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Article

Reconstructing the eclectic psychiatry of Thomas Ferguson Rodger

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Abstract

This paper provides an introduction to the approach of the Scottish psychiatrist, Thomas Ferguson Rodger (1907–78), as reconstructed from his archive. Rodger's contribution has been largely neglected within the history of Scottish psychiatry. This paper amends this neglect through situating Rodger's eclecticism in relation to both the biopsychosocial approach of his mentors, Adolf Meyer and David Henderson, and psychiatry's de-institutionalization in the 1950s and 1960s. It is posited that Rodger's eclecticism was a considered response to the pressures of this transitional phase to balance physical, psychological and social approaches, and a critical acknowledgement of the instability of contemporary psychiatric therapeutics underlying how contemporary therapies functioned. More psychodynamic than his predecessors, the importance of social relations for Rodger led him to acknowledge psychiatry's limitations.

Keywords

Biopsychosocial, de-institutionalization, eclecticism, Scottish psychiatry, Thomas Ferguson Rodger

Introduction

Thomas Ferguson Rodger (1907–78) was the first Professor of Psychological Medicine at the University of Glasgow (1948–72) and a consultant psychiatrist at several Glasgow hospitals. His career encompassed – and to a degree influenced – a period of important change as traditional asylum-based psychiatry was being replaced by a developing general hospital- and community-based psychiatry. Davidson (2009: 414) has called Rodger ‘perhaps the most influential psychiatrist practising in the West of Scotland in the 1950s’. Yet at present his professorship and involvement in psychiatry represents something of a hiatus in scholarship on mid-twentieth-century Scottish psychiatry relative to recent research on both his predecessor, the prominent psychiatrist David Henderson (Morrison, 2014), and the most famous alumnus of Rodger's own department, R.D. Laing (e.g. Beveridge, 2011; McGeachan, 2014; Miller, 2004).

This article fills this gap by introducing Rodger's wide-ranging psychiatric approach as reconstructed from his personal archive and contextualized within the mid-twentieth-century psychiatric landscape. It positions Rodger's eclecticism as both a modification of the biopsychosocial or dynamic model of Adolf Meyer and Henderson, and a response

precipitated by psychiatry's new position within the general hospital. With the post-war establishment of the British National Health Service (NHS) and the gradual process of de-institutionalizing psychiatry which followed, antagonisms have been identified in relation to the advocacy of physical treatments, psychiatry's alliance with general medicine, and the use of social approaches in psychiatry (Bennett and Morris, 1982: 8; Long, 2011). Towards the end of the 1940s and 1950s, prominent psychiatrists sidelined social/psychological insights and methods, advocating new physical treatments as a means of re-orienting psychiatry in relation to general medicine (Long, 2011: 228). In contrast, psychiatric social workers believed that 'interpersonal' (p. 229) difficulties persisted beyond the use of physical treatments, and that only the patient's readjustment within their community could secure lasting mental health (pp. 229–32). This article characterizes Rodger's eclecticism as a considered response to psychiatry's de-institutionalization, and specifically to how this transitional phase rendered more pronounced the challenge of mediating between disciplinary allegiances. Furthermore, it is posited that Rodger's approach – a combination of physical treatments such as electroconvulsive therapy (ECT) and tranquillizers with a version of psychoanalytic psychotherapy – issued from a self-critical awareness about the lack of scientific legitimation for contemporary therapeutics. More psychodynamic than Meyer and Henderson, Rodger's recourse to psychoanalytic psychotherapy was linked to his recognizing the importance of social relations in the patient's recovery. Ultimately, the primacy of social factors led Rodger to acknowledge psychiatry's limitations.

Background

Born in Glasgow on 4 November 1907 (TFR biography, 2012), Rodger is remembered in an obituary for the University of Glasgow's alumni publication as 'displaying unusual intellectual gifts since childhood' (A.M.S., 1978a). There is an intimation that his eclecticism was apparent in his early life; 'too young' after his secondary education to go directly into medical studies at the University of Glasgow, this allowed him 'the opportunity to indulge his attributes as a potential polymath by taking a degree in science and studying politics before obtaining a medical degree with commendation by the age of twenty-one' (A.M.S., 1978a). Elsewhere it is reported that Rodger displayed the capabilities to succeed in any area of medicine, but chose 'to devote himself to the relatively neglected and unpopular sphere of psychological medicine' (A.M.S., 1978b). During this time, he played an active role in the political life of the University: Rodger was friendly with lawyer and Scottish Home Rule advocate John McCormick, and together they 'gave up Labour Party affiliations to found the

Glasgow University Scottish National Association together' (MacQueen, 2013: 363).

Nonetheless, Rodger reverted to his 'original Labour Party loyalties' as the Scottish National Party moved towards the right (p. 363).

After being awarded a BSc in 1927 and an MB ChB in 1929 (TFR biography, 2012), he worked as 'assistant to Sir David Henderson, at Glasgow Royal Mental Hospital', informally known as Gartnavel (A.M.S., 1978b). Following this employment, he, like Henderson, worked under the 'most influential teacher of psychiatry', Adolf Meyer, at the Johns Hopkins University, Baltimore (A.M.S., 1978a). From 1933 to 1940, he was again employed at Gartnavel as Deputy Superintendent and, additionally, as an Assistant Lecturer in Psychiatry at his alma mater (TFR biography, 2012). His military service in the World War II, which exerted a formative influence upon his later psychiatric approach, began with the role of 'specialist' in the Royal Army Medical Corps from 1940 to 1944, before working as a 'consultant in psychiatry' with the Army Medical Services while stationed in South East Asia Command and India (A.M.S., 1978a). He was awarded the 'rank of Brigadier' and his wartime involvement reforming 'techniques of officer selection and personnel deployment made him an acknowledged authority' (A.M.S., 1978a). The fact that he remained an 'adviser' to the War Office throughout his professional life (A.M.S., 1978b) perhaps shows the significance of his individual wartime contribution. After the war, he took up a position as Senior Commissioner on the General Board of Control for Scotland until 1948, when he was offered his professorship (A.M.S., 1978b).

