**Chapter 3:**

**The Many Faces of Basil James**

***Bear welcome in your eye, your hand, your tongue.***

***Look like the innocent flower******. But be the serpent under't.***

***Introduction***

Basil James - at times Dr Basil James, then Professor Basil James, and for eight years Director of Mental Health in Wellington - was a complex person, a critical individual in my story. This chapter’s title, and the way I organize it are derived from the multi-faceted way he projected himself. Even before emigration I had interacted with him in small degree. To give a coherent account of how I came to know him, and my eventual view of what he stood for, I must explain the circumstances of my emigration to New Zealand. This narrative forms the first part of this chapter. After this I piece together my impressions of Basil James under several subheadings - how he came across in his various roles. Of course, as Shakespeare told us, each of us ‘*in his time plays many parts’.* In this famous soliloquy from *As you like it[[1]](#footnote-1),* the ‘seven ages of man’ occur in sequence, not simultaneously; yet in the persona[[2]](#footnote-2) of Basil James we see many facets revealed in multiple circumstances in the same stage of his life. This section of the chapter is based mainly on my own encounters. The section which follows is more orthodox – a timeline of his life - as I reconstructed it later, from multiple sources. Some parts of his story seem to have been deliberately hidden. It took inquisitive sleuthing on my part (and that of a trusted friend) to uncover what I could of what was hidden. One of the most revealing discoveries was his three years of military service in Cyprus in the 1950s. The last section of the chapter sums up the complexity of his life, and of course raises remaining questions.

***Personal Reminiscences*: *My Last Years in Britain*:**

This section is based mainly on my own experiences. It is an area in all chapters I write here, which is most personal, sensitive and hard to write. Am I objective? Of course not! Autobiography never is. In a wider sense even the best scholars on historical matters are not – or ever be - objective. It always involves careful selection of detail from a potentially infinite field. Selection is as much shaped by the overall conclusion as the conclusion is shaped by the evidence. An author should then preface his considered statements with the caution ‘*This is how it appears to me’*. This is true even in the natural sciences. Exploration starts from a limited range of evidence. Later, conclusions which had been seen as immutable, may have to be abandoned when another generation’s scientists apply them more widely. Given this I have tried to be fair and even-handed in dealing with the problematic person in focus here.

After obtaining a doctorate from Glasgow University in 1973, I had a post-doctoral position in Oxford University Laboratory of Physiology. The experimental research I did there proved to be crucial for my later work as a theoretician; it was generally a positive time. However, as mentioned earlier, I experienced another episode of florid psychosis, as I tried to wean myself off prescribed medicines. I was admitted briefly to the Warneford Hospital in Oxford – a good hospital, I should say. It was quite dramatic from my point of view, yet - in retrospect – also educational, as I started the journey to scientific understanding of mental disorders, my own included. I learned there that the diagnosis on my head was ‘schizophrenia’. The young psychiatrist who showed me this, typed in my file, probably did so on principle, knowing I had a good education and was bright enough to interpret the information wisely. Apart from this, I recall more sinister events.

Soon after discharge, I went to an evening seminar at the Radcliffe infirmary on autism. At one point, the lady speaker expressed the view that stresses in families raising children with autism were so severe that it would be better, if possible, for those children to be killed. I was in a fragile state after the period in hospital. I had been led to believe that such attitudes were one reason Britain had fought a World War. Little did she know anyone like me was in the audience. I walked out in tears.

At this stage, there was a chance I might stay on in research in Oxford. The head of the Physiology Laboratory knew I was keen to go into the area where psychiatry and brain science intersect. He arranged for me to meet a researcher across the way, who he thought might interest me. It was a weird meeting. He showed off his micro-dissecting skills in an anaesthetised laboratory mouse, whose head, bit by bit was detached from its body, while its circulation stayed intact (and was carefully connected to a micro-circulation device). I never learned the objective of this amazing feat, but rebelled against it, as I do now. Even then, I had a highly conceptual approach. This was just fancy technique, no concepts, little sign of intelligence, and no connection to humanity. So I applied for a post-doc position in another university.

When I told the head of department, he was clearly displeased that I had turned my nose up at the skills of that researcher. Even worse, I was planning to go elsewhere. I remember his enigmatic line: *‘Morally speaking, who is responsible?*’ I translate what he implied: *‘I know your story. You’re a vulnerable guy. I offered you a way forward; I offered you protection; and you turned your back on it. . . On your own head be it*!’

So, I arrived at that other university. The period was something of a disaster; for about a year I was unemployed, but I applied for academic and research jobs in Britain and overseas, including New Zealand. One of these was a lectureship job in the Department of Physiology, in Manchester University. Early in 1976, I was called to an interview before a large panel, seated around a long table. All I remember of the questions was one about the nature of my psychiatric problems, which I had alluded to in my application. I replied ‘*It was a schizophrenic illness’.* Today, that question would be illegal, in that it was intended to discriminate. However, I was offered a temporary lectureship, for six months. Better than nothing, but not much better.

I need to explain why I was so open about my psychiatric history. Growing up in Britain in the 1950s, I was aware, yet scarcely consciously, how restricted was the flow of information on important matters. Of course no-one knew what was happening politically. This is normal most times for most people in most countries. Things of greater personal importance were ‘off limits’ – especially for teenagers in the 1950s – sex! - a topic which never fitted into the war effort. In the 1960s the Beatles discovered that sexual attraction and impulses were quite normal - even in our own supremely rational species. For this, they would doubtless have won the Nobel Prize - for Physiology and Medicine, not Peace - but for the fact that Nobel Prizes are not given to groups of more than three scientists!

Joking apart, by the end of the 1960s, I was alert, in an unspoken way, to the great harm done to so many by this conspiracy of silence; but sex was not the only taboo subject. Serious talk about anything subjective, emotions, and notably talk about ‘mental disorder’ – called it what you will – was also taboo. Few people had adequate language here, apart from literary pioneers such as DH Lawrence. So, openness about my past experiences was an instinctive reaction to information suppression of the time. A good friend in the lab in Oxford – himself son of another refugee who fled Austria in 1938 - was startled by how open I was. We are still close friends. Thirty years later, on a visit to Britain he admitted ‘*You were right Robert, and we* [including here his wife] *were wrong’*.

In this context, in early 1976 I notice an advertised job in ‘behavioural science’ in the Department of Psychological Medicine, far away in the University of Otago, in the South Island of New Zealand. The advert seemed to offer a position where serious research could blend the different approaches I sought to amalgamate. I am not sure whether I applied for this job. Otago University, understandably, destroys records of failed job applications, and I certainly did not get this job. It would have been in Basil James’ department; and he would have framed the advert. In deliberating on this, I wrote to friend in Otago, a New Zealander who I met in the Physiology Laboratory in Oxford. He had returned home, to a position in the Department of Anatomy in Otago Medical School. He advised me *not* to try for that job, suggesting instead that I apply for a position in the Anatomy Department. It was good advice, and changed the course of my life. Medical references were sought, provided and assessed by New Zealand immigration authorities, and in Otago University, by – guess who - Basil James (or at least he was copied into the correspondence).

I now understand the situation better. The bio-psycho-social model of mental disorder was then popular talk. It made sense as a broad philosophical position for clinical practice, but not, I suggest, for rigorous scholarship or research-based science. I certainly wanted to blend insights from biology and psychology, an endeavour which I thought possible in principle, yet difficult in detail. Only now, as I approach age 80, do I feel somewhat confident to expound on this as a scientist. As for blending this with social insights - all very well in principle, but there really are limits to deployment of natural sciences methods in so-called ‘social sciences’. Methods are so different that attempts are likely to be problematic.

Over the summer in 1976, I received a long and generous letter from one WD (Bill) Trotter, head of the Anatomy Department at Otago, to which I replied showing my interest. Late in September, just as the teaching term started, I received a telegram offering me a lecturing position. I went to the head of department, a straight-talking Welshman, seeking his advice. He told me straight out ‘*Go for it! With your health record, you don’t stand a chance of a secure academic position in this country’*. Brutal, shocking, yet honest; and I should have been thankful. No-one had been so straight before, although I had long played my cards as if what he said were true, to ‘draw the fire’ of prejudiced individuals. After that, I wasted no time; I walked down the road to the post-office and cabled my acceptance to Bill Trotter. *Impulsive?* Not really. It was a quick decision made confidently - my mind already prepared.

I traveled to Otago via stops in the Persian Gulf, Bombay, Hong Kong, and Sydney over easter 1977 - long-haul flights being rare in those days – arriving, I think, on 13 April. Immigration is seldom straightforward - so many new impressions, leaving new arrivals vulnerable for many months. With a secure job, my introduction was easier than for many, yet not always easy. Bill Trotter was a wise and humane man, not a great figure in research, yet conceptual and principled in his thinking, taking his responsibility to his staff seriously. Others in the university tried to take advantage of me - I infer - because they knew secrets I had divulged in my application. I need not dwell on that. More significant is my first introduction to the medical faculty, I think in early May 1977.

Faculty meetings occurred in the Barnet lecture theatre, a small theatre, steeply raked, of ‘rotunda’ design. I was seated three rows above ground level, on the left-hand side. As I was introduced to the faculty, Irecall the piercing glance in my direction from the person I was soon to know as Basil James, seated in a similar position on the right side. Perhaps there was anxiety in his glance. What was going on for him at the time? He had just become, or was about to become, president of the newly ennobled *Royal* Australian and New Zealand College of Psychiatry. He was an active publicist for psychiatry, a discipline in the health services which had long been severely neglected. At the time he was busy with a ‘Telethon’, raising funds to found what became the Mental Health Foundation. The slogan for this was ‘*How much can you take before you give*?’. The outgoing Chief Ombudsman’s report on Lake Alice had been released a month earlier; CCHR had staged a demonstration in Wanganui on contents of the report; and by 24 May, there was release of another part of Sir Guy Powles report. Professor James said nothing in public on these events. Perhaps he did not want to be associated with anything which could cast doubt on the new Royal College.

***The Many Faces of Basil James*:**

***As Academic and Scholar*:** A little later, Bill Trotter arranged a meeting with Basil James in his office in the Anatomy Department. I recall some of the erudite conversation. Colin Blakemore, a rising power in British neuroscience, had recently been made head of the Physiology Laboratory in Oxford, where I had worked; and, in the previous northern autumn, he had delivered the prestigious BBC Reith Lecture series (under the title: ‘*Mechanics of the Mind’*). I remember Basil’s view that Blakemore was too young to tackle such a hard topic. I vaguely remember asking if there could be such a thing as a ‘subjective fact’. Somehow, we got onto anthropology, and I recall Basil offering his detached, erudite thoughts on *cannibalism*, of all things, as needed when protein supplies are limited (perhaps following contemporary comment on a movie released on the topic). It was a rather puzzling direction to take the conversation, when I was there, naïve, and inexperienced, as a new arrival in the country. In the end, he invited me to join in his departmental discussions. I never did: I had too much on my plate adapting to a new job. However, it was not an unfriendly meeting, and we parted on good terms.

