic rottenness can be exposed only on a small scale, never in comprehensive fashion.

Two-thousand three hundred years ago, in the warlike world of east-Mediterranean city states, a brand of professional advocates arose, whose task was to argue the case for whoever would pay the bill. These were the ‘sophists’. In their midst arose their Athenian adversary, archetype of all gadflies, the semi-mythical Socrates, who regularly exposed in public debate – so we are told – the shallow style of argumentation used by sophists. As we are told, he paid for his provocative behaviour with his life, an event which had a profound impact on the young Plato, and soon after on Aristotle. He first in the west to make the attempt to define formal reasoning with words in systematic fashion. Today, we generally distinguish reason from rhetoric (province of the sophists). Nonetheless, despite all Socrates tried to do, for the next 2000 years, across most of Europe, rhetoric was a necessary part of a young man’s education. The difference between reason and rhetoric is easily explained. In reasoning, conclusions are supposed to follow from the premises. In rhetoric, the conclusions are known in advance, and the sophist’s skill is to weave together arguments, evidence and emotional appeal to convince a gullible audience of those conclusions. Briefly then, rhetoric is ‘reversed reasoning’.

*In the three scenarios summarised above, all in my recent experience, legal and judicial experts used procedural tricks of their trade to ensure that certain directions of testimony, and argumentation, as presented in public, were essentially ‘off limits’. As a result this ensured that some conclusions could never be reached, because evidence and analysis in their favour was out of scope. This too is a form of reversed reasoning, where conclusions precede rather than follow evidence. It a modern version of sophistry, which I would like to call* ***’procedural sophistry’.***