After the war, he established his own department at the Southern General Hospital, and with the surgeon J. Sloan Robertson he contributed to that hospital's position at the forefront of the incorporation of 'Psychological Medicine and Neurological Sciences' (TFR biography, 2012). Concomitant with his professorship, he fulfilled prominent positions in official bodies, both domestic and further afield: he was 'a member of the Expert Committee on Mental Health' in the World Health Organization; he contributed to the expansion of the Royal Medico-Psychological Association in both Scotland and Britain, and was appointed 'Chairman of the Scottish Division in 1962' and President of the National body in 1965; and he was also involved in the formation of the Royal College of Psychiatrists, aiding in the development of its 'educational policies' (Timbury, 1978: 170). He received a CBE in 1967 (TFR biography, 2012).

His papers, including lectures, draft publications and patient case notes, were deposited in the University of Glasgow Archives in 1982 by his son, Alan Rodger, and are an

untapped resource for explorations of both Rodger's own approach and broader issues in psychiatry from the 1930s to the beginning of the 1970s.

The Scottish 'biopsychosocial' approach and British psychiatry

Rodger's eclecticism can be positioned within the lineage of the 'biopsychosocial' approach in psychiatry, in particular in relation to its Scottish presence in the form of Henderson's engagement with both Meyer's 'dynamic' or 'psychobiological' framework (Meyer, 1910; Morrison, this issue) and the 'psychosocial' as conceptualized by the 'public health doctor', J. L. Halliday (Hull, 2012: 73). Eclecticism has been described as a combination of 'theories', 'methods' or the 'individualization of treatment' (Ghaemi, 2010: 15) which is conceptually authorized by the biopsychosocial framework. The biopsychosocial approach can be understood as an alternative to biological reductionism in psychiatry and, as set out in a 1978 article in the *Annals of the New York Academy of Sciences* by its America initiator, George Engel, it sought to incorporate 'the biological, psychological and social' into the consideration of all ill health (Engels, 1978, quoted in Ghaemi, 2009: 3).

Although the terminology of the 'biopsychosocial' emerged later than Meyer's work, Sabshin (1990: 1268) argues that Meyer's 'personal style reflected the biopsychosocial approach' which subsequently emerged with Engel. Meyer identified the importance of 'life-experiences' in the development of mental disorder, advocating a 'genetic dynamic approach' where 'interest in the physiological must fit into the study of the total pattern of a person's current behaviour and its biographical origins' (Lidz, 1966: 322). Meyer thus depicted illnesses not as arising from different physical sites, but as 'different reaction patterns' determined by both make-up and events in an individual's life, that is, distinct materializations of the individual's inability to adjust (p. 327).

Although Rodger encountered this approach directly through working with Meyer, these ideas and their adaptation were additionally transferred to him in his earlier career at Gartnavel under Henderson. Morrison (2014: 22) argues that Henderson's uptake of Meyer's precepts resulted in a shift in Scottish psychiatry 'away from its former emphasis on the description of symptoms, classifications and brain pathology, and towards the study of individual personality, set within and reacting to his or her environment'. This move can be discerned in a 1930s draft article by Rodger, then 'Assistant Physician' at Gartnavel, entitled 'The Classification of Paranoid States', where he thanked Henderson, the Physician-Superintendent, for allowing him to discuss these patient cases (DC 081/3/1/2/1: 16).¹ Here Rodger critiqued the established Kraepelinian system of classification, questioning the utility

of its multiple categories in the diagnosis of patients. Instead, he assented to Meyer's psychobiological viewpoint and concept of 'reaction-types' as a conceptual basis for classifying mental disorders (p. 14). Like Meyer and Henderson, Rodger foresaw how this framing in turn pressed psychiatrists to obtain more intimate knowledge of their patients' lives so they could 'seek in the individual case those special factors which will direct us to a prognosis' (p. 15).

Additionally, the Scottish intellectual climate provided the opportunity for interaction with related ideas surrounding the 'psychosomatic' espoused by Halliday, as indicated in Rodger's lectures as well as in a 1951 letter from Halliday to Rodger about psychotherapy (DC 081/1/1/4). Halliday (1948: 9) proposed a more unified understanding of the patient's ills by attending not only to 'a body (or *soma*) that reacts to the environment' in a physical manner, but also to a '*psyche*' that has a corresponding 'psychological' or 'social' response (original italics). Hull (2012: 82) summarizes Halliday's 'mature' theories from the late-1940s as 'psychosomatic affections as arising out of psychosocial disorders' in an injurious environment, and situates their development within a particular Glaswegian context of 'medical holism and medical modernism' (p. 84).