Basil James did not publish much academic writing and was an amateur in serious research. However, at the Queenstown Congress of RANZCP in October 1979 he gave a lecture entitled *‘Science, Psychiatry, and the Seduction of Emma Bovary’*. The context for this appears to have been as outgoing president but he may also have been ‘setting out his stall’ as future Director of Mental Health in Wellington. His lecture started with allusions to Gustav Flaubert’s novel *Madame Bovary* and then worked towards recent philosophy (mentioning Carl Popper) and physics (citing Werner Heisenberg and Neils Bohr). From Heisenberg, he drew on the idea that an observer is never truly objective and separate from what is observed. Bohr’s concept of ‘complementarity’, originally about different but equally valid descriptions of light, was applied to psychiatry: Sometimes one must think in biological terms, sometimes in psychological or social terms, with no contradiction. He ended on the theme that psychiatry could sit alongside physics, contributing to realignment across large areas in the worlds of scholarship, philosophy, and science. The lecture is probably his most considered account on the bio-psycho-social approach to his profession. On rereading it 40 years later, I still find it appealing on an important topic, but I also felt he was ‘name dropping’ of experts in areas where he really knew little. My antipathy to Basil James was on other grounds.

I remember other facets of Basil’s thinking: Could human behaviour be predicted? I thought not; but he assured me that it could be. This might follow from a version of Pavlovian psychology he had acquired during training, on which I write more later.

In New Zealand, then as now, there were huge disparities in health care provision between cities and rural areas. At the time, news from China told of basic training given to vast numbers of ‘barefoot doctors’ for rural practice. Basil recommended the same principle in New Zealand, to make health care more widely affordable. I can hardly disagree in principle (although he could not have meant it literally).

In a letter to me, he expressed a wish to redesign the entire psychiatric diagnostic system. Well, yes! - and I have tried to do the same.

He had a lifelong interesting in the psychology of sexuality. This was clear from his earliest days as a specialist (see below). In 1972, one of his first appearances in broadcast media was a discussion about ‘bikey gangs’. Apparently, Basil James had been a keen motor-bike enthusiast in his early days in Cardiff. In discussion he spoke of bikey gangs as mainly male, a group activity, as they gained confidence in their sexuality. The emphasis on sexuality came again in the title of lecture described above, and in 2012 (seven years before he died) he contributed a chapter in a book entitled Orgasmology, edited by Annamarie Jagose, prominent at the time in the Australian LGBT community.

***In Correspondence*:** I recently rediscovered all his correspondence filed away, starting in late July 1977, soon after the meeting in Bill Trotter’s office. It was mostly about the newly formed Schizophrenia Fellowship. He was curious about its origins in the British association of similar name a few years earlier; and I sent him literature I had from that body. Mainly the tone of his messages was routine courtesy. In the new local group, I vividly remember the despair and unquenchable anger of aggrieved parents. I never learned the roots of that anger, but Basil James was a major source of it. In June 1978, in another letter, I addressed him as ‘*Dear Professor James’*, keeping my distance as it were. In his reply he wrote as a post-scriptum ‘*I think our use of Christian names should be reciprocal’*. Obviously already, any bond of trust was hardly reciprocal, as it had been - immediately - with Bill Trotter. No doubt, I was influenced by the anger and anxiety I heard from the Dunedin group.

By July 1978, I had informed him of events in the new local group of Schizophrenia Fellowship. His reply was less cordial: ‘*I must express some disappointment, though, at the apparent failure to at least attempt a liaison with professionals, and, as far as I can tell, with related community groups such as the Mental Health Foundation* [now in existence after the successful Telethon]. *In endeavours of this kind, an alliance between professionals and the community is so important, and when one has such accessible professionals as in Dunedin, I believe it to be a great tactical error not to make use of it’.*

My comments? In bridge-building exercises, those who take the initiative may also be taking a risk and are thereby vulnerable; while these who wait to be approached, retain their power. There was already a huge imbalance of power. If it is intended to build trust, he who ‘holds the aces’ should first make sure that they understand the context as far as possible and should then strive to minimize the imbalance and give the party with lesser power a sense of genuine agency. One way, at an early occasion, is to ask for a meeting, when the one who holds the aces would be in a minority, open to novel, even unsettling interactions. He thereby voluntarily cedes some power to the others. Basil James was starting to realize that my affiliation with SF put him and me, to a degree, in opposition. However, he appeared unaware of the context, especially the anxiety levels in the Dunedin group, and, after my receipt of that letter, of my own growing anxiety. The phrase ‘such accessible professionals’ made an assumption he was not entitled to make - really an implied assertion, not a genuine attempt to build trust. By implicitly *asking* for trust, rather than taking the initiative and striving to build it, he took it as read that he was the authority and held the reins of power. Perhaps he had a wish to control.

By April 1979, I - or perhaps the Dunedin group collectively - circulated to many mental health professionals around the city, material about the Dunedin branch with two ‘boxes’ for response, at the foot of the page. In response Basil James gave me two more names to whom the message should be sent including the Principal Nurse in Charge of Community Nursing Services (who happened to be his wife). There followed an interesting paragraph:

 *You will see that I have ticked one of the boxes at the bottom of your letter, but not the other – i.e. - Would I like a chance to meet the group?’. Now I think your group should take an even stronger initiative in liaising with professional psychiatry. I think it is very much in their interests to invite leading psychiatrists quite directly to initiate liaison. Don’t leave the initiative to others, would be my advice.*

The convoluted semantics here is hard to decipher, but I take it to imply that:

* He assumed he knew the interests of the Dunedin group better than they did.
* The Dunedin group should take the initiative.
* It should do so by inviting ‘leading psychiatrists’ – to initiate liaison.
* The last two statements contradict each other; yet they appeared to include himself as the leading candidate. (I remember him saying to me over the phone, that he was the leading psychiatrist in New Zealand at the time – ‘and had considerable influence in Australia’)

***Face-to-face*:** In person, Basil James was quietly forceful. I recall a tiny detail of his conversational style. When he was explaining something, he tended to enunciate specific words - usually words referring to concepts - in a way to draw attention to them. It was a little unusual. Perhaps he using those words as Pavlovian conditioning signals. Certainly it seemed to be a deliberate and rather pointed communication. Strategy.

Once when I was in his office, as a potential mediator, he let me know that he already knew some families in the Dunedin group, presumably via issues he had to deal with, regarding their offspring. I never had any real evidence of this: It could have been a ploy to impress me of his quasi-omniscience (standard practice in military or police interrogation). He referred to the Dunedin group collectively, dismissively, but with scant knowledge, as a ‘therapy group’. He advised me not to work too closely with them. ‘*They’re not your sort of people’* he said. How was he to know? . . .or was he ‘sounding me out’? Could I be co-opted as an ally?

I was in regular contact with the three brave souls from Christchurch who founded the Schizophrenia Fellowship as a national body. Despite jarring comments just described, I did arrange for one of the National Coordinators to travel south to meet Professor James. I remember his sharp question, perhaps on this occasion: ‘Are you financial?’ Given the timidity and kitchen-sink administration of that pioneer organization, compared to his health service colleagues, it rather missed the point.In correspondence in early 1980, leading up to this meeting, he wrote:

*‘I have often expressed the view that professionals in the mental health field particularly should concern themselves with community organizations such as Schizophrenia Fellowship. It is of course important that they do so in a non-intrusive way and avoid any temptation to professionalize things to such a degree that the very value of the alternative health care source is unviolated. I think we have a good deal to learn from each other without being in any way in conflict.’*

After the meeting, which I attended, I made detailed notes for the visitor. Professor James began with the comment that the Schizophrenia Fellowship had been very shy of involvement with professionals. The national Coordinator, who became a very good friend, responded by saying that many parents had very bitter experiences at hands of professionals. To this, Professor James responded with ‘*We want to know about that’*. By use of the plural ‘we’, I assume he was referring to his profession collectively, taking a leadership role for that profession. Continuing, she said that while complaints about treatment of patients themselves were few, parents felt they were often disregarded, or subject to the implicit accusation of being a ‘schizophrenogenic mother’. She also assured him that SF as a national body *did* need to involve the psychiatric profession. I have two other lines from Professor James in my notes:

‘*It should not be for patients and parents to have to learn to communicate with their doctors. It should be the doctor’s job to know how to communicate.’*

. . .and

‘*Your being a mother of a schizophrenic son gives you’re a qualification on this subject which I do not have. I’m thankful I don’t have it, but I must respect your qualification’*

Clearly, Basil James knew how to make the right noises if the occasion required it. Did it ring true? Perhaps. He may have been learning fast. Such encounters, with maligned parents of people with schizophrenia, especially on behalf of a collective body was probably new to him.

Usually, when I wrote to Basil James it was on behalf of the Dunedin Group. It was rare for group members themselves to contact him. In mid-winter 1980, an event occurred which left me badly hurt. I knew nothing of how local politics worked in New Zealand – very vigorous actually – and was inexperienced in dealing with his likes. I am not sure what happened, but I made a bad mistake, and he exploited it without compunction. Probably in the aftermath of the meeting with the national Coordinator, there was a group meeting which I missed, because I was in bed with a cold; and at this meeting a decision was taken to invite Basil James to meet the group. When I received notice of the meeting, I then also wrote a handwritten note to Basil. The meeting came, in mid-July. Basil - ever so smooth handled it to perfection, and as he walked out, he left my note on his seat. I immediately grasped his game and picked up the note before anyone could see it; but the damage was done. I had been portrayed as two-faced to the rest of the group. I believe he had betrayed me. I think he had already formed the wish to split me from that group, and I had given him a golden opportunity; in the end he succeeded, at least for several years. Of course, he had no idea of the context of his action. My first child was born at the end of that week (I was by then married.). An occasion when I and my wife should have been full of joy was marred because I was on the rack of anxiety. Basil James’ specific motive may have been based on anxiety about what I, as a relatively new member of the medical faculty, might learn in interaction with a group whose views did not quite accord with his own, and indeed, might be based on very painful encounters with local mental health services.

So, my early impressions received strong confirmation: Basil James did like to be in control. He tried to avoid situations where he was not. Nonetheless he was versatile, flexible and pragmatic. After many years reflection - I also ask *‘Was he acting entirely as a mental health professional? . . . . . or was he at least in part, something different?’* Decades later, it was experiences like this, amongst many others, which led me, as a community representative in RANZCP, to organize the symposium on anger resolution. Those bitter experiences were also a seed from which grew serious study of the history of psychiatry as a discipline and profession.

***Relations with Mental Health Professionals*:** Professor James was said to be a very good host, with regular hospitality in his house in an expensive part of Dunedin, just above the medical school. I was never one of his guests. Many years later, I met up with a member of his department throughout the 1970s. When I hinted at my dark suspicions of what Basil James’ other objectives might have been, he had no idea what I was talking about.