Once more, I end my chapter with a line from Shakespeare’s *Macbeth:*

***Stars hide your fires! Let not light see my black and deep desires!***

1. My own hypothesis, still needing much work to fill out detail, is as follows: When our memories of episodes of each day are first registered, they are tightly linked, in the brain, to a representation of the context in which they were acquired, the memory and the context being dealt with separately. During sleep (and way beyond anything of which we are aware), memory traces are ‘reassorted’, so that they are no longer tightly bound to the context in which they were acquired. As a result, they become available more freely for association with other memories or ideas represented in the brain, initially acquired in other contexts. A casual observation, which the reader may recognize, support this view – that the ‘best ideas of the day’ often come the very moment we wake each morning. [↑](#footnote-ref-1)
2. Griesinger W. (1861) *Mental Pathology and Therapeutics.* (Engl. Trans. 1867. London: New Sydenham Society). [↑](#footnote-ref-2)
3. MacLleod N. (1900) The bromide sleep: A new departure in the treatment of acute mania. *BMJ*, 20th Jan, p. 134. [↑](#footnote-ref-3)
4. Epifanio G (1915) L’ipnosi farmacologica prolungata e sua applicazione per la cura di alcune psicopatici. *Rivista di Patologia Nervosa e Mentale,* 20, 273-308. [↑](#footnote-ref-4)
5. Klaesi J (1921) Ueber Somnifen, eine medikamentöse Therapie schizophrener Aufregungs-zustände. *Schweizer Archiv fur Neurologie und Psychiatrie,* 8:131; (1922) Ueber die therapeutische Anwendung der ‘Dauernarkose’ mittels Somnifen bei Schizophrenen. *Zeitschrift für Gesamte Neurologie und Psychiatrie,* 74:557-567. [↑](#footnote-ref-5)
6. Quastel JH, Ström-Olsen R. (1933) Glucose-insulin administration in prolonged narcosis. *Lancet,* 221, 464-466; McCowan LM, Ström-Olsen R. (1934) Prolonged narcosis in mental disorder: results of treatment in 107 cases *Journal of Mental Science* 80, 658-669; Hennelly TJ (1936) Prolonged narcosis in manic-depressive psychosis. *British Journal of Psychiatry* 82,608-614. [↑](#footnote-ref-6)
7. Kaplan RM. (2013) Deep sleep therapy in Australia. *Australasian Psychiatry*, 21, 505-506. [↑](#footnote-ref-7)
8. Fraser HF, Isbell H. (1931) Abstinence syndrome in digs after chronic barbiturate medication. *Journal of Pharmacology and Experimental Therapeutics.* 112, 261-267 [↑](#footnote-ref-8)
9. Dunning HS. (1940) Convulsions following withdrawal of sedative medication. *International Clinics* 3, 254-264; Osgood CW (1947) Convulsive seizures after barbiturate withdrawal. *JAMA*, 133, 104-105. [↑](#footnote-ref-9)
10. Palmer HA. (1937) The value of continuous narcosis in the treatment of mental disorder. *British Journal of Psychiatry*, 83,636-678. [↑](#footnote-ref-10)
11. Clapp JS, Loomis EA. (1950) Continuous sleep treatment. Observations on the use of prolonged, deep continuous narcosis in mental disorders. *American Journal of Psychiatry*, 106, 821-829. [↑](#footnote-ref-11)
12. Sargant W. (1942) Physical treatment of acute war neuroses. *BMJ,* Nov. 14, 574-576. [↑](#footnote-ref-12)
13. Palmer HA. (1945) Abreactive techniques – Ether. *Journal of the Royal Army Medical Corps* 84, 86-??; Shorvon,HJ, Sargant,W. (1947) Excitatory abreaction: with special reference to its mechanism and the use of ether. *Journal of Mental Science,* 93, 709-732. [↑](#footnote-ref-13)
14. Beard JAS. (2009) Dr William Sargant (1907-1988) and the emergence of physical treatments in British psychiatry. *Journal of Medical Biography,* 17, 23-29. [↑](#footnote-ref-14)
15. Garmany G, Shorvon HJ, Lowy S. (1954) Discussion on abreaction. *Proceedings of the Royal Society of medicine,* 45, 155-162. [↑](#footnote-ref-15)
16. Sargant WW, Slater E. (1940) Acute war neurosis Lancet ii, 1-2. [↑](#footnote-ref-16)
17. Ström-Olsen R. (1933) Somnifaine narcosis: toxic symptoms and their treatment by insulin. *Journal of Mental Science,* 79, 638-658. [↑](#footnote-ref-17)
18. I add a personal recollection here: In the period from late 1966 to mid-1969, as treatment for my own psychiatric problems, I was myself heavily dosed with various antipsychotic agents. Sedative effects were disabling. This has been a common experience for many patients over decades since then. Psychiatrists or mental health nurses often seem unaware of how badly some patients are incapacitated by sedation. Either they do not know the difference between sedative and antipsychotic effects; or they are influenced by old notions that enforced bed rest is a suitable way to treat people with overactive minds. [↑](#footnote-ref-18)
19. Walter CJ, Mitchell-Heggs N, Sargant W (1972) Modified narcosis, ECT and antidepressant drugs: a review of technique and immediate outcome. *British Journal of Psychiatry*, 120, 651-662. [↑](#footnote-ref-19)
