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2 George W. Brown's contribution to psychiatry

The effort after meaning

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What would psychiatry have been like if it hadn't been for George Brown? Some things would have been just the same. The biological juggernaut would still have rolled, we would know just as much about neuro-transmission, neuro-imaging, neuro-pharmacology and genetics; and there would have been the same meticulous attention paid to nosology.

But what would we have known about the importance of social factors in schizophrenia and depression? In both these, George has left the field looking very different – and he has inspired a whole generation of other investigators to repeat his studies, and demonstrate the way that theory devised in England works in other, very different environments. Studies of life events, emotional expression, childhood experience of abuse and exact measures of social disadvantage have all been pioneered by George, but have also been taken forward by psychiatrists and other social investigators.

Early on in his career with the MRC Social Psychiatry Unit, George did an apparently simple piece of research on patients with schizophrenia. He examined the visitor's book (which, by law, had to be carefully recorded) in two mental hospitals over two periods in 1950/1 and 1955/6. In the first period, when 37 per cent of all patients stayed for more than two years after admission, those who had received no visitors during the first two months of their stay were much more likely to stay longer than two years – 83 per cent compared to 25 per cent. In the second period, both hospitals had a more active discharge policy with only a smaller proportion detained for more than two years. In one, where 21 per cent were still longstay, the difference between those visited and not visited remained, but not significantly so (27 per cent versus 18 per cent). In the other, with a more active policy (7 per cent longstay), the difference remained significant – 16 per cent versus 4 per cent.

George discussed the possible interpretation of his findings, with appropriate modesty, but the point to emphasise for a psychiatrist was that here was a social variable, capable of predicting outcome as strongly as many 'symptomatic' or other familiar psychiatric variables, which had been overlooked – and George's study has been forgotten, although it may still be relevant to the revolving doors and overloaded acute units of present day community psychiatry.

Social factors were not something to be taken seriously by most psychiatrists. They were treated more as a convenient 'lump' of variables which was left over to explain things which could not be explained by 'real' psychiatric variables – diagnosis, symptomatology, family history, age and type of onset. But the studies that John Wing and George published together in *Institutionalism and Schizophrenia* (1960) demonstrated convincingly that the symptomatology of chronic schizophrenia was profoundly influenced by the patient's social environment, and that the 'natural history' of the disease reflects the 'natural history' of the institution. The measures that were proposed in that book for the social correlates of institutionalised patients were clearly George's work, and represented a radically different tradition from the descriptions reported by other observers such as Goffman or Russell Barton.

Received opinion has always had difficulty in accepting George's views. The original paper on precipitating events and schizophrenia (1968) was rejected by the *British Journal of Psychiatry* on the grounds that it was too far-fetched to think that schizophrenia could be caused by psycho-social events. George has courageously pursued the hypothesis that social events and situations can, if they follow certain sequences, cause a psychiatric illness and can also be implicated in recovery. This hypothesis received only a little encouragement from studies of schizophrenia where the 'weight of causality', as measured by the 'brought forward time' (Brown, Harris and Peto, 1973) was small.

If social factors seem not to make a major contribution to the cause of schizophrenia (and the jury is still out on this question), George's early studies provided plenty of evidence that they affect the course of the illness very profoundly. From the ward atmosphere of the institutions, George moved to the family atmosphere in people's homes. This, and the degree of exposure of the patient to it, are now recognised as important variables which can be altered by appropriate interventions. George's studies have led to a large amount of research on this topic, out of which have developed family interventions which have been given the 'Cochrane accolade' of evidence-based efficiency.

George's work on the influence of expressed emotion – in particular critical comments by key family members – on the course of schizophrenia have led directly to a wave of further research studies on family life and schizophrenia – now culminating in the Thorn training programme for psychiatric community nurses. This new role of the community nurse will probably do more good for people suffering from schizophrenia and for their families than any other single change in community mental health services.