He was successful in bringing important psychologists and psychiatrists to Otago. One visitor was RD Laing, radical Scottish psychiatrist (and for a while, cult figure), author of ‘*The Divided Self’*; another was John Bowlby whose important work on ‘attachment theory’ was based on observing parents and infants in interaction; and Norman Sartorius, German-Croatian psychiatrist, a rising power who would hold many leading positions in world psychiatry, and who I met many years later, in 2017, at a conference in Hong Kong.

These invitations provide insights into what might have been formative influences for Basil James, in his specialist training. In London – apart from the maverick Sargant at St Thomas’ – there were two sources of power and influence, with quite different approaches. The Institute of Psychiatry attempted to be the modern face of institutional psychiatry, emphasizing diagnoses, treatment, and all the rest, as adaptations of the clinical style found elsewhere in medicine. The Tavistock Institute, which originated to help victims of shell-shock victims after the first World War, was guided by the dynamic psychiatry of Freud, and Jung, and their later offshoots. After the second a World War its leaders formed the World Federation for Mental Health. Its agenda was ‘mental health’, wider than psychiatry with a somewhat globalist emphasis on social psychiatry. The split between these two approaches spread to psychiatrists elsewhere in Britain and in other countries. Both Laing and Bowlby were close to the Tavistock philosophy[[3]](#footnote-3).

Basil James was supportive of fellow mental health staff, provided they did not disagree with him. The Schizophrenia Fellowship in the late 1970s had a medical advisor, a young psychiatrist, perhaps not very experienced, but supportive and thoroughly honest, and I seem to remember, not fond of Basil James. The antipathy - even scorn - was mutual. It was hard to succeed in psychiatry if you wanted to challenge what was accepted as normal. In 2012, in the context of my ‘Anger Resolution’ symposium in 2012, I contacted another psychiatrist, now highly respected but working in General Practice in Auckland. He described to me his experiences in 1983, as follows[[4]](#footnote-4):

‘*The forces of the status quo even then when I commenced training in 1983  were powerful - to oppose or question them was to risk what happened to me which was being excluded from the psychiatry training scheme (which I was for a year - the comment being that I was “not fit to become a psychiatrist”*)*though when I did reapply a year later, those who supported me had rallied to ensure I did get back into training. It is impossible to work in psychiatry and not hear the continued anger and grief and trauma of those who endured the worst aspects of institutional care, yet many still manage to be deaf to this’.*

My overall conclusion: Basil James liked to be in control, was generous and a great ally if you accepted his authority, but a dangerous adversary if you did not. It is no surprise that different people held widely different views of him. However, within these limits, he was pragmatic and versatile, without the apparent fundamentalist zeal of William Sargant.

***Relations with his University and Health Service Colleagues*:** As acrimony increased with Professor James over my affiliation with the Schizophrenia Fellowship, Bill Trotter, seeing my rising anxiety, advised me to steer clear of things causing me strife. The deputy head of department, who had been around a long time, observing all the intrigues in the faculty and its headstrong personnel, was more direct: ‘*Don’t tangle with Basil’*.

Soon after the events described above, SF, as a national organization, raised funds to bring from Britain Professor John Wing from the Institute of Psychiatry in London. He was a leading social psychiatrist a strong supporter of the British National Schizophrenia Fellowship from its inception and became its medical adviser. He and his colleagues had considered carefully the ‘schizophrenogenic mother’ hypothesis and could find no evidence to support it. I had met him once or twice before leaving Britain – abrasive meetings, I should say, but, in context, not that surprising. Now, when he visited New Zealand, the context was different. I was present when the group met him in a Dunedin hotel. The next day, he was to have a one-on-one with Professor James. I would love to have been a fly on the wall at the meeting next day with JK Wing. I remember his acid words at that hotel meeting: ‘*Basil James needs his head banging’*. What the basis for this was, I never discovered. It could have reflected antagonism between his own institute and the Tavistock[[5]](#footnote-5); or hostility with Sargant at St Thomas’s, a far from cordial relationship. Basil James had links both with Sargant - perhaps his protégé at one stage - and also probably with the Tavistock. How Basil managed this I have no idea. Sargant and the Tavistock were poles apart, I believe.

Another person I knew in early days in Otago was Michael Cooper, at the time Professor of Economics at Otago and for a while Chair of the Health Board. In his retirement he lived not far from Masterton where I now live. He had many health problems and is now deceased. In his last years I met him once to talk about issues I deal with now. He had traveled overseas with Basil James when the latter was Director of Mental Health and knew him well in his professional role. I was aware that Basil James was not well-liked in Otago University, except amongst his mental health colleagues. Michael Cooper said something more specific, referring to the 1970s, that ‘many people thought he was a charlatan’.

Another person I met recently in a similar context - mentioned in the last chapter - Warwick Brunton, had been an administrator in Wellington, working alongside Basil James in the Ministry of Health. As I told my story, he raised reasonable objections, to soften my more conspiracy-like inferences. When I mentioned the name of Basil James, his eyes lit up. I said: ‘*I have my views about that man’*, and he replied emphatically, ‘*So do I!*’.

Lastly, I mention my very good friend, one-time Mental Health Commissioner, and community advocate, and, in retirement returning to her first love, writing very good poetry, albeit sometimes beyond me. This was Julie Madeleine Leibrich, who died in late January 2020. She whole-heartedly shared my misgivings about Basil James; and it was her sleuthing which revealed a side of his life which he seems to have concealed while alive, his period of military service in Cyprus in the mid-1950s.

 ***As a Political Operator*:** Basil James certainly believed in political action. In 1964, soon after arriving in Dunedin he founded a Society of the Discouragement of Physical Punishment in. Schools. He had school-age children. He may have been shocked to find punishment in schools was often quite severe.

In faculty meetings, he was sharp-witted, often radical, and oppositional to what he saw as a reactionary faculty, which could not grasp the role of social factors in most branches of medicine (as he saw it). He had an instinct to say things which challenged habitual assumptions of those to whom he was talking. I remember when he gave a talk in the Anatomy Department, he felt free to pass general comments, some of them critical, on the discipline of anatomy. At that time his department was some way distant from the main part of the medical school. When faculty meetings were scheduled, as a gesture of protest, he habitually left his office at the appointed time, arriving conspicuously late. I remember once, after the faculty made a decision, he growled from the back row his rejection of the line - ‘*carried unanimously’* - to summarize the decision, preferring ‘*nem con’* (‘no-one disagreed, some abstained’). He was a skilled, forceful protagonist, who easily polarized debate. For one with his temperament and views out of kilter with faculty colleagues in other departments, this was inevitable.

I add my observation that those who had seen active service during the war, or in years soon after it ended did often present themselves to the world in an angry and provocative manner. I can envisage that the unprecedented horror of events during World War II did indeed challenge our most fundamental and deeply entrenched assumptions. Growing up in such a world might lead some to be habitually provocative when conventional views were parroted.

In late 1976 and 1977 Basil James was curiously silent on a critical issue, the revelations on what had happened at Lake Alice Child & Adolescent Unit. I found no public statement attributed to him on this. However, a year later, on 25 May 1978, he was reported saying: ‘*By using the Lake Alice situation as a scapegoat there was a danger that the disastrous national shortage of psychiatrists might be ignored. . .If we focus only on the one single case, we might be led to the illusion that all can be put right by enacting some fine-sounding legislation. Individual human rights of course need protection by law but are no substitute for good professional practice*.’

These lines were a bit odd: Was it really ‘one single case’. Was Basil James not aware that there were many? If ethics meant anything to him, he should have been more inquisitive and active. Grievous violations of ethics should have overridden attempts to protect RANZCP. Had there been greater emphasis on ethics in preceding years, psychiatry might have been a more attractive specialty, and shortage of psychiatrists less severe. Even odder, Selwyn Leeks had been named as the main culprit and Basil James knew him from 10 years previously, when they were together in the same Otago department. As mentioned in the previous chapter Basil James was probably the one to invite Leeks down south, sometime in 1973. In any case, one gets an impression of Basil James distancing himself from the possibility of being questioned on a topic where he had important knowledge to impart, or perhaps of investigation by CCHR.

In March 1981 his appointment as Director of Mental Health was announced in the New Zealand Gazette. The statutory role of Director of Mental Health is about implementing the mental health Act, focused on conditions under which compulsory admission to hospital or institutional care is authorized[[6]](#footnote-6). It is not primarily about the many other aspects of mental health care and psychiatry. Thus, the position is wrongly named: Its functions were not about the entire mental health field, but specifically about the Act. Basil James tried to use the position for a wider agenda. This fitted his wider profile: He became the first Vice-President for Oceania of the World Federation for Mental Health (1979-81) - an organization with a wider agenda than just psychiatry - and was Secretary to the Board of this body from 1981-1985. For ten years he served on the Expert Committee for Mental Health for the WHO. From his position as director of mental health position he was regularly on radio and TV as a public front for psychiatry. Between 1982 and 25 September 1989, Sound Archives New Zealand has eleven audio or video recordings involving him. Added to these, in 1987, was a series of four TV interviews with prominent New Zealanders (including ex-Prime Minister Robert Muldoon), under the title ‘On the Couch’[[7]](#footnote-7). No Director of Mental Health since then has been so public. Indeed, such a public profile was generally unusual for psychiatrists, except in Britain in an earlier decade for William Sargant, and in the 1980s, Anthony Clare (in neither case from a central government-appointed position).

I do not know how this media profile was arranged. Was it somehow Basil James’ initiative? . . or was it TV or radio producers, who realized he made good viewing or listening, in an area they wanted to support? It was consistent with his earlier activities, such as the Telethon in 1977 and fitted into what seemed to be one of his key objectives, to bring about major reform in a neglected but important area of public life. To achieve this from the position of Director of Mental Health was perhaps implausible. Reform for mental health care, was ultimately under the Director-General of Health. Such a program of comprehensive reform was started in 1983, by the holder of that position, Dr Ron Barker. It was not primarily a role for his subordinate, in the Directorate of Mental Health.