Thus the development of Rodger's psychiatry along both physicalist *and* psychodynamic lines can arguably be attributed most directly to his close professional association with Meyer and Henderson. It can perhaps also be attributed to his immediate psychiatric environment in Glasgow rather than to a wider British context, albeit Scottish psychiatry cannot be easily distinguished from British psychiatry as Meyerian ideas were also assimilated south of the border. *A Text-book of Psychiatry* (Henderson and Gillespie, 1927) was the authoritative work for postgraduate psychiatry students in Britain and was reissued into the 1960s, while Meyer's practices were also transferred to a new post-war generation of psychiatrists through the teachings of another former pupil, Aubrey Lewis, at the Maudsley Hospital (Gelder, 1991: 431–2). The proliferation of a Meyerian framework does not, however, seem to have ensured the easy uptake of psychotherapeutic methods within wider British psychiatry.

In their analysis of topics in the *British Journal of Psychiatry* over the twentieth century, Moncrieff and Crawford (2001: 349) state that 'biological' formulations of mental illness have consistently overridden 'psychoanalysis or social psychiatry'. According to Jones (2004: 508), the incorporation of psychotherapy within the NHS was only 'gradual', owing partly to the esoteric nature of psychoanalysis as well as the emergence of rival, more economical behavioural techniques (p. 507). As Neve (2004: 411) writes, British psychiatry

following the inception of the NHS has a ‘mixed history’ in which psychiatric services could evolve according to contrasting models (2004: 410). For example, Neve describes the ‘eclecticism’ of the Jungian British psychiatrist Ronald Sandison, who treated his NHS patients with physical therapies, such as ECT, insulin coma therapy or LSD, which were ‘strictly’ accompanied by psychotherapy to ensure an effective recovery (p. 410). Contrastingly, William Sargent in London was ‘anti-psychotherapeutic’ in his advocacy of physical therapies (p. 410). Sandison’s approach, largely congruent with Rodger’s, evidences that ‘some parts of the NHS psychiatric system’ could evolve according to an eclectic model but that economic constraints and the need for therapeutic efficacy were ever-present factors (p. 410).

De-institutionalization and conflicting treatment models

As both Jones’ and Neve’s comments seem to indicate, how an individual psychiatrist’s therapeutic philosophy manifested itself was always shaped by the pressures and therapeutic aims of the NHS. As Neve (2004: 412) surmises, the treatment ‘contenders’, whether ‘social psychiatric, institutional ... , psychotherapeutic’, which make it onto ‘the medical stage’ in a given period are decided by an interplay of factors such as political and social occurrences, economic stringency, the rise of ‘psychopharmacology’ and so on. In Rodger’s case, the permutation of physical, psychological and social methods practised should be understood in the context of moves towards the de-institutionalization of psychiatry (paralleling the creation of the NHS) which occurred in post-war Britain. At times, Rodger situated the impetus for this broad movement within World War II military psychiatry. The experience of advising military administration on matters such as personnel selection prompted him and his colleagues to ‘design new roles for ourselves in the post-war world; legislation to encourage the formation of general hospital units; the gradual abandonment of autocratic methods in mental hospitals; the framing of the National Health Service and Mental Health Acts’ (Rodger, 1966: 3).

Yet Rodger’s rhetoric perhaps belies the complexity of de-institutionalization. Bennett and Morris (1982: 5) write that the decrease in inhabitants of ‘British mental hospitals’ since the 1950s was ‘less the expression of a single process and coherent philosophy than the outcome of ... different objectives, emphases, and intellectual foundations’, some of which are summarized here. Early steps in the provision of alternative psychiatric care followed the realization of the reality of mental breakdown in World War I (Freeman, 1996: 55). Initiatives ranging from the establishment of a ‘few outpatient clinics’, principally in London,

which offered psychotherapy, to the founding of the Maudsley Hospital in 1923 as ‘the first public psychiatric hospital’ not under the constraints of the ‘Lunacy Act’ can be viewed as early efforts towards psychiatric provision external to asylums (p. 55). The aftermath of World War II led to a more concerted government strategy to address ‘incoordination, neglect, and under-provided populations’ of mental hospitals through creation of ‘a National Health Service’ (p. 56). Challenges to the ‘legitimacy’ of the mental hospital grew stronger from the end of the 1950s, initially coming from sociologists such as Erving Goffman and then increasingly from within the psychiatric profession itself (Scull, 2004: 429). Eradication of prejudice towards the mentally ill was embedded in new legislation such as the Mental Health Act 1959 and the 1962 Hospital Plan in England and Wales (Mayou, 1989: 770, 772). Both of these acts had Scottish correlates; Rodger praised the Mental Health (Scotland) Act 1960 as enabling mentally ill individuals to be admitted to hospital ‘on exactly the same footing as physically ill patients’, while removing the ‘legal distinction’ between hospitals for the mentally ill and general hospitals (DC 081/4/2/10: 1).

Freeman (1996: 56) highlights how community psychiatry should be broadly situated in terms of ‘the Welfare State’, which obviated the necessity of staying in mental hospitals to access medicine and refuge, and thus facilitating treatment at home. Yet he also acknowledges the important role played by different ‘physical treatments’ in facilitating the de-institutionalized treatment of mental disorder (pp. 56–7). While the widespread employment in Britain of ‘electric convulsive treatment (ECT) and leucotomy’ at the end of the 1940s led to greater patient ‘turnover’, this positive outcome was negated by high ‘admissions’ and ‘serious overcrowding’ (p. 56). The import of ‘neuroleptic drugs’ from France in the ‘mid-1950s’ was a catalyst for greater change, resulting in a fall in numbers residing in mental hospitals in England and Wales (p. 57). By the 1960s, the advent of ‘antidepressants and tranquilizers’ was accompanied by greater ‘out-patient’ and ‘domiciliary care’ (p. 57). Rodger clearly acknowledged the revolutionary effect of these new physical treatments upon mental health care. Tracing the introduction of physical treatments up to the advent of tranquillizers and anti-depressants in the mid-twentieth century, he stated, ‘[a]ll this has transformed the treatment of mental illness’, eliminating the ‘chronic manias’ previously seen and rendering the mental hospital ‘a different place’ (DC 081/4/1/1/32: 17). Yet he simultaneously connected these physical treatments with the opening up of therapeutic possibilities in psychological or social spheres, and furthering the de-institutionalization of psychiatry. He posited that ‘[t]he use of all these new forms of treatment’ enabled the adoption of ‘group therapy’ as well as the ‘therapeutic community’ model (p. 18).