20. Here I have both personal and professional experience to contribute. I am sensitive to sedative effects of these medicines, but even on tiny doses of another anti-psychotic drug with sedative properties - thioridazine (‘Melleril’) - I was incapacitated. I now am strongly of the opinion that recommended doses of such medicine as antipsychotic agents are generally too large, and they are prescribed in an inflexible manner, regardless of differences between people in optimal dose - which vary over a ten-fold, even a twenty-fold range, in different patients. [↑](#footnote-ref-20)
21. talk to Samaritans at Leeds, September, 1971. [↑](#footnote-ref-21)
22. In the 1890s, Carl Wernicke’s approach to treating severe depression was bed rest with sleep, good nursing care and good nutrition; and he states that this treatment of a disorder with considerable risk to life (from suicide) was usually effective. However his method did not include drug-induced sleep. [↑](#footnote-ref-22)
23. Stengel E. (1951) Intensive ECT. *British Journal of Psychiatry* 97, 139-142. [↑](#footnote-ref-23)
24. Dominic Streatfield website: https://dominicstreatfield.wordpress.com/2010/11/16/interview-with-nightingale-nurse-number-two/3/ [↑](#footnote-ref-24)
25. ‘I have used various forms of continuous sleep treatment since 1940 on several thousands of patients, and recently patients have been kept under narcosis for two’ or more months while intensive electric convulsion therapy can also be given; the longest course of narcosis has been over four months.’ [↑](#footnote-ref-25)
26. According to an interview with Hugh Freeman one year before he died, (‘In conversation with William Sargant’ 22.04.1987, *Bulletin of Royal College of Psychiatrists,* 11, 290-291) [↑](#footnote-ref-26)
27. Bromberger B, Fife-Yeomans J. (1991) *Deep sleep: Harry Bailey and the scandal at Chelmsford.* Simon and Schuster, Australia. [↑](#footnote-ref-27)
28. Sargant W. (1976) Will Sargant defends himself. *World Medicine,* 14th January, p. 31. [↑](#footnote-ref-28)
29. William Walters Sargant (1988) *Lancet,* 331, 695-696; WWSargant (1988) *BMJ,* 297, 789-790. [↑](#footnote-ref-29)
30. John Deryk Pollitt *BMJ* 2005; *British Journal of Psychiatric bulletin,* 29, 355-356. He had obtained a Doctorate of Medicine from the University of London, in 1958, with a thesis on obsessional states [↑](#footnote-ref-30)
31. William Sargant (1988) *Lancet,* 331, 859. [↑](#footnote-ref-31)
32. William Sargant, Emeritus consultant, St. Thomas’s Hospital London. *The Psychiatrist,* 12,556. [↑](#footnote-ref-32)
33. I have spoken with a nurse who supervised this, who regards it as the most disturbing part of her long career. [↑](#footnote-ref-33)
34. William Walters Sargant (200?) *Oxford Dictionary of National Biography*. [↑](#footnote-ref-34)
35. *BMJ,* 1967, 28th, Jan, 229 [↑](#footnote-ref-35)
36. NZ Sound Archives: System ID 7621: GMNZ –‘*Complaints about deep sleep therapy’* [↑](#footnote-ref-36)
37. New Zealand Herald, 4th April, 2015. [↑](#footnote-ref-37)
38. The Mellsop-Radford report has detail on cases before this, but they appear to be regular use of ECT, not the special procedure of DST. [↑](#footnote-ref-38)
39. Presumably, Dr James Hannah. [↑](#footnote-ref-39)
40. Georgina Jones *The Medical Council of New Zealand: A personal and informal perspective of events during my time as Chief Executive/Secretary/Registrar from 1986 to 2000.* [↑](#footnote-ref-40)
41. ODT 10 May 2002. [↑](#footnote-ref-41)
42. From the General Medical Council offices in Manchester, I learned that Martinus *was* registered as a practitioner in the UK, each year from 1962 to 1972 (but not before or after these dates). In 1962 and 1963 he had an address in central London, near Paddington station. After 1963, until 1972, the address given in GMC files is in Sri Lanka. The evidence from GMC includes the fact that his first medical degree was from the University of Ceylon in 1955. It is likely, therefore, that he went to London in the early 1960s (or sooner?) for more advanced medical training. This detail is compatible with this claim. [↑](#footnote-ref-42)
43. For those with time and inclination to follow this up (presumably in Australia), I provide detail I have on this company: **H.D.G.Martinus Pty Ltd.** *Company Office Holders:* Ceased former director: Martinus, Hettiarachchige Don George, 8 Rozelle Hospital\*, Church St, Leichhardt, NSW2040 and Martinus, Stella, Catherine (same address, and also ceased former secretary). No annual reports seem to have been filed. No details of shareholders or finances, or purpose of company. Date deregistered: 10.07.1992. Reason deregistered: S574 (“Power of commission to deregister defunct company”) Further details on funds in and out of this company sought from Australian Securities & Investment Commission, 1.06.2014 (Reference Number: 89286531). [↑](#footnote-ref-43)