This said, a central area for change, in which Basil James had to be involved, was mental health legislation. Since 1983, discussions were under way for reform of the 1969 Mental Health Act**.** After release of a long report from the Ministry of Health, on 11 March 1984, there was a TV discussion on revision of the Act, with Dr James amongst participants. Diverse - even contradictory – views were voiced, but generally supporting liberalization. Comments included ‘*the Act should be scrapped’*, ‘*needs to be protection of patients from psychiatrists’* and (from a legal mind) ‘*specific behavioural criteria are* needed’ (for compulsory admission). Dr James was now not closely aligned to the spokesperson from the Mental Health Foundation, despite his vigorous activity seven years earlier which raised funds to establish that Foundation. He made interesting points:

‘*The Mental Health Act is out of date. Any definition of mental illness that we have thought of is circular, meaningless, or so rigid as to be useless. We need to put in exclusionary conditions, so that people are not committed by virtue of criminal behaviour alone, taking drugs, immoral behaviour or political views alone, or religious views or sexual preference alone. World-wide, there is concern about use of psychiatry to enforce political conformity, particularly in the Soviet Union. “Danger to self and others” is impossible to determine; that is the dilemma we find ourselves in as we try to rewrite the Act’.*

Already he was involved in redesign of the 1969 Act and went into some detail:

‘*A psychiatrist, a lawyer and the Health Department are already making plans for this, to be incorporated into the revised Act. Locally constituted and independent review tribunals, consisting possibly of a psychiatrist, a lawyer and a community representative, to review continually on the patient’s request, with 3-monthly, then 6-monthly hearings, in an informal setting, like the family court.’*

*‘The general structure* [of the 1969 Act] *is OK. It can be no more than a structure, but major changes are needed.’*

*‘Good clinical practice to form an alliance – a contract which is mutually agreed is highly desirable.’*

To my reading that last utterance seems a little forced, somehow saying what he was supposed to say. It is reminiscent of a paragraph in the Declaration of Hawaii, adopted on 31 August 1977 by the World Psychiatric Association (see Chapter 4).

*A therapeutic relationship between patient and psychiatrist is founded on mutual agreement. It requires trust, confidentiality, openness, co-operation and mutual responsibility. Such a relationship may not be possible to establish with some severely ill patients. In that case, as in the treatment of children, contact should be established with a person close to the patients, and acceptable for him or her.*

*If and when a relationship is established for purposes other than therapeutic, such as in forensic psychiatry, its nature must be thoroughly explained to the person concerned.*

The main author of that Declaration, Swedish psychiatrist Dr Clarence Blomqvist, admits, in an associated article, that he was trying to reconcile the ‘benevolent paternalism’ based on the Hippocratic Oath, which guided medical ethics in Europe, and the more legalistic basis in the USA, derived from the US Constitution. To my mind, the words of Basil James in the debate in 1984 betray a link to the US concepts of ethics and perhaps to that Declaration. In my view, the subtlety of interaction between doctor and patient, especially in psychiatry, does not allow it to be captured by such a simple form of words.

In December 1987 a new Mental Health Act was tabled in parliament to replace the 1969 Act. If passed, it would have come into force on 1 April 1988, but this did not happen. On 16 November 1990 a revised version was introduced with a longer title (Mental Health [Compulsory Assessment and Treatment] Act 1989), intended to come into action on 1 July, 1990[[8]](#footnote-8). This also did not happen. The New Zealand Bill of Rights Act 1990 *was* passed through parliament on 28 August 1990. It led to adjustments in drafts of the new mental health act, which eventually became the Mental Health (Compulsory Assessment and Treatment) Act 1992, which is still in operation.

This tortuous course is perhaps to be expected. The 1987 bill was prefaced by a 6-page ‘explanatory note’, starting by stating ‘the Central Dilemma[[9]](#footnote-9)’

*Perhaps more than any other area of law, mental health law is bedevilled with questions that are probably unanswerable. The underlying question can be simply stated: In what circumstances should a civilised society insist on treating a mentally disordered citizen who is incapable of giving consent or, worse still, is capable of giving consent but refuses to do so?*

*Supplementary questions include-*

*(a) Is Society ever justified in insisting on non-consensual treatment on the ground of the interests of the patient himself or herself, or is such treatment only justified on the ground that the patient is a danger to others?*

*(b) Conversely, is non-consensual treatment of a patient ever justified on the ground that the patient is a danger to others?*

*(c) If non-consensual treatment is rejected as being too invasive of human rights, what is to be done with the patient who, untreated, is a danger to others?*

*(d) If the answer to question (c) is some form of detention, what form and in what type of institution?*

*(e) Where decisions are to be made in such cases, who is to make them? Doctors, on the ground that they are essentially medical questions, or Judges on the ground that they are matters of civil liberties?*

*(f) What is the proper relationship between the criminal justice system and the health system where offences have been committed by persons suffering from mental disorder?*

For draft legislation, I find this candid acknowledgement of the difficulty – nay impossibility - pleasantly surprising, that fully rational law in this area may be impossible. I write ‘pleasantly surprising’, because legal thinking, perhaps more than in any other profession, is committed to a view, going back to classical Roman law, that rationality is a defining feature of human nature. As a neuroscientist who has thought long and hard about higher nervous functions, I cannot accept this model of human nature. When reasoning is based on false premises, of course there come times when prior conclusions become unworkable, especially in defining exceptions to those supposed defining features. Another point which makes legislation here so difficult is that drafts have to gain majority approval in the central democratic institution, our parliament; but, if truth be told, the confusion and conflict on that issue amongst our MPs will be every bit as intense as amongst the general public. Centred on the very concept of human nature, it becomes a fierce battle ground whether seen in philosophical, political, legal, economic or religious terms. Views are so diverse that mental health law is destined forever to be a matter of uneasy compromises, ever-shifting emphases, and controversy.

Despite these imponderables, emphasis in the proposed new legislation *had* shifted, as we read in the next paragraph of the explanatory note:

*Under the Mental Health Act 1969, the emphasis is placed on detention. Broadly, the question to be determined is whether a person should or should not be detained in a psychiatric hospital. Once an order has been made for such detention, treatment may follow. In this Bill, the emphasis is changed to a consideration of the need for treatment. If that is established, a decision is then made as to whether treatment should be provided on an outpatient or an inpatient basis.*

Honest acknowledgement of the insoluble nature of the dilemmas in this area, as well as the shift in emphasis to treatment rather than detention and containment, seem to reflect Basil James’s thinking, expressed in the TV discussion nearly four years earlier. I must say, I am impressed by the serious intent shown in these hints of the debate.

Basil James remained in the position of Director of Mental Health a little over 8 years. On 8 December 1989, rather suddenly, he announced his resignation to take a position as foundation chair of Psychological Medicine, James Cook university, Cairns, Queensland. Why did he resign? The insoluble nature of legislative reform was a fact. Dr James seems to have made a worthy contribution to the debate. Intelligent compromises had to be made, and were made. The problems were hardly a reason to resign.

Perhaps other pressures led to his decision. In 1980 a serious complaint by Ms J. Schaverien (Psychiatric Social Worker at Carrington hospital) against Auckland Hospital Board focused on Oakley Hospital. This consisted of the two wards remaining after the split of an older Oakley hospital, the rest becoming Carrington hospital. The complaint led to investigation by deputy Ombudsman, Lester Castle. He criticised both the board and certain clinicians. His report never mentioned the Director of Mental Health, Dr James, but did mention the Director General of Health. This seems to be a correct reading of the role of the Director of Mental Health. Beyond this, wider problems of mental health care across the country led the Minister to appoint Judge Ken Mason to conduct a far-reaching inquiry[[10]](#footnote-10), including specific concerns about Oakley. Judge Mason reported in August 1988 at which time there was no local deputy in the Auckland region from the Ombudsman’s office. Minister of Health Caygill asked Dr James to work with Auckland Hospital Board to resolve problems of psychiatric services in its region. He was asking Dr James to carry out duties beyond his official role. There was uncertainty about who – if anyone – had the power to challenge the authority of medical specialists and the Auckland Health Board, short of replacing the Board with a commissioner. When interviewed on 10 October, 1988, Dr James stated: ‘*The report is inevitable – a chronical of what has gone wrong, and the tragedies and disasters’ –* but he also came out very firmly with a note of optimism, referring to ‘*clearing the air after a* thunderstorm’. It was certainly not Dr James responsibility. Nonetheless, concern over Oakley intensified further through 1989.

On 31 December 1989, reports of an interview with Donna Chisholm included: ‘*Dr James took voluntary retirement from the Health Department, after eight years as mental health director, marked by turbulent years at Oakley hospital.’* He is quoted explaining his decision ‘“*There was a lot of soldiering on for years, as the Auckland scene changed from a wounded system to a debacle*”, he says “*I had a sense of responsibility, but not the authority to put it right”*’. Given the limited statutory role of the Director of Mental Health, he said it exactly as it was. Whatever his ‘sense of responsibility’, statutory responsibility lay at higher levels in the Ministry of Health and elsewhere. Chaos in mental health services, especially in the Auckland region, was not his responsibility. His explanation again is not an adequate reason to resign.

However, in July 1989, a third problem arose for Dr James: Deep Sleep Therapy was mentioned in parliament for the first time. At this stage there had been little or no press coverage on this. However, in the previous chapter I concluded that Professor James knew about use of Deep Sleep Therapy at Cherry Farm hospital. He is likely to have referred young people to narcosis units there. Evidence suggests he wanted to avoid his name being mentioned in this context. The possibility arises that he resigned his position and relocated to avoid media scrutiny. Various other facts bear on this:

* He took his decision 10 months before the Minister of Health commissioned Mellsop and Radford to conduct an enquiry into DST. At the time he could have guessed that an enquiry of some sort was in the offing, but not that the terms of reference would exclude attempts to identify the ultimate locus of responsibility.
* By the time Mellsop and Radford were commissioned to enquire into DST, he was in Australia. It seems he was never interviewed, despite being a key informant.
* Their report never mentions Basil James.
* Despite being a prominent public figure in the 1980s, his name has hardly ever been mentioned in newspapers after he left.
* When he died in 2017, there was no obituary in local news media, as far as I discovered.

I conclude that he resigned and went to the position in Queensland to escape the possibility of media scrutiny (or worse). It is likely that those who framed the Terms of Reference were mindful of the need to protect present or past public servants. Mellsop and Radford may have been guided to avoid naming Basil James. This is very odd. If my inferences are correct, the issue of who bore responsibility for Deep Sleep Therapy raised far bigger issues than evident at the surface. Why else should more than one state agency, and perhaps several news media collaborate to protect Dr James?

***As a Clinician*:**It is important that I document Dr James’s clinical style as far as possible, from when he first started practicing to when he became Director of Mental Health. Going back more than fifty years, I start by explaining two trends which were part of ‘post-war reconstruction’.

Basic principles of medical ethics are very old but were strongly reinforced by the Nuremberg Trial of Doctors in 1946/47 and the Declaration of Helsinki in 1964. Nonetheless, in early years of the Cold War, the supposed urgency of the situation was so great that renewed emphasis on medical ethics had little impact on practice of many physicians. Operationalizing the principles, for instance as formal procedures to document ‘informed consent’, developed slowly and started to become mandatory only after the Belmont report in USA in the late 1970s (which documented a series of atrocious breaches of ethics by the medical profession in the USA in past decades). Thus, in the 1960s and 1970s, although principles were well established, practice on the ground often paid little more than lip service.