Additionally, these contributed to a ‘rapid advance’ in psychiatry which eventually spurred the Acts of 1959 in England and 1960 in Scotland, with this new legislation paving the way for ‘community psychiatry, of psychiatry in the general hospitals and foreshadow[ing] the end of the mental hospital itself’ (p. 18).

Rodger’s brand of eclecticism arose within this context, reflecting those seemingly discordant treatment approaches which have been identified in relation to psychiatry in the general hospital and community. Long (2011: 223–4) has situated ‘somatic’ or ‘physical’ treatments, along with their advocates who sought to bring psychiatry closer to general medicine after the implementation of the NHS, in opposition to ‘social’ approaches. ‘[P]sychiatric social workers’ believed ‘social re-integration of the patient following treatment’ was still a vital task (p.223). In this period ““[p]hysical” and “social” models of psychiatric treatment ... contested not only the aetiology of mental illness but also the nature of care, treatment and cure’ (p. 223). Bennett and Morris (1982: 8) articulate a similar antagonism between the contrasting psychiatric sensibility underlying the initial motivations for de-institutionalization in the 1930s and the later move towards ‘community care’ in the 1960s: while the employment of ‘outpatient clinics’ and incorporation of psychiatry into ‘the general medical community’ was at first impelled by the ““medicalization” of psychiatric care’, the later community-oriented treatment of mental illness was driven by ‘social models of care’ and a minimization of hospital-based treatment. Yet, as Long (2011: 233) notes, this opposition between ‘physical’ and ‘social’ frameworks was to a degree a ‘false dichotomy’, since ‘[i]n practice physical and social approaches to treatment frequently co-existed within hospitals’. Arguably, the psychological model is in some sense implicit within the above references to the social approach. For example, Long depicts the foundation of the social in psychiatry as the ‘growing acceptance of psychological explanations for people’s behaviour and capabilities’ (p. 225) and covers ‘psychological treatments’ in her discussion (p. 233).

An eclectic approach

Rodger’s eclecticism was a response to the challenge of negotiating a framework for treatment around these different conceptualizations of mental illness and cure. He articulated how his desire to position his department at the Southern General ‘in relation to general medicine’, and to conduct it ‘on modern lines’, posed problems in mediating between disciplinary loyalties which were similarly felt elsewhere (Rodger, 1966: 3). Referencing the ‘difficulties’ of the America psychiatrist Roy Grinker, whose early advocacy of psychoanalysis led his students to leave ‘general psychiatry’ behind in favour of training as

‘private practice psychotherapists’, Rodger admitted that he too ‘found it difficult to achieve the balance I desired between instruction in terms of psychodynamics and an adequate consideration of other approaches’ (p. 3). This dilemma was rendered more pronounced and pressing within the new post-war general hospital setting: ‘[i]n the National Health Service, where the pressure of work dictates what we are able to do, and should do, the need to find this balance is imperative’ (pp. 3–4).

Faced with the contrasting ‘biological, psychological and social views of reality’ which vie for prominence in psychiatry, Laugharne and Laugharne (2002: 209) identify ‘the modernist road of drawing these theoretical strands together into the “biopsychosocial model”’ as a potential course which can be taken. While Rodger can be situated within the holistic, modernist context which Hull (2012: 84) identifies for Halliday, his own comments indicate his eclecticism was a critical response to the instability of contemporary psychiatric knowledge rather than being straightforwardly sustained by the biopsychosocial framework. Psychiatry in the half-century preceding Rodger’s professorship was marked by an ‘orgy of experimentation’ in physical treatments such as ‘inducing fevers’ to intercept developing psychosis, using insulin comas to cure schizophrenia, stimulating convulsions by ‘camphor, metrazol, electricity’ in cases of ‘affective psychoses and schizophrenia’ and, most drastically, psychosurgery (Scull, 1994: 8). Although initial ‘marginal gains’ sufficiently validated lobotomy, enquiries into its underlying mechanisms revealed that methods for assessing its, and indeed all current therapeutics’, ‘precise clinical value’ were lacking (Pressman, 1998: 12). Gach (2008: 401) writes that, wary of the zeal over apparently impressive innovations, later ‘investigators had become more conservative, admitting the need for careful evaluative methodologies, strict self-criticism’. Some of these controversial practices such as leucotomy were still pursued in Rodger’s department in the 1950s and 1960s, but, as evidenced in records of the Southern General case conferences, their prescription was accompanied by concerns about the effects on patients functioning in their home environments.² A case conference from the early-1960s, called to ‘review the results of leucotomy’, demonstrates that different aspects of the patient’s life were scrutinized after the surgery before it was eventually judged ‘successful’. These aspects included: the patient’s own perspective on the surgery, whether ‘intellectual deterioration’ or ‘lack of drive’ had occurred, changes in ‘appearance’, the opinion of the patient’s spouse as well as their marital relationship (HB 17/11/2xlvii). This is not to suggest that Rodger himself actively prescribed leucotomies; in another 1960s case conference, he quashed the possibility of psychosurgery

for a female patient arguing that as ‘her big asset was apparently her initiative ... the effects of leucotomy might well be disastrous from this point of view’ (HB 17/11/2xlvi).