His first studies of depression, both in the community and the clinic, were more encouraging, suggesting the importance of severe loss events and a predisposition of vulnerability often brought about by losses early in life. It is the further investigations in this field, covering both depression and anxiety, and their different aetiologies, which George has pursued so imaginatively and persistently. Thirty years ago, depressive illnesses were divided into endogenous and reactive varieties: no social causes were sought for the former, the secret to the aetiology being sought in genetic loading in the family history – with an implication of multiple recessive

characteristics – or perhaps mutations, if this was negative. George's early research showed conclusively that each type of depression was equally likely to follow a loss event, and the conventional dichotomy was eventually discarded by clinicians.

The dichotomy that replaced 'reactive versus endogenous' was the milder 'neurotic versus psychotic' depression. George showed that the difference between these was mainly one of severity (Ni' Bhrolchain, Brown and Harris, 1979), a conclusion that was replicated in a later study using different techniques (Goldberg, Bridges, Duncan-Jones and Grayson, 1987). Other studies related different prevalence rates for anxiety and depression to different social circumstances in the populations studied (Prudo, Harris and Brown 1984).

However, George's most enduring work in the field of affective disorders is likely to be the light he and his co-workers have thrown on the determinants of vulnerability to depressive illness. His team has shown that while both childhood and adult adversity led to depression, only childhood adversity led to anxiety in adult life: the social antecedents of the two affects had to be considered separately (Brown and Harris, 1993; Brown, Harris and Eales, 1996). More recent work has dealt with the importance of humiliation and entrapment as life situations predisposing women to depressive illness (Brown, Harris and Hepworth, 1995).

George's method has been careful empirical demonstration, linked to a philosophy that similar events can have different meanings for different individuals, so that 'checklist' approaches to life events are exposed as shallow and incapable of accurate prediction. Some of his research has led to direct and obvious benefit to the mental health services and their patients. But this work is but the tip of an iceberg of substantive research whose approach has been neglected by psychiatrists although George's methods – careful interviews and analysis of the resultant findings – are, or should be, the methods which all psychiatrists use.

The most obvious explanation for this is related to Karl Popper's experiment with his student classes. He told them 'to observe' – much to their bewilderment. All observation requires a hypothesis about what one is observing. The average psychiatrist does observe the interaction and interplay of events on his or her patients, but does not collect data in a systematic way. Systematic data collection itself presupposes hypotheses on how it should be used. George follows, and has further developed, the Social Psychiatry Unit's fine tradition of developing both theory and methodology together. He has paid particular attention to the time sequence of events and has categorised them in an empirical manner so that trained interviewers can record them in a reliable way as judged by inter-rater agreements. This is the approach which psychiatrists use for recording the clinical state of the patient, but not so assiduously for the social state and history – although it has been thought about, using Adolf Meyer's life chart, for instance.

Inter-rater reliability, by itself, is of little use unless what is assessed has some validity, and it is on this point that George has been so original. Psychiatrists have regularly asked their patients about upsetting events, but have generally left them to define what these were. George prepared a pre-selected list of possible events – not in itself an original idea. He pays tribute to Holmes' and Rahe's pioneering studies but does not support the use of the arbitrary scores which they gave to

events. He pointed out that an event can have enormously different 'meanings' – a pregnancy, for instance, or a child leaving home. It is the meanings which matter and these can only be assessed in context by obtaining as much relevant information as possible about the subject, both past and present, in order to be able to assess the events' significance. But this assessment was judged by others (George's team) and not by the person's own interpretation or reaction, nor by the psychiatrist's knowledge of an ensuing illness. By his insistence that meaning must be re-introduced to the interpretation of psychopathology, George has both humanised social psychiatry and rendered it capable of scientific respectability. It is perhaps his most enduring legacy to psychiatry.