Early years of the Cold War led to intensified scrutiny of public servants, to guard against security breaches. In the USA anti-communist purges were linked to attempts to identify homosexual men in the public service, because of the supposed risk of their being blackmailed. The trend spread to Britain. Same-sex acts between men had been criminalized for hundreds of years in England, although the concept of homosexuality, as personal identity did not exist until the late nineteenth century, initially in Germany. In Britain, convictions under the old law were relatively rare prior to the second World War, but by the early 1950s they had increased 5-10-fold in various criminal categories. The absurdity and brutality of this, which included the conviction, and later suicide of Alan Turing, led to moves to reform the old laws. The Wolfenden Report, published in 1957, recommended to the UK government, that ‘the State’ should focus on protecting the public, rather than scrutinising people’s private lives. It recommended decriminalizing same-sex acts between consenting adult men in private. For the first time in English law, it introduced the notion of homosexuality as personal identity. Homosexuality then became a medical condition to be treated, rather than same-sex acts being behaviours to be punished. However it was not until ten years later that the [Sexual Offences Act 1967](http://www.bl.uk/LGBTQ-histories/lgbtq-timeline#Sexual-Offences-Act) partially legalised same-sex acts in the UK between men over the age of 21 conducted in private. Before 1967, male homosexual acts were still crimes. The rigour with which the law was enforced may have been strongest in the armed forces[[11]](#footnote-11). Between release of the Wolfenden report, and 1967 there was an ‘inter-regnum’, when psychiatrists devised ways to ‘treat’ homosexuality, now seen as a mental disorder, albeit one leading to actions which were crimes.

Dr James specialist training as a psychiatrist was undertaken in Bristol from 1958. By June 1960, he was a registrar at Glenside hospital in a northern suburb of Bristol. I already mentioned Dr James interest in the psychology of sexuality. In that month (in my estimate) he conducted a procedure of aversion therapy on a young man, a former soldier, to cure his homosexual tendency. Details were published in BMJ on 17 March 1962[[12]](#footnote-12). The method was horrific. After explaining the psychological theory behind what he was to do, to his patient, treatment started. In a darkened room, apomorphine (a nausea-producing drug) was injected two-hourly, along with brandy, and at times of nausea, prominent presentation of nude men along with a tape-recorded voice repeating messages about supposed psychological origins of homosexuality (father deprivation) and its adverse social consequences. This went on for 30-36 hours, when it was stopped because of acetonuria (a complication of repeated vomiting). Twenty-four hours later the procedure was repeated[[13]](#footnote-13). After this, he was awakened every two hours at night, with tape recorded congratulatory messages, stressing the advantages of reversing his homosexuality. The results claimed for this drastic procedure was that his patient lost interest in his own sex, and his interests shifted to the opposite sex ‘*so that he has become in all respects a sexually normal person’.* The paper cites William Sargant (*Battle for the Mind)*. Nine months later, another letter in BMJ from Dr James (now working at a hospital in Leeds), and his senior colleague and probable supervisor, Dr Donal Early, reported the longer follow-up for this patient, again referring to his regaining ‘normal sexuality’.

The day after Dr James’ paper was published, an article in the respected British Sunday newspaper, *Observer* (18 March 1962) had the headline ‘*How doctor cured a homosexual’*. It was apparently influential in persuading young gay men in Britain to seek treatment for homosexual tendencies. In the next three months the letters section of BMJ had about eight contributions, most supporting what Dr James had done, but with some cautions and caveats. The first of them (BMJ 31 March) was strongly critical not only of Dr James’ method, but also of BMJ for publishing the paper. Six months after Basil James’ paper, a similar method was employed on another young man - Billy Clegg-Hill (full name and title: Viscount Gerald William Clegg-Hill) in the UK military. He died soon after in a military hospital, from complications of the procedure.

Where did this bizarre method come from? I note that in Bristol there was the prestigious Burden Neurological Institute. At the time the American neuroscientist, William Grey Walters was working there, a prominent advocate of the analogy between brains and computers, and more widely, of the ‘Engineering model’, for psychology. One of the few papers cited in Dr James’ paper was ‘Freund K, 1960’. It is not clear that Dr James had seen the original, since he refers it to a section in a book by HJ Eyesenck (*Behaviour Therapy and the Neuroses), published also in 1960.* Who was Freund, and what was in the citation? Before the war, in Prague, capital city of Czechoslovakia, there was a significant research institute studying human sexuality. In the post war period, with the country now under Soviet suzerainty, the institute continued its research. Amongst many other projects was a thorough and large-scale attempt to ‘normalize’ the sexuality of homosexual men, using Pavlovian theory. Publications from the Prague institute appeared in various languages in the 1950s, often expressing caution about the effectiveness of the method. By 1960, laws in Czechoslovakia changed, so that same-sex acts between men were no longer crimes. In that year a review article from the Prague researchers was published in English; and this was what Dr James cited. In letters to BMJ following Dr James’ article, no-one referred to Freund’s paper. Presumably they assumed the method was his own idea.

The methods in Dr James study were more-or-less the same as those from the Prague institute, except in one respect: In Prague there were numerous short sessions of conditioning (around 2 hours), over a period of several months of therapy. Dr James attempted to condense treatment into a single session of more intense conditioning, the entire process being complete in less than a week. Undoubtedly it was which made the process dangerous, and questionable on ethical grounds. Where did it come from? I hardly think from his psychiatric training; but it could have come from experience in Cyprus, not necessary his own practice, but what he knew was happening, and, whatever the method, the need to get results fast.

I showed the description to a psychiatrist old enough to have been practicing in the 1960s. He *did* know of aversion therapy in the 1960s, using the nausea-producing agent ‘antabuse’ to treat alcoholism; but it was nothing like the prolonged procedure in Basil James’ BMJ paper - just a few hours in duration. In my reading, the only account of aversion therapy which approaches this in intensity, is from William Sargant in 1951, also using emetic drugs to treat alcoholism[[14]](#footnote-14). In its sheer brutality, as well as the regular night-time waking, the method seemed more like one used in the military to ‘soften up’ captives prior to interrogation, than to any ordinary treatment in a healthcare setting. In terms of accepted practice at the time - even in early Cold-War days in Britain - what Dr James did in Bristol was ‘off the scale’ in ethical terms; but it might *not* have been had some of his previous experience been as a military physician. Given that it *was* aversion therapy, and that homosexual acts were illegal, I ask if it was ‘treatment’ or ‘punishment’. In earlier chapters, I asked about Leek’s practice at Lake Alice, and Martinus’s Deep Sleep Therapy; and the same question must be asked here: *Was the ‘therapy’ for that young man for his same-sex preference done in a health-care context?*

After arrival in New Zealand, Dr James continued this style of treatment. The best-known case was Ralph Knowles, a 20-year-old theology student in Dunedin who was advised to seek medical treatment for his homosexual preference. He was treated by Dr James in 1964 in the manner described above[[15]](#footnote-15). In 1967 he published substantial papers on the method in the New Zealand Medical Journal[[16]](#footnote-16); and from conversation with a friend who was a student at Victoria University, Wellington in the late 1960s, it was well known to students there that this was the treatment on offer at that time.

At some time, Otago University prepared a brief profile about James, which I learned from the current Human Resources Director there might have been used as a press release, around March 1981, when he was appointed as Director of Mental Health. I am also told that it never was used in this way. From this semi-official profile, there are interesting statements about his self-declared clinical and research interests:

*While at Dunedin, Dr James has developed a particular interest in consultative work involving liaison with other clinical departments, one aspect of which relates to unwanted pregnancies. In teaching he is particularly interested in audio-visual techniques. His research interests are in suicide, relationship between psychiatric illness and ordinal position in the family, ad intra-ocular tension. Professor James has produced a number of publications, mainly related to behaviour therapy, the potential of which method of treatment is now receiving world-wide recognition. He holds a Diploma in Psychological Medicine of the Royal College of Physicians and Surgeons and is a member of the Australian and New Zealand College of Psychiatrists.*

This profile predated his appointment as Director of Mental Health by some years. It refers to the Australian & New Zealand College, rather than the Royal College, putting it before 1977. The fact that he was just ‘a member’ of this college, and the prominent statement about Basil James’s experience with behaviour therapy suggests that it may have been prepared in the early 1970s. The statement about his interest in consultative work involving liaison with other clinical departments, is supported by evidence of the title of a lecture he delivered at University of Colorado Medical Center on 17 July 1972, when on Sabbatical leave: ‘*The psychiatric needs of the non-psychiatric general hospital patient’.* It is a worthy topic for a lecture, in my view, and I have no doubt that it was a major concern for Basil James. I doubt if he made much headway on this topic in Otago medical faculty. I offer no opinion on whether this was due to his at times provocative style, or the instinctive conservatism of the faculty.

A most interesting point is the claim that Dr James had acquired a Diploma in Psychological Medicine from the Royal College of Physicians and Surgeons. In Britain prior to establishment of the Royal College of Psychiatry, this body was preceded by the Royal Medico-Psychological Association which awarded diplomas as professional qualification. The new college was founded in 1971. Detail from Otago university went beyond anything I had learned about Dr James at that point. I therefore enquired to the Archivist, at the library of the Royal College of Physicians, asking for the date when he acquired this diploma. The reply I received next day was very interesting: After acquiring his basic medical degree from the Welsh National School of Medicine in 1954, the last year when he had registration to practice was 1973. Between those years the archivist told me that he found no mention of Dr James having any qualification from any of the Royal medical colleges in Britain. The only such college whose title combined medicine and surgery is the Royal College of Physicians and Surgeons of Glasgow, which is hardly relevant. Moreover, there is no evidence that he ever acquired specialist registration as a psychiatrist in Britain. On 21 October 1971 he *did* obtain specialist registration in Psychological Medicine or Psychiatry with the Department of Health in Wellington, but this was probably the first time he had specialist registration. Thus it seems that his original appointment in Otago University, and his promotion in 1969 as head the Department of Psychological Medicine there occurred at times when he had no specialist qualification in either psychiatry or psychological medicine[[17]](#footnote-17)

After becoming Director of Mental Health, one of Dr James’ TV appearances (20 July 1984) was in a 30-minute discussion on Homosexual Law Reform. In the previous decade there had been two unsuccessful attempts at legislative reform. In the discussion he commented that ‘“*Homosexuality” is word that should only be used to describe the preferred sexual preference. It doesn’t say anything else.*’ People with that preference ‘*vary amongst themselves as much as any other group, rather than seeing the whole person as abnormal’.*

Q: Is it abnormal?

‘*I certainly don’t like the word “abnormal”. Statistically speaking I think those who are continually homosexual are in the minority, and I’d rather see them in terms of a minority group . . .Lives of homosexuals are often very complicated, largely because of community attitudes and especially their sense of persecution by laws that make their preference illegal.*’

These views seem to reflect a more modern view than those prevailing 25 years earlier. I have no idea whether he was aware how his views had changed, especially on use of the word ‘normal’. Probably there had been a genuine shift. When I met Mike Wesley-Smith early in 2021 he passed on a small item of information, that at one stage Professor James offered an apology to RANZCP for his former method of treatment. I was not told the terms in which the apology was made, nor the date. I assume it was before Dr James started to rise in the ranks of the college, to become president, probably in early 1970s. A significant date is December 1973, when the American Psychiatric Association decided that male same-sex relationships were no longer to be listed as a disorder. In the Australia and New Zealand College of Psychiatry a similar decision had essentially been made 18 months earlier[[18]](#footnote-18). I see no reason to question the sincerity of Dr James’ apology, nor that he regretted what he did in the insidiously coercive environment of earlier years, whether it be medical, military, or the two combined. However, there was never a hint of *public* apology, especially to the young men subjected this ‘treatment’. The college of psychiatry was not transparent. Despite later efforts, it is still hardly transparent.