Rodger’s eclecticism can thus be situated, albeit not straightforwardly, within this more self-critical heritage. He highlighted the underlying ‘uncertainty’ (Double, 2002: 900; 2007: 331)³ regarding what methods were effective and asked why, apart from the contingencies of medical training, a psychiatrist should adhere to one school rather than to another. Admitting his own fallibility, Rodger (1957: 5) posited that ‘the problems facing us are complex, their nature is not revealed to us and we cannot know beforehand to which approach they will yield’. He prompted his colleagues to engage in reflexive inquiry: ‘[w]hy we hold a particular point of view and attach our loyalties to one group rather than another is not clear to any one of us’ (p. 5). Rodger’s ‘eclectic position’ was hence ‘a mid-point’ between ardent advocates of ‘psychotherapy and somato-therapy’; it was not a conclusive answer to the dualist debate, but rather an environmentally sensitive care of the patient where considerations were ‘particularised in the setting of the treatment of the diseased’ (DC 081/4/1/1/25: 13). Eclecticism, for Rodger, was viable to stay abreast of ‘growing knowledge’ (DC 081/4/5/9: 1) and was fitting for this transitional time, but it did not offer a definitive statement on either the causation or cure of mental illness. He explained:

It can happen ... that a system of thought which satisfies the requirements at a particular stage in the development of a subject such as psychiatry becomes outmoded and inadequate when new facts have to be taken into account. It is at this stage that eclecticism becomes justifiable with the likelihood that it will later be replaced by a new unified system of ideas capable of expressing the acquisitions of knowledge which disturbed our previous mode of thinking. (DC 081/4/5/9: 1)

Rodger’s growing appreciation of an eclectic psychiatry is evidenced in various public pronouncements. In an 1966 article about changing currents in psychiatry, he wrote that psychiatrists had lately taken on ‘an ecumenical approach’ and were ‘prepared to consider any point of view which may have some relevance to the work we are doing’ (Rodger, 1966: 4). In a draft address for an unknown audience entitled ‘The New Eclectic Psychiatry’ from the 1950s/60s, Rodger explained that his title was proposed by his staff who had ‘concluded that our approach is now an eclectic one’ (DC 081/4/5/9: 1). As his colleagues accommodated their methods to the possibilities of physical treatments (Rodger, 1966: 4), he too had to ‘make demands on myself’ in accepting non-psychological approaches (Rodger,

1957: 6). Although Rodger's 'training and [my] personality ... have led to a lifelong preference for psychological explanations of causation',⁴ this focus had been moderated by new advances in schizophrenia, genetics and pharmaceuticals (p. 6). Speaking in the early-1950s, he elaborated upon how this 'eclectic approach' operated in practice: in the diagnosis and treatment of the patient, the psychiatrist would accord significance to the 'psychological and interpersonal aspects of the disease and its treatment but equally would be motivated to initiate treatment of a physical rather than psychological nature' (DC 081/4/1/1/25: 12). This 'eclectic philosophy' dictated that, even if a 'purely physical treatment' had been advised, consideration was duly given to the environment in which the treatment occurred, how the patient felt about it, as well as the 'interpersonal relationship' in which they were enmeshed (DC 081/4/1/1/25: 12–13).

Despite describing his psychiatric pathway as an 'escape ... into a total, holistic or so-called organismic approach' (Rodger, 1957: 4), unsettled contradictions surrounding the efficacy of physical versus psychological treatments persist in Rodger's psychiatry, as reconstructed from his archive. The researcher encounters confirmation of psychiatrists' 'confident assertions' and justifications for unsubstantiated physical therapies (Long, 2011: 238), alongside that persistent concern with the patient's social relations and environment attributed by Long to psychiatric social workers (p. 231). Although Rodger's eclecticism can be seen simply as echoing the mixing of physical and social/psychological methods which actually occurred in general hospitals (p. 233), at times his praise of revolutionary physical treatments sits incongruously with his repeated framing of these methods in relation to psychotherapy and object relations psychoanalysis as means of elucidating interpersonal issues.

In a lecture from the 1960s, Rodger assessed the introduction of tranquillizer drugs in entirely progressive terms. These drugs suppressed the 'actual symptoms of mental illness', shortened the duration of suffering and made the patient compliant to other techniques such as psychotherapy (DC 081/4/2/10: 7–8). Tranquillizers contributed to a more congenial hospital environment and promoted the recovery of the patient: 'instead of patients, because they are difficult to handle, being herded together, controlled or disciplined until their behaviour becomes so restricted and stereotyped they are more or less inert, they remain responsive, co-operative and capable of being interested' (p. 8). Similarly, he spoke of the benign nature of Chemical Shock Therapy and ECT, although he situated their therapeutic worth in relation to psychotherapy. He acknowledged their 'unfortunate' names and clarified that 'the treatment has nothing to do with shock and convulsion and[,] as it has come to be

modified by drugs and anaesthetics, is very straightforward, not unpleasant, and not at all [a] dangerous treatment' (p. 4). He added that this treatment was 'remarkably successful' as it alleviated depression in two to three weeks where in the past it would have taken five to nine months (p. 5).