The development of this approach, with theory and methodology going hand in hand, has led to a series of important publications and to an accumulation of carefully collected and rated observations which allow for many further testings of theory. Just as the earlier studies led to important developments of assessment and treatments in psychiatry, so George's more recent work, over the past twenty years, will influence psychiatry in the future, both in theory and in practice. He came to a field where social factors were largely ignored or glossed over and he has left it at a stage where no serious commentator can doubt the importance of social factors, each one of which has been carefully documented.

It is paradoxical to accuse someone as original and creative of being too conventional, but if there is a shortcoming it is his acceptance of conventional nosology and his preference for dichotomising social variables which are clearly continuous. Where nosology is concerned he relaxes somewhat, it is true, and allows his subjects to be non-cases, mildly depressed or 'case depression', or non-case, mildly anxious and 'case anxiety' or any combination of these two affects. Indeed, it was this approach which allowed him to view subclinical depression and anxiety as vulnerability factors for later 'caseness' of depression.

George ignores genetic factors in his theorising about depression and does not approve of vulnerability factors like neuroticism, even though the evidence for the importance of this variable is fairly persuasive. He has also said little about personality styles as a determinant of vulnerability. He avoids structural equation modelling and multi-wave sweeps of the same population over many years. His work has been mainly confined to working-class women and he therefore has little to say about middle-class women and men, which is a pity since it is becoming clear that alcohol problems share common roots with anxiety and depression, and are often a predominately male way of dealing with difficulties.

However, his choosing to focus on working class women is due to the higher prevalence of depression in this group and, since his methods are highly labour-intensive, he has really had little choice in this matter. His refusal to consider dimensional models of symptoms ensured that psychiatrists and other clinicians were comfortable with his approach, and this made it more likely that his research would be funded. As it was, he faced enormous critical onslaught from psychiatrists during the early years after he left the Maudsley: at least he could point out that he was using the same clinical concepts that they were, and so his research could not be lightly discounted.

At present, the theories of biological psychiatry have an immense influence on psychiatrists, but there are serious gaps in the 'biology' which is used, with its overwhelming emphasis on physical reductionism, to the exclusion of ecology and psychological behaviour, whether individual or social. George's approach, with its painstaking attention to detail, coupled with the accumulation of data and imaginative insights into how it might be analysed, is much closer to the methods used by Charles Darwin than are the complex statistical programmes of genetic analysis and hereditability. These analyses recognise environmental factors as important, but rather as the residual factors unaccountable by genetics. But an interaction between the two is now recognised and accepted by all current researchers. George has made environmental factors his special study and especially the home environment (past and present) of his subjects. Biological psychiatry will only come of age as the rightful descendant of Darwin when the environment is given as detailed an analysis as the chromosomes.

Working with George is like studying with an inspiring, demanding, good-humoured and infuriating trainer. He makes the same high demands on his colleagues as he does on himself. Perhaps his most infuriating characteristic is his creativity. Just when a careful edifice of argument and logical conclusions has been constructed, he knocks it down and wants to try a different, perhaps more interesting, approach.

A good deal of research can be rather boring, pursuing ideas which are not particularly new, along lines which are fairly familiar – the 'paradigms' of Thomas Kuhn. George overflows with ideas. He does not horde them. Indeed he tests them, and his colleagues, to destruction and the experience is never boring.

This same generosity permeates his many interests beyond the social sciences, including literature, music, painting, poetry and, in particular, sculpture. For George himself is a sculptor and his search for truth is, in our view, rather like that of a sculptor, searching for the essence hidden in the wood or stone, and working with its grain.

All the best works of art remain as fresh and stimulating as when they were finished. George's papers have the same quality. They do not 'age'. His studies on *Expressed Emotion and Schizophrenia* (1972) continue to inspire important research and practice today. His brilliant essay on 'The Mental Hospital as an Institution' (1973) was 're-visited' twenty years later by Professor Peter Huxley who found it highly relevant to many aspects of current community care. It is equally relevant, not only to those many parts of the world where traditional institutions still dominate the psychiatric scene, but to any service where institutional habits and attitudes are still powerful obstacles to change: that is just about everywhere.

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