The second early publication of Dr James was another single case study published in a specialist journal *Behaviour Research & Therapy*, dated 1964, from St James Hospital in Leeds. He was the co-author, with JC Little as first author, the title *‘Abreaction of conditioned fear reaction after eighteen years’*. It was about treatment of persisting war-related traumatic neurosis, with methods like those of Sargant twenty years earlier, with ether rather than barbiturates. It was strongly influenced by Pavlov, and Sargant is cited twice. As in Sargant’s practice, and in Dr James BMJ paper, the aim was again to change the workings of a person’s mind/brain comprehensively, by inducing powerful emotional reactions.

What else can be said about Basil James’s clinical practice? In the 1970s, possibly earlier, he was using the hallucinogen LSD to aid therapy. The information I have is that this occurred in Christchurch, not Dunedin, but I recently met someone whose mother was in the private clinic in Dunedin, Ashburn Hall, where LSD was in use. This need cause little comment. Many psychiatrists in several countries had been doing this since the late 1950s.

Psychotherapy in a broad sense is an essential skill for every psychiatrist, but it is inherently difficult for me to know details of any individual practitioner’s style. In the televised discussion in March 1984 on reform of the Mental Health Act, one of Dr James’ statements provides a clue. He referred to ‘*good clinical practice to form an alliance - a contract which is mutually agreed is highly desirable.*’ I have heard this line before in the context of psychotherapy. Was he surfing the neoliberal wave, turning routine human interactions (including health care), into contractual relationships. If so, he made unrealistic assumptions about rationality of people, who might be under stress, and ignored the power imbalance (a flaw in many contracts).

More disturbing to me personally, when I met him in the late 1970s, he espoused the dogma of the ‘schizophrenogenic mother’. As stated in my introductory chapter, I am sensitive to its implications; and this was amplified when I learned of the bottomless anger, much of it focused on Dr James, from aggrieved parents in the Dunedin branch of Schizophrenia Fellowship. It was probably an important item of belief for Dr James: I recently met a GP, who trained in Otago in early 1970s. Professor James suggested to him that he write a dissertation on the topic.

I summarize how I perceive Basil James’ clinical style. Over the decades there were big shifts. His original style was brutal biologism, informed by a simplistic version of Pavlov, combined with Sargant’s abreaction (derived from Freud). It attempted to change fundamental aspect of personal identity – sexual preference. Twenty-five years later, he had acquired a more humane and realistic approach to this topic. In between, or coincident with both these phases, he had a stage of assigning the cause of major mental illness to inadequate parenting of infants, again a cruel approach. However, it is likely that he gained more sympathy when he actually met embittered parents, or at least their more communicative spokesperson. In these stages, he was also using hallucinogenic drugs in treatment, and probably gave quiet support to colleagues undertaking Deep Sleep Therapy. He was certainly willing to try new approaches. This may have amounted to uncritical following of current fashions, but he could learn from experience. This empirical – and at times experimental - approach seemed to have had little basis in theory. One might suggest that his extreme method of treating homosexuality, and later his use of LSD, had a theoretical basis in Freud’s concept of abreaction; but this was shallow theory. Despite his fluency with philosophical concepts and some modern advances in science, he was in no position to critique the latest trends by examining their plausibility based on any deeper theory. It is also unclear to me that there was any deep ethical commitment at the core of his practice; and some of what he did (or supported in practice of his colleagues) was shrouded in secrecy. I am tempted to suggest that his use of the concept of ‘complementarity’ might have been a useful way to resolve – or to absolve himself from – the contradictions in his practice over the years. However, standing far back, such blind empiricism has in truth characterized all areas of medicine if one goes back far enough. Inevitably, since it was ‘hit-or-miss’, and there were bound to be serious mistakes. In this situation doctors deploy methods which would not stand up to scrutiny in the context of today’s ethics; and these physicians would hardly want to advertise what they had been doing.

***Scientific Theory Underlying Dr James’ methods.***

I must comment in more detail on the scientific theory implied in Dr James’ procedures for gay conversion. The first half of last century was ‘the golden age of associationist psychology’. It took two forms. From Russia, a process of ‘conditioning’ had been established, in which a conditional stimulus became associated to an unconditioned one, by repeated pairing of the two. As a result, responses initially elicited by the latter could come to be evoked by the former. Scientists and clinicians in USA learned about Pavlov’s work in the 1930s, well before their British colleagues. Pavlov’s writings reached Britain in translation only towards the end of the war and were a major influence at that time on William Sargant. I remember my puzzlement at the time, as the fashion for Pavlovian behaviour therapy reached Britain in the early 1960s.

In North America, another type of conditioning was investigated, in which actions emitted by an organism came to be associated with their consequences. Depending on whether the consequences were favourable or unfavourable in relation to the organism’s motives, actions were encouraged or suppressed. In 1952, from the McGill university Psychology Department, in Montreal, a ground-breaking experiment on free-moving laboratory rats was reported by James Olds and Peter Milner[[19]](#footnote-19). The experiment identified brain pathways, which if stimulated electrically by the rat’s own actions, produced reinforcing effects on the very same actions. The phenomenon was widely studied in following years and is now known as ‘brain stimulus reward’, or ‘intracranial self-stimulation’. Existence of such pathways had been inferred from previous studies of behaviour. It is the biological basis of learning mediated by reward.

Both forms of association are important aspects of animal psychology, including human psychology; but neither of them, singly or together, constitute the fullness of psychological processes available to mammalian species, whether animals or humans. Pavlov was aware of this, but most researchers in North America were more naïve, thinking that all human actions could be reduced to contingencies of reward or punishment and their respective impacts on behaviour. The underlying assumption in both types of conditioning was that stimuli, even after conditioning, were unconditional triggers of items of behaviour. We now know this is quite wrong. Crucial behavioural experiment, again in rats, had been conducted in the late 1940s showing how incomplete were associationist accounts of learning and ‘stimulus-response theory’. The shift to a more complete ‘cognitive’ account of psychology - now universally accepted - was slow to take root. Sargant and James were strongly influenced by the simplified version of Pavlov circulating in Britain from 1945 to 1965. Sargant never caught on to cognitive psychology. Neither had Basil James in his 1961 paper, nor in his longer papers in New Zealand in 1967; but he had a versatile mind, and was, I think, more pragmatic. Whether or not he could express the newer, more complete version of psychology in scientific language, I do not know; but I believe he changed over the years to more realistic psychological models.

***Further Detail on Basil James*:**

Basil James was born on 17 May 1930, in Whitchurch, a suburb of the Welsh capital city of Cardiff (home of the Welsh National School of Medicine). This was the suburb in which the city’s mental hospital was located. Cardiff was one of the first centres in UK to use DST, I assume at Whitchurch. He graduated in medicine from Cardiff in 1954. A psychiatrist there, T.J.Hennelly, published on DST in the 1930s and was practicing there at the time Basil James did his training, this being prior to introduction of antipsychotic drugs. In 1953 Basil James married Geraldine Rita. Their first child was born in Cardiff in August 1954. After this he (accompanied by wife and child) were posted to military service in Cyprus. They were there for three years. Two further children were born there (March 1956; February 1958). After that, he returned to Britain for specialist training in psychiatry, at Glanrhyd Hospital, Bridgend, Wales in 1958, and by mid-1960, was a registrar at Glenside hospital, in a northern suburb of Bristol. As far as I know, while in Britain, he was never on a specialist register, nor was he registered as a GP. In 1963, he moved to St James hospital, Leeds (known locally as ‘Jimmy’s).

It is a little odd that he found himself at St James hospital. Leeds University medical school had one of the oldest departments of psychiatry in England, but St James hospital was not part of the medical school. By all reports it was then a run-down institution, still awaiting post-war rejuvenation[[20]](#footnote-20). His taking a position there might have indicated a down-grade in his career expectations and might be a clue to his emigration shortly after.

In 1964, with wife and three3 children, he emigrated to New Zealand, sailing on the ‘Southern Cross’ from Southampton to Wellington between 26 May and 29 June, to take up a lectureship in the relatively new Department of Psychological Medicine in Otago University. His arrival documents specify him as a ‘Medical Practitioner’, rather than a psychiatrist. On 16 March 1965 he was first registered as a practitioner in New Zealand. He became head of department in 1969. On 21 October 1971 he obtained specialist registration in Psychological Medicine or Psychiatry with the Department of Health in Wellington, probably the first time he had specialist registration. In May 1972, he travelled to Israel (via Canberra) Tel Aviv, Israel. Departure documents from Sydney now specify him as a psychiatrist. Otago University tells me this was regular scheduled sabbatical leave. I assumed that this destination enabled him to join the fourth International Congress on Social Psychiatry, held in Jerusalem (21-26 May). After much surfing of the web, I eventually obtained the program and list of participants for this congress, and many possibly relevant abstracts. His name was nowhere to be found. He may well have joined this congress, but it was not to deliver a paper. This is a little odd, but need not raise any suspicions, were it not for another odd fact, that he was appointed to his position in Otago, and then promoted to head the Department of Psychological Medicine at a time when he had no specialist qualification in the discipline.

I learned more from Otago University of Dr James’ movements during this period of study leave: He spent five weeks in Britain visiting centres of excellence in psychiatry. In June 1972 he attended a conference on *Life Stress and Illness* sponsored by the Science Committee of NATO, at Beito, Norway (a high-country retreat, suitable for alpine sports). The book arising from this meeting, does not mention Dr James, and I find no evidence that he delivered a paper. He then spent five weeks in the USA, including a visit in July to the Colorado Medical Centre at Denver (see below). Between 25 and 29 September, he attended the fourth World Conference on Medical Education of the World Medical Association, at Copenhagen, Denmark.