Yet Rodger's enthusiastic rhetoric in relation to physical treatments was undermined by his lack of faith in them as a standalone cure. This wariness of a sole reliance upon physical methods emerged when discussing the difficulties of giving equal weight to contrasting approaches in educating medical students. The teaching ethos of his department, as stated here, espoused an impartiality towards the two medical models; their objective was to produce 'a psychiatrist equally at home in psychotherapy and pharmacology, who can treat his patients in the most effective way' (Rodger, 1966: 4). This aim stemmed from concern about the compelling impression made upon students by the relief of symptoms which followed the prescription of medication, but with only the sparsest examination of the patient's past and present circumstances (p. 4). Rodger's emphasis on thorough history-taking contrasts with the earlier pronouncements of Egas Moniz, inventor of the lobotomy, who reasoned that the lingering impassivity in patients in early trials could not be definitively ascribed to his operation as 'the personality of the patient' had not been learned in advance (Moniz, 1937: 1379–80).

Psychoanalytic psychotherapy

Rodger's use of physical treatments was therefore accompanied by psychoanalytic psychotherapy, the latter being crucial to the psychiatrist's work (Rodger, 1966: 4). He did not undergo an orthodox training in psychoanalysis, which required a personal analysis (DC 081/4/1/1/69: 2). His departmental staff employed a 'relatively brief' psychotherapy blended with the techniques of psychoanalysis, representative of that offered by the NHS (p. 3). A lecture from 1951 is probably representative of Rodger's views on the utility of psychoanalysis within his department. Analytic theory facilitated psychiatrists' interpretation of the 'content of the neuroses and psychoses', transforming the 'inchoate and unstructured' into material which was 'ordered and significant' (DC 081/4/1/1/45: 13–14). Although psychoanalysis was not regarded as offering 'a total explanation' of mental illness or indeed indicating the correct therapy for the majority of cases, in variously modified forms it played a role in NHS psychiatry (p. 14). Analytic outgrowths such as 'group therapy', the 'therapeutic community' and the supportive use of psychotherapy with drugs and physical therapies enabled a quicker and 'more effective' treatment (p. 15).

To an extent, Rodger's moments of explicit advocacy of psychoanalysis mark points of divergence between his psychiatry and that of both Meyer, and to a lesser degree, Henderson. Rodger's archive offers some sense of how he had come to regard these pivotal figures at the pinnacle of his career. He situated Henderson and his colleague R.D. Gillespie at the helm of initiating the 'modern approach' in psychiatry in Britain, extolling their co-authored *A Text-book of Psychiatry* (1927) as exerting a 'lasting influence on British psychiatry' (DC 081/4/5/9: 2). This work's 'successful marriage' of Kraepelinian classification with psychobiology had, in Rodger's eyes, rescued Kraepelin's system from 'sterility' through being brought into contact with Meyer's 'critical contribution' (p. 2). Similarly, this updating of Kraepelin had sustained Meyer's ideas, which provided a 'fertile approach' to the patient's difficulties but lacked the 'phenomenological precision' upon which a system of psychiatric 'classification' could be built (pp. 2–3). Despite these plaudits, in this lecture of the 1950s/1960s, Rodger suggests a keenness to distinguish his own approach from his dynamic predecessors. He thought that their incorporation of the 'laboratory or organic approach' with the 'psychological' had been so 'thoroughly assimilated that it no longer provide[d] any inspiration and please[d] neither the organicists nor the psychoanalysts' (p. 3).

Other considerations imply that the distinction between Rodger's psychoanalytic orientation and his mentors' viewpoint was less stark. In the same lecture, he depicted the psychobiological approach as partially accommodating a progression into psychoanalysis. Although he argued that the 'psychological' aspect of Meyer's framework was defeated by the informative power of psychoanalysis, he believed that 'paradoxically' the prominent position of psychoanalysis in America could be imputed to Meyer (DC 081/4/5/9: 4). Rodger clearly set Meyer in close proximity to the uptake of psychoanalysis; he had been involved in the establishment of the American Psychoanalytic Association and had been instrumental in Freud's trip to America at the beginning of the twentieth century (p. 4). Notwithstanding Meyer's 'expressed criticism of psychoanalysis', 'many' of his students made an uncomplicated trajectory from Meyer's 'Phipps clinic to the psychoanalytic couch for training' (p. 4). On Rodger's account, this was the reason for the success of 'dynamic psychiatry' in the 1940s in some places rather than in others; this approach had 'flourished on a Meyerian substrate' in Britain and America, whereas in places where psychiatry aimed to link a 'phenomenological' viewpoint with 'neurological data', then psychoanalysis and psychiatry remained antithetical (pp. 4–5).

Additional to Meyer's paving the way for psychiatry's adoption of the psychoanalytic method, Rodger's appreciation of psychoanalysis can also be set on a continuum with Henderson's expressed 'modified eclectic approach' (Henderson, 1964: 254). Henderson admitted how with time he grew convinced that disorders of a psychological origin were cured most effectively by psychotherapy and that, although he used the above 'modified' eclecticism anticipative of Rodger's approach, he also referred individuals for 'more prolonged' psychoanalysis if necessary (p. 254). Henderson was not uncritical of psychoanalytic techniques: he labelled them costly of time and money, and a 'dangerous weapon' when used by 'lay therapists' who could worsen the patient's distress through 'erroneous theories' (p. 255). Yet, Rodger's adoption of psychoanalysis can be interpreted as following on from and fulfilling Henderson's projection of how psychoanalysis would be integrated into the mainstream of psychiatry. Henderson predicted that in the near future 'the principles governing psycho-analysis will be absorbed, as psychobiology has been, into the main body of psychiatric knowledge' (p. 254). For him, psychoanalysis had also propelled preventative psychiatry into encompassing 'child guidance clinics' and 'out-patient and in-patient' general hospital services (p. 255), initiatives with which Rodger was closely allied.

Sutherland (1989: 35) implies that Rodger's adoption of psychoanalysis within his department was notable rather than being common to psychiatry departments in Scotland at that time, proposing that Rodger contributed to its preservation in inhospitable conditions. Miller (2015: 304) writes that the standing of 'psychoanalytic-psychotherapy' declined after the war and that the NHS was 'culturally and economically unsympathetic to analytic psychotherapy', although it supplied this treatment to an extent (p. 305). Rodger drew an unfavourable comparison between the successful integration of psychoanalysis into American university departments and mental hospitals, which he had observed on a recent transatlantic trip, and the situation in Britain where psychoanalytic training was only available in London (DC 081/4/1/1/69: 2). He argued that American institutions were 'headed by psychoanalysts who take a very broad approach to the subject of psychiatry', encompassing neurophysiological and biochemical studies, and that this catholicity was 'the kind of healthy state of affairs' towards which his British colleagues should strive (p. 2). For Rodger, the existence of a sole Institute of Psychoanalysis was a 'real handicap' which deterred British psychiatrists outside London from undertaking comprehensive psychoanalytic training (p. 2).

In his discussion of psychiatry and homosexuality in 1950s Scotland, Davidson (2009: 403) views Rodger as possessing a 'more psychodynamic approach' than his Edinburgh contemporaries, noting his contact with analysts such as Ronald Fairbairn and Winifred

Rushforth, as well as his alertness to the ideas of Carl Jung, Freda Fromm-Reichman and Melanie Klein (p. 415). Sutherland (1989: 35) writes that Angus McNiven, Superintendent of Gartnavel, and Rodger 'were free to express their interest in psychoanalytic thought – and indeed they enabled this to survive in Scottish psychiatry when it could well have been lost for the next few decades'. Rodger, along with W.M. Millar, head of psychiatry in Aberdeen, instituted 'a notably psychodynamic climate' among their colleagues at the beginning of the 1950s (Sutherland, 1989: 142). Rodger hired Thomas Freeman, a psychoanalyst who had qualified in London while employed at the Tavistock clinic, and Rodger's department, along with MacNiven's hospital, was 'closely linked' with the Lansdowne Clinic, a facility for 'out-patient psychotherapy' which engaged two psychoanalysts (p. 142). Rodger clearly saw a place for orthodox psychoanalysts in the hospital, since he expressed his appreciation of 'the value of a trained psychotherapist' who could instruct trainee psychiatrists (DC 081/4/1/1/69: 2).

Apparently contradicting this stance, in the 1960s, Rodger anticipated that 'only a biological explanation' of depression would enable the 'psychological', 'biochemical and neurophysiological facts ... to be fitted together' to explain both its causes and the efficacy of physical treatments (DC 081/4/1/1/53: 2). An investigation by psychiatrists Freeman and John Cameron in the 1950s nonetheless shows the models of understanding actually operative in Rodger's department. Significantly, this experiment relied on the terminology of object relations psychoanalysis to elucidate the interpersonal difficulties which persisted after ECT. An article by Cameron, Freeman and Stewart (1954) in the *British Journal of Psychiatry* appears to report this experiment, stating that 'two groups of female patients suffering from involuntional depressions' were investigated (p. 478). While the first group received 'routine clinical examination', the second group 'were studied intensively during their treatment by group psychotherapy conducted by two of the authors' and were the source of the experiment's principal insights (p. 478). Discussing this research, Rodger referred to a 1940 article by Grinker and Maclean conjecturing that convulsions alleviated depression through breaking up the 'depressive equilibrium', and by releasing 'aggressive drives' which had been constrained by 'the inhibiting super-ego functions' (DC 081/4/1/2/13: 5). In cases where ECT worked, it was accompanied by 'a freer expression of aggression in dreams, fantasy and in verbal or motor activity' (p. 5). This 1940 article was also referenced by Cameron et al. (1954: 489) in discussing their experiment, and Rodger commented that 'the themes which emerged in the course of group therapy confirmed the views of Grinker and Maclean' (DC081/4/1/2/13: 5). The important insight of Cameron and Freeman, however, was the

necessity of having a ‘good object’ such as a family member within the patient’s own home environment (pp. 5–6). A full recovery was not ensured by ECT but was dependent upon ‘the restructuring of the super-ego by the incorporation’ of this ‘object’, and therefore was shaped by the domestic environment and relationships to which the patient returned (pp. 5–6).

Reporting the same findings in a different lecture, Rodger stated that with isolated individuals it was important to initiate a ‘psychotherapeutic relationship of a positive kind’ which would continue even after ECT had begun (DC 081/4/1/1/29: 7).

Conclusion

The emphasis in Cameron et al.’s (1954) findings on the continuation of recovery through social relationships points back to Rodger’s own concerns with social and community psychiatry, often encountered in his archive. Rodger argued that the increase in individuals suffering from neurosis was unsolvable by purely medical means, but required the restoration of a ‘sense of community and mutual responsibility’ which had been lost in modern urban society (DC 081/4/1/1/29: 12). He proposed a sweeping extension of expertise in mental health care, arguing that, ‘[w]ith few exceptions everyone who receives the benefits of a higher education and everyone who is given a position of leadership in the community has it in his powers either to improve or impair the mental health of those for whom he is responsible’ (DC 081/4/4/12: 5–6). In line with Rodger’s incorporation of physical and psychological methods, this strong social emphasis was to a degree inherited from Meyer who first attended to the ‘domestic and occupational’ aspects of the patient’s worlds and thus advanced the idea of ‘psychiatric social services’ (Macfie Campbell, Meyer Archives Series II/353/124, quoted in Double, 2007: 335).