In 1977 he started a two-year term as President of the Royal Australian and New Zealand College of Psychiatry, and also launched a ‘Telethon, to raise funds to establish the Mental Health Foundation. In October 1979, he and his family all took out New Zealand citizenship. In March 1981 it was announced that he was appointed as the next Director of Mental Health. The previous Director, Dr Stan Mirams had retired late in 1979. There was then, apparently, an eighteen-month interregnum when the position was vacant. My OIA request to the Ministry of Health gave no clarification of the exact date of his appointment. However, enquiries in Otago University led me to the entry in the Gazette, dated March 1981: The simple explanation for the delay then seems to be that Dr James was in principle appointed when Dr Mirams retired, taking out citizenship as a requirement to fill the position; and the delay was related to the difficulty filling the Chair of Psychological Medicine before he could take up the position in Wellington. However, I learned that the announcement in the Gazette caused some consternation within Otago University administration, on the grounds that they were never consulted. Moreover, his replacement, Paul Mullen took over the Chair in 1982, a delay of approaching another year (perhaps more). Neither of these fact supports the simple explanation. There are intriguing unresolved questions in this story. *Why the delay in his appointment to the position in Wellington?*

 In July 1989 DST was mentioned in parliament for the first time, and by early December 1989, he had resigned from his position as Director of Mental Health. In mid-1990, several press articles came out about DST, some mentioning Dr James. One of them, in the Dominion on 27 August 1990 was based partly on a phone call the reporter had had with Dr James the previous day. I do not know if the call was made to a New Zealand or an Australian number. In early September 1990, he contributed to a TV program on use of LSD in psychiatry, recorded some time earlier, by which time he was certainly in Australia. On 21 September 1990, Minister of Health, Helen Clark set up the Mellsop-Radford enquiry. The Terms of Reference, no doubt approved by Minister Clark, did not include investigating the chain of responsibility leading to the Deep Sleep Therapy programs across New Zealand.

In November 1992, the new Mental Health (Compulsory Assessment and Treatment) Act passed through parliament. After relocation, his visits to New Zealand in professional capacity were very rare, for instance to learn how new mental health legislation he helped design was operating. He returned once on 14 May 1994 to visit the new forensic service in Auckland - celebrating its 5th birthday - of which, he was reported saying, ‘*Auckland can be hugely proud’*.

At James Cook university, he remained as head of department until 1997. Between 1995 and 1997 he was President of the Australia and New Zealand Association of Psychotherapists. After this, he continued activity as a psychiatrist in his retirement, often in forensic cases. In 2002 the Mental Health Foundation, in whose foundation Dr James had played a central role, celebrated its 25th year, and published a history. Basil James wrote a memoir for this history and may have visited New Zealand as part of the celebration. In 2014, when I was a committee member with RANZCP, the annual congress was held in Sydney. Basil James was in the audience when I gave a paper. After my presentation he took the trouble to meet me and shake hands. It was, a routine courtesy, yet nonetheless significant. In May 2016, the congress was held in Brisbane, and the college honoured him with an award. He died in 2017 in Queensland. While he was alive, little was known publicly about what he was doing before he came to New Zealand in 1964. This is odd because he had been an important figure in New Zealand. An obituary written by Professor John Allan provided more detail, but with no mention of attempts to change sexual preference in homosexual men.

I should add that I learned of Basil James’ apology from lawyer/journalist Mike Wesley-Smith, who was by that time working for the Royal Commission. I infer that the Royal Commission somehow learned of this by communicating with RANZCP, probably directly with John Allan, professor in Queensland, who was well placed in the college. He probably knew more of Basil James’ entire life story than anyone else, including details now in archives of RANZCP which are not public. One wonders: What else is there on Basil James in those archives? What other evidence has the Royal Commission collected which will not, or cannot be made public? Overall, one has a strong impression that Basil James has hidden his tracks, perhaps to prevent uncomfortable secrets being known. Could these secrets be related to his decisions to relocate to New Zealand in 1963, and to resign his position in 1989?

***Military Service in Cyprus*:**

While Basil James was alive, there was little awareness that, as a recently qualified doctor he was posted to Cyprus on National service. It *was* revealed in Professor Allan’s obituary. Before that, in principle it was public knowledge, but it was hard to discover. Prior to the obituary, I knew this, from the sleuthing of my good friend, the late Julie Leibrich. Basil James, plus wife and children all became naturalized New Zealand citizens on the same day in 1979. That *is* public knowledge. Two of his children were born in Nicosia, during the period when he was in Cyprus. He had the rank of lieutenant, a commissioned officer, part of the Royal Army Medical Corps – ‘Basil James MB, conscription number 444040.’ This information *was* in the public domain, but hard to find, unless you knew what to look for; and was never mentioned in his public profile while he was alive. However, in the never-released profile which I received from Otago university, there is the line ‘*served in the Royal Army Medical Corps* from 1955 to 1958, being based for a large part of that period in Cyprus’. This leaves intriguing uncertainty: What was he doing – and where – in the remainder of that three-year period? In any case, the usual period for National Service for conscripts at the time was two years. Basil’s explanation for accepting a 3-year assignment was that it was part of the deal he struck to be there with his new wife, and infant child. Perhaps he also had an important role there – not ‘top brass’, but possibly ‘medium brass’.

At that time Cyprus included a huge military base, with about 40,000 troops, and certainly also with much US influence. The period 1955-59 in Cyprus saw the unfolding Suez crisis (October 1956). The lead up to that and the wind down from it must have been times of great uncertainty there. Add to this the second crisis, the period of the EOKA insurgency, when many Cypriots wanted union with Greece. In this situation, a few hundred determined people (identified as terrorists by UK government) with local knowledge and support could challenge a much larger force. It was not to be resolved by massive show of strength, but rather by intelligence. Sometimes, with incipient bomb threats, answers were needed quickly by strong methods of interrogation. There *was* torture, and a few people died under torture, not, I believe, by the army, but by the ‘special branch’ (that is MI6). Early in 2019, survivors of this received a payout from the UK government in settlement of their case, following a precedent set a few years earlier regarding brutality experienced by Kenyans during the MauMau insurgency. Mostly, it seems to have been unsubtle brutality - but something more subtle may have been going on, as ‘research into methods of interrogation’, yet kept hidden. It is now known that, during the various insurgencies during the wind-down of the British empire, such methods were progressively refined. Because of the Geneva Convention against torture, it was regarded as important to devise method of enhanced interrogation which left no mark - not only no mark, but no written record, no ‘manual’ about the techniques to be used. They were passed on by word of mouth amongst practitioners in this dark art. At the time of ‘The Troubles’ in Northern Ireland they were known as the ‘five techniques’.

The fact that torture occurred in Cyprus and elsewhere was hardly a secret. It was known amongst journalists in Cyprus, although they could not publish what they knew. It was also a topic of debate in the Westminster, accompanied by fervent - if implausible - denials by government officials, including Prime Minister Harold MacMillan.

***My Hypothesis*:**

In earlier chapters, I explained a conclusion I was forced to draw: What went on at Lake Alice Child & Adolescent Unit under Selwyn Leeks could not be conceived as having therapeutic objectives but made good sense in military or military intelligence contexts. Long before I knew details of abuse at LACAU but knew of Basil James’ military service in Cyprus, the nature of the EOKA insurgency, and the methods used at the military base there, I had formed a similar hypothesis: *What went on at Cherry Farm under George Martinus had non-therapeutic objectives which made better sense in a military or intelligence scenario.* I also recall a small incident, I think in 1979 or early 1980, which may be significant, and contributed to my suspicions along these lines. I was in Basil James’ office in conversation when the phone rang. He answered, and a brief conversation followed. After he hung up, he explained to me, in breezy fashion ‘*That was the Ministry of Defense’*. There could have been various reasons for the call[[21]](#footnote-21), but I did not forget it. It was part of my ‘joining the dots’ in recent investigations. In short, long before I knew of the visit of Richard Helms, Director of CIA, to New Zealand, in July 1972, I had already formed this hypothesis; and it was mentioned in the first version of my report on DST sent to the Royal Commission.

I now raise a third conjecture on the same lines: Could this hypothesis apply to what Basil James did at Glenside hospital in June 1960? One strand of evidence makes this plausible: On 26 February 1960, one Alexander Kennedy, Professor of Psychological Medicine at Edinburgh University, gave a lecture to the prestigious scientific establishment in London, the Royal Institution. The lecture was entitled ‘*The scientific lessons of interrogation’*. Kennedy’s lecture described how lessons from wartime interrogation might be applied in peacetime treatment of psychiatric illness. Details of methods he described included sleep deprivation, partial sensory deprivation, hypnotism, sounds (‘white noise’), distortion of sounds and visual stimuli making them into formless sensory images, and drugs – including amphetamine. The aim was to disorient prisoners and undermine their sense of personal identity, prior to interrogation.

Shocked reactions to this at the time, both in newspapers and in parliament, were mentioned in a BBC documentary broadcast in 2009[[22]](#footnote-22). There was concern that methods described by Kennedy had been used by British interrogators, himself included, during the war. Kennedy strenuously denied this. However, documented evidence uncovered by BBC investigators indicates that he *had* used such methods at a site near Cairo, as psychiatric adviser to the Intelligence Services for the Middle East there. It did not occur in regular military interrogation, but rather as at an offshoot of MI5 in the region. Documents suggested that MI5 disapproved; but the BBC documentary suggests that there were ‘pressures’ on Kennedy and others to use such methods. There was no hint of where the pressures came from. However, it was mentioned that he had trained in Washington pre-war on a Rockefeller scholarship. He spent some time (1936-7) at Johns Hopkins medical school, Baltimore, I assume on that visit. It is unlikely that his paths crossed those of Sargant at this time; but when war broke out, and he was back in Britain, he was posted to the Sutton reception centre (1939-41) before going to Crete at the time of the 10-day battle there (20-30 May 1941). It is likely that he would have known Sargant.

Four months after his lecture, Kennedy died (11 June 1960) of a cardiac infarction. His obituary in BMJ steered clear of his wartime activity but mentioned that ‘an earlier warning [of his heart problem] had happened a year before.’ Kennedy may have known that his days were numbered and wanted to give at least an indication, before he died, of what he had done during the war (if not exactly a death-bed confession).

After much searching, I acquired a copy of the full text of Kennedy’s lecture. As I studied it, I realized why there had been such alarm; but I also started to realize that its author had an acute scientific mind, and that the case he put forward was unique, well argued, and well expressed, albeit to a lay audience, in somewhat conversational style, and without references in the text version. Another obituary[[23]](#footnote-23) agrees that he was one of the best intellects in British psychiatry at that time, yet not really a scholarly researcher. It also comments that he was a somewhat flamboyant in his talk, a which ‘sometimes made the listener hard put to distinguish truth from fiction’. In this respect he was similar to both Sargant and James and could be criticized as playing on ‘shock-horror’ aspects of what psychiatry seemed to be evolving into. As a young man had been a boxer. Later, as a psychiatrist, he knew about extreme situations.

Ethical questions were certainly raised by what he said, which were so big that it was hardly suitable for him to discuss them in the setting of his lecture. There were many similarities between the case he advanced, and ideas and practice of both William Sargant and Basil James; but there were differences. His case was subtle and nuanced. As a scientific advocate for his version of psychiatry, he was far superior to either Sargant or James. In the next chapter, I expand on this, to summarize the gist of the ideas he advanced. I point out here that Kennedy’s lecture was published as ‘Part 1’ (of three parts) for volume 38 (for 1960) of Proceedings of the Royal Institution. In other words, it would have been available in print by April, or May 1960, probably a couple of months (in my estimate) before Basil James conducted his study to reorient the sexual preferences of one of his patients.

The most authoritative account of torture by British forces in the post-war period is a monograph by Ian Cobain published at the start of 2013[[24]](#footnote-24). It confirms all that was said about Kennedy in the BBC documentary, including the methods he had used near Cairo, that this was part of a US-influenced interrogation practice, that he had learned some of the methods from police in USA, and that the objective – unlike most of the torture in use at the time – was to turn the loyalty of captives, to produce effective double agents, and to do this as fast as possible. Just how fast – I can find no clear evidence. Most important, Cobain states that these methods were used in Cyprus during the EOKA emergency.

Earlier in this chapter, I mentioned my conversations about Basil James to a few people who had worked closely with him. I suggested to one of them, the economist and former health board chairperson, the late Michael Cooper, that Basil James might have been working for intelligence agencies. He told me he thought this was quite plausible. In view of his frailty at the time, I did press him for more detail. I have also mentioned my friend Julie Leibrich who had also worked closely with Dr James on community mental health matters when he was located in Wellington as Director of Mental Health, and she had the position of Mental Health Commissioners there. She finds my hypothesis plausible and can well see Basil James being capable of working on the side as an intelligence agent.

***Summary*:**

Basil James, like all of us, had his strengths and weaknesses. Considering the backwardness of psychiatry when he arrived in New Zealand in 1963, he was a seminal figure in bringing to public consciousness this important area of health and well-being. However, regardless of his activities in the 1960s, by the 1970s he must have known of serious malpractice at Lake Alice and Cherry Farm; yet, as head of Department in Otago, as President of RANZCP, and then as Director of Mental Health, he did nothing. It was for others to take the initiative. Apart from this he was remarkably secretive about his activities and movements – about his military role in Cyprus, his activities when visiting Israel in May 1972, and the circumstance of his appointment as Director of Mental Health are puzzlingly obscure.

His clearest objective seems to have been to preserve the reputation of RANZCP, perhaps when under pressure from CCHR, and I infer, to avoid exposure of his own darker side. Grievous ethical transgressions in our mental hospitals were secondary matters. Like many others, he was a prisoner of the times in which he lived, ensnared by the vice of history. He, like innumerable others - myself included - was buffetted by fads and fashions, ideas and ideologies swirling around at the time, and undoubtedly by government control of information, and frank propaganda.

Within a couple of years of arrival in Otago, as a member of the medical faculty, I found myself as a possible bridge between parents in the local branch of Schizophrenia Fellowship and the psychiatric establishment in Dunedin, especially Professor James. I learned to my considerable cost that the act of betrayal of trust[[25]](#footnote-25) in a semi-public forum, was part of his ‘tradecraft’. His behaviour was more like that expected of an intelligence agent, than that of a true health professional. I was hurt by Basil James at that stage, but there is no need now for me to feel personally embittered. In the words of Madame de Stael, who lived through, and commented on the French revolution ‘*Tout comprend rend trés indulgent’*, or in its approximate English translation ‘*To know all is to forgive all’*. We are all flawed creatures. My objective here is to identify failures of systems and structures, not of persons. Nonetheless, in pursuit of that objective, there are questions to be answered about Basil James:

* ***Did he have any links to the military before his time in Cyprus? (Perhaps OTC [Officers Training Corps] at secondary school; or similar links at University)?***
* ***What was his knowledge of, or participation in torture in Cyprus?***
* ***At that time did he have links with MI5, MI6, or the CIA?***
* ***What or who was driving his gay conversion method at Glenside hospital?***
* ***Did he ever meet William Sargant? What was the extent of their interaction?***
* ***Why did he emigrate in 1963?***
* ***Why, while he was alive, did he conceal his military service in Cyprus?***
* ***How was it possible for him to be appointed to a lecturing position in the Department of Psychological Medicine in Otago and, in 1969, to be promoted to head that department, when he had no relevant specialist qualification?***
* ***Why was he never interviewed or named in relation to the inquiry into Deep Sleep Therapy?***
* ***Why did he quit as Director of Mental Health in December 1989?***
* ***Why did the Terms of Reference for the Mellsop-Radford investigation exclude examining the chain of responsibility for DST?***
* ***Who, in higher levels of administration in New Zealand, in RANZCP, and perhaps in Otago university knew what he was hiding?***
* ***In his later years, was there any sign of remorse?***
* ***Was he glad in the end never to have had his secrets exposed?***

I return to some of these questions in the later chapters. I end this chapter with another line from Shakespeare’s *Macbeth*:

***What need we fear who knows it, when none can call our power to account?***

1. Jacques, the wise fool in Shakespeare’s play. [↑](#footnote-ref-1)
2. The etymological derivation of our word ‘person’ is the Latin word ‘persona’, still in English usage, indicating originally ‘a theatre mask’. [↑](#footnote-ref-2)
3. Erwin Stengel, mentioned in my introductory chapter, had worked briefly at the Institute of Psychiatry, but was not comfortable there, and so became foundation professor in my home city. [↑](#footnote-ref-3)
4. Dr David Codyre, personal communication: A few years later, after completing his training, and now a registrar psychiatrist, Dr Codyre visited Lake Alice hospital, tasked with reviewing all the patients in the “back wards” many of whom had not had a medical review for years. He also worked in an acute ward there, and saw a couple of patients who spoke of experiences in the Child and Adolescent unit under Dr Leeks. To Dr Codyre, then relatively naïve, what they described was so bizarre it sounded delusional, yet he knew they were speaking of their own experiences. [↑](#footnote-ref-4)
5. After the end of the war in 1945, the Tavistock clinic developed a new organization – the Tavistock Institute for Human Relationships. It was still guided by Freudian theory, but focusssing on group dynamic, group psychology and industrial psychology. [↑](#footnote-ref-5)
6. In accordance with section 91 of the Mental Health (Compulsory Assessment and Treatment) Act 1992, the following powers, duties and functions are conferred on the Director of Mental Health:

General administration of the Act under the direction of the Minister and the Director-General of Health

Issuing guidelines on the Act, and standards on the care and treatment of patients; and

Specific provisions with respect to special patients, including the granting of short-term leave.

Earlier Acts defined the role in similar terms. [↑](#footnote-ref-6)
7. On 12 January 1987, the tables were turned Rosemary Vincent for NZ Womens Weekly interview Dr James (*“Putting the Psychiatrist on the Couch”*). [↑](#footnote-ref-7)
8. <http://www.nzlii.org/nz/legis/hist_bill/hmhaatb1989182639/hmhaatb1989182639.html> [↑](#footnote-ref-8)
9. <http://www.nzlii.org/nz/legis/hist_bill/mhb1987181138/mhb1987181138.html> [↑](#footnote-ref-9)
10. ‘Report of the committee of the inquiry into the procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patient.’

https://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/2DC94A246D93272C4C2565D7000DDA26/%24file/Mason%20Report.pdf [↑](#footnote-ref-10)
11. The significance of military service at this period is complicated. During the second World War, for lower ranks, pressure of military life seems to have led to a more relaxed attitude to homosexuality; but for higher ranks, as the war progressed, stigma against gays intensified. After the war, it would probably have extended to times when both Dr James and Billy Clegg-Hill served. Amongst nurses, many gays were recruited post-war into the profession where they found a more open atmosphere. However strict quasi-military discipline imposed during the war persisted for many years. This meant that nurses were compelled to follow orders without thought of the ethics of what they were doing; and at higher levels of the profession, as in the military, anti-gay sentiment prevailed. Details come from a recent monograph, entitled ‘*Curing queers’* by Tom Dickinson (Manchester University Press, 2014). [↑](#footnote-ref-11)
12. Basil James (1962) Case of homosexuality treated by aversion therapy. *BMJ* 1, 768-770. [↑](#footnote-ref-12)
13. I am not the only person who still trying to get at the truth about this part of Basil James’ life story: *Bristol Post* (27 February, 2016) recently ran a story about this entitled  ‘*Hospital tried to “cure” gay man with bizarre* *treatment – Bristol in the 1950s’.* [↑](#footnote-ref-13)
14. Sargant W (1951; ii) BMJ, 311-316. [↑](#footnote-ref-14)
15. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5883162/> Bennett,JE, Brickell,C (2018) Surveilling the Mind and Body: Medicalising and De-medicalising homosexuality in 1970s New Zealand. *J Med. History, 62,199-216.*  [↑](#footnote-ref-15)
16. James B (1967) Behaviour therapy applied to homosexuality. *NZMJ 66,742-8;* Learning theory and homosexuality. *NZMJ 66, 748-54.* [↑](#footnote-ref-16)
17. On 7 June 2023, I wrote to the British Royal College of Psychiatry asking two questions, answers to which might exist in their archives:

(i) After his specialist training in Bristol, did Dr Basil James ever make an attempt to obtain the specialist qualification from the Royal Medico-Psychological Association?

(ii) If he did - and presumably was not successful - is there any record of why he was not successful?

At the time of posting this revision of chapter 3 (27 June 2023), I have received no answer. [↑](#footnote-ref-17)
18. In May 1972 General Council of the ANZCP adopted the following resolution: ‘*That the … [College] strongly condemns community attitudes and laws which discriminate against homosexual behaviour between consenting adults in private*.’ [↑](#footnote-ref-18)
19. Peter Milner (1919-2018), originally from Barnsley, South Yorkshire, trained as an engineer, and after the war, transferred his expertise to the field of physiological psychology. In the 1990s, I met him a couple of times during visits to Montreal. [↑](#footnote-ref-19)
20. It was also the location where one Jimmy Savile, hospital porter, was starting his criminal predatory sexual behaviour. [↑](#footnote-ref-20)
21. I now know another reason why Professor James might have been in communication with our Ministry of Defense. On 4 November 1979, the Iran hostage crisis hit international news, as part of the overthrow of the Shah’s regime. On 27 January 1980, a group of six hostages escaped, in a plan put together by CIA and Canadian diplomats. A recently released diary shows that New Zealand diplomats were also involved, taking considerable risks in doing so. Our Ministry of Defense may have contacted Professor James seeking his insights on how to handle this fast-moving story. [↑](#footnote-ref-21)
22. <https://www.bbc.co.uk/sounds/play/b00nv91x> [↑](#footnote-ref-22)
23. https://history.rcplondon.ac.uk/inspiring-physicians/alexander-kennedy [↑](#footnote-ref-23)
24. Ian Cobain: Cruel Britannia: A Secret History of Torture. Portobello Books, 1 January 2013. [↑](#footnote-ref-24)
25. On the prompting of the one person I know who was subjected to DST at Cherry Farm, I wrote a brief account of this unsettling experience. This document has been provided for the Royal Commission, and I could provide it again. It would be painful, but not impossible for me to testify about this episode. It came to its culmination a few days before my first daughter was born, so I am not likely to forget it. Only very recently did I explain this incident to my daughter (now happily married with two wonderful grandsons for me). [↑](#footnote-ref-25)