There is nonetheless a sense in which Rodger’s advocacy of community psychiatry originated from diminishing confidence in the capacity of psychiatry to resolve all mental unease. In the 1950s, he lamented, ‘I nowadays feel appalled by the magnitude of the psychiatrist’s task ... we are face to face with the apparently limitless demands of the community’ (Rodger, 1957: 7). Two decades before, Rodger and his colleagues had declared that the ‘solution of massive social problems’ was within their grasp, but he regretted ‘speak[ing] as confidently as we did then’ (p. 7). This sense of psychiatry’s futility in solving distress as rooted in the social structure of the patient’s life is affectingly evident in the ‘sad tale’ of a female patient dating from the late-1950s. As this patient’s anxiety and depression were ‘entirely related to her life situation and state of affairs at home’, Rodger related in a letter to another practitioner, ‘I cannot see where psychiatric treatment could help’ (DC

081/7/3/2/8/4). This woman's depression was not responsive to ECT, while tranquillizers could aggravate her situation further. Although his lectures frequently expressed his conviction about the worth of physical treatments and, indeed, psychotherapy, here Rodger wrote plainly and with disappointment of his failure to offer a viable therapeutic option: 'I was very sorry for her and I very much regretted that I could not suggest anything that could be done'.

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Notes

References

(a) *Archival sources* (MS = handwritten, TS = typescript)

(i) Papers relating to Thomas Ferguson Rodger held at University of Glasgow Archives:

Administrative/Biographical History [TFR biography] for Papers of Thomas Ferguson Rodger, 1907–1978, Professor of Psychological Medicine, University of Glasgow, Scotland (Archives and Special Collections, University of Glasgow, May 2012); accessed (16 July 2014) at: <http://archiveshub.ac.uk/search/summary.html?recid=gb248-dc081&rsid=59bb034&hit=2&startRecord=1&maximumRecords=20#rightcol>

Halliday JL (31 Oct. 1951) Letter to Rodger discussing the benefits of psychotherapy and enclosing his typescript paper titled 'Ophthalmology and Psychosomatic Medicine' [TS] DC 081/1/1/4.

All the following are attributed to Thomas Ferguson Rodger:

- DC 081/3/1/2/1: (c.1930s) Draft paper titled 'The classification of paranoid states' [TS].
- DC 081/4/1/1/25: (early 1950s) Lecture notes titled 'Psycho-biological psychiatry' [TS].
- DC 081/4/1/1/29: (c.1956) Lecture notes titled 'Changing concepts in psychiatry' [TS].
- DC 081/4/1/1/32: (c.1960s) Lecture notes titled 'The history of psychiatry' [TS].
- DC 081/4/1/1/45: (c.1951) The doctor-patient relationship [MS].
- DC 081/4/1/1/53: (c.1960s) Notes on depression [TS].
- DC 081/4/1/1/69: (c.1950s-1960s) Lecture notes titled 'Psychotherapy' [TS].
- DC 081/4/1/2/13: (c.1950s-1960s) Notes for a lecture to staff and students of St Mary's Hospital, Paddington titled 'Prognosis in involuntal depressive states' [MS].
- DC 081/4/2/10: (c.1960) Notes for a talk given to Bearsden Church Group titled 'Modern developments in psychiatry' [TS].
- DC 081/4/4/12: (c.1960s-1970s) Notes for a paper for an unidentified meeting or conference titled 'The future of psychiatry' [TS].
- DC 081/4/5/9: (c.1950s-1960s) Notes for a draft lecture or address titled 'Eclectic psychiatry' [MS and TS].
- DC 081/7/3/2/8/4: (late 1950s) Letter from Rodger to another Professor, filed in patient case notes [TS].

(ii) Records of the Southern General Hospital, held at NHS Greater Glasgow and Clyde Archives at the Mitchell Library, Glasgow:

HB 17/11/2xlvii: (c.1960s) Case Conference [TS].

HB 17/11/2xlviii: (c.1960s) Case Conference [TS].

(b) Publications and thesis

A.M.S. (1978a) Obituary: Professor T. Ferguson Rodger. *The College Courant* 61: 39.

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[Notes]

¹ The documents from Rodger's archive are cited here by reference number rather than date. Grammar, spelling, etc., of the original quotes will be preserved unless indicated otherwise.

² In recognition of the sensitivity of patient case notes and their relatively recent nature, I have refrained from providing precise dates.

³ This interpretation of Rodger's eclecticism as a response to the 'uncertainty' of psychiatric treatments is informed by Double's articulation of Adolf Meyer's psychobiology as cognisant of the 'the inherent uncertainty of medicine and psychiatry' (Double, 2007: 331) and the 'uncertainties of clinical practice' (Double, 2002: 903). Rodger's alertness to the precariousness of psychiatry can thus be seen as inherited from his mentor Meyer, along with his apparently contradictory stance towards physical therapies. The latter was perhaps more marked in Meyer's 'characteristic compromising attitude' which tolerated harmful physical interventions (Double, 2007: 333).

⁴ Rodger's psychoanalytic orientation is evident in his World War II publications reporting on wartime conditions such as night-blindness and effort syndrome; in one paper, he and his co-authors speculate that 'deep analytical investigation' would reveal the aetiology of the latter disorder (Wittkower, Rodger and Wilson, 1941: 534).