John Bowlby (1907 – 1990)

Interviewed by Leonardo Tondo in London, England, on January 11, 1990

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For the interview,Bowlby spent almost an entire afternoon with me in his sparsely furnished office at the Child and Family Department of the Tavistock Centre in London, on a cold and wet day shortly before his death in 1990. The place had an old wooden desk, two chairs, many books, and a window facing a courtyard. The interview ended in the early evening as the intense red light of sunsetfilled the room. In returning to my hotel by tube, I thought that some great men show a certain degree of modesty, available, and peaceful because they feel secure of themselves and do not need to make much fuss to show they are around. This is believed to be the last interview given by Dr. Bowlby. In it, in addition to the paramount role of early separations and losses in future personality development, he stresses the importance of research as the basis of advancing knowledge, and the value of prospective rather than retrospective information for all psychological approaches in child psychiatry; the extreme importance of assessing present and past behaviour; the similarities (evaluation of psychologic development) and differences (observation versus speculation) between his attachment theory, psychoanalysis and cognitive therapy; and his 'share of criticism' from former psychoanalytic colleagues. In addition, he provides essential information about the development of maladjusted children, their recognition, clinical assessment, and treatment; how to manage children in hospital and how to help them to deal with separations from their parents and with adoption. From the entire interview my two favourite statements were those referring to a psychotherapist as a patients' companion who may help young patients to go down a dark passage and get a ball, and that cognitive therapists should learn the importance of emotions, and psychoanalysts that of thoughts as well as of actual life-events.

The Interview:

LT: May I ask you when and how you began to study about attachment and loss?

JB: Well, it all started in the 1930s, between the years 1936 and 1940. I was working as a child psychiatrist in London and I was also completing my training in psychoanalysis. Now, one of the concepts to which I was alerted very early was the importance of early parent-child relationships and the extent to which adverse experiences within the family could have an adverse effect on the child's physical and mental health. At that time my psychoanalytical colleagues were very disinclined to take account of adverse life events as important for child-development. You see, Freud in his early work, about 1895, attributed hysterical problems to sex abuse in childhood and only later he decided that these events had not really taken place but instead they were imaginary. He believed that the patient was describing imaginary events in childhood. That was the time when the word fantasy started to be used in psychoanalysis. And in the 1930s in London there was a strong attitude that one should never believe a patient's stories about sexual abuse or any other adverse experience from parents, and that the patient's account had not to be trusted not to be valid. Instead, I thought that adverse events were of great importance and I set out as a young psychoanalyst and a young child psychiatrist to demonstrate that real life events in early childhood played a major part in determining mental health. So that is how my plan, which I stuck to ever since, began. At that time, it would have been very difficult to do any systematic research on ill-treatment of children by their parents. First of all, the climate of opinion was very much against the idea and secondly, without tape and video recorders we had no means of validly recording adverse attitudes, statements, or adverse behaviour on the part of parents towards children, so that the idea was un-researchable. This circumstance led me to concentrate on separation and loss because separations and losses could be validly recorded–they had either occurred or they had not. And the reason I focused on separation and loss was partly because it was researchable. In addition, I had observed in a child guidance clinic, a number of cases where the personality of the child who had become delinquent and unmanageable, seemed to me that it had certainly to have had earlier been preceded by very highly disrupted relationships between child and mother. So as an antecedent event it could be shown to be that such early events were present statistically significantly. With the orientation that I brought to the study I thought that it was likely to be an important connection. There was a lot of internal clinical evidence to suggest that early adverse experiences had led to outcomes

that included children who seemed to have no emotional relationships, did not seem to care, who did not seem to be influenced by praise or by punishment, and went their own way. They truanted from school, ran away, pilfered, and so on. Although they seemed quite content, they were emotionally cut off. Well, that is where everything started. You see I was not dealing with depression I was starting from a condition which I believe is in fact the early phases of a psychopathic personality.

LT: Did the shift of your research from psychoanalysis to the attachment theory change your attitude towards psychoanalysis?

JB: Well, not really. You see, there are two reasons why I think psychoanalysis has been an important development. The first is this: that there is no other professional group which in the past, and certainly not from the 1930s through the 1950s, paid any attention to intimate personal and emotional family relationships, jealousy, anger, guilt, shame, love, grief, and so on. Psychoanalysis saw such early emotional relationships as a problem to be studied in its own right and no other group did. Psychiatrists and psychologists did not, and no one else did. The only professional group, which might be said to have dealt with this area, were, of course, religious professionals. Priests and ministers of religion always dealt with these problems, though not scientifically. Freud and early psychoanalysts made an attempt to study these problems. That is the first reason and, of course, another aspect, which appealed to me, was that it was involving a form of developmental psychiatry and psychology. It saw the current problems of a person in terms of his history, despite a much greater emphasis put on fantasy by most other analysts in contrast to the few who thought that real life events were of great importance. Different people gave life events different degrees of weight. I gave them a very considerable weight. I could not have found any other group of people as much in common as I had with the psychoanalytic society at that time. I remained an active member of the society and, in fact, I became training secretary and vice president. I played quite a major part in the British psychoanalytical society between 1944 and 1962.

LT: Did you have the chance to meet Freud?

JB: No, he came to this country in 1938. He was very old and unwell and he only saw a few old friends. I was a very young junior psychoanalyst at the time.

LT: Did your first study of separation and loss go through further developments from its initial steps?

JB: Yes, well the initial step was to connect a group of cases in which I thought this type of problem was present. In fact, what I did at the London Child Guidance Clinic where I was working, I collected two groups of patients: 44 children who had been referred to the clinic because of stealing and 44 who had been referred for reasons other than stealing, and I could compare these two groups. The ones who had been referred for stealing showed a statistically significantly greater incidence of disrupted early relationships than the other participants. This study was published in 1944 (Bowlby 1944). So, that was a retrospective study, and I started the next phase after the war when I served as an army psychiatrist from 1940 to 1945.

LT: Where? Here in England?

JB: I was in England, yes, and I was in a research unit most of the time. We were concerned with selecting those suitable for commission to become officers. I was associated with this work from 1942 onwards. This was a very valuable experience for me because I was working with two or three clinical psychologists and got some kind of a research training in the army, which was very convenient. When I resumed child psychiatry after the war, in the beginning of 1946 I was offered a post at the Tavistock Clinic to take responsibility for a department of children and parents. And so, my first task, of course, was to reorganise the clinical services, and then the training, and then to start a research project. My plan from the beginning was to resume research in the field of the adverse-effects of early disruptions in family relationships.

LT: What kind of signs of early disruptive relationships were you collecting?

JB: Well, a child might have been in a hospital certainly for a long period–12 months or 2 years. I was interested at that time in disruptions which lasted not less than six months, occurring

before the fifth birthday and the disruption might be due to admission to a hospital or being in an institution. Alternatively, it might be due to a mother giving a child to a foster mother, with later return to the natural mother, or it might be an illegitimate child who was first here, then there, and then somewhere else. There were many social conditions, which lead to these disruptions, but the disruptions were the real criteria for my study.

LT: Was the development of your study considered linked in some way to psychoanalysis?

JB: Well, you see, this is an important issue. Psychoanalysis is a development of psychiatry, therefore patterns of development which occur in early childhood are relevant to psychoanalysis. So, I was studying atoms of development in the early years. Of course, Freud (1)never did that. His theory of development was entirely retrospectively conceived. In England there was always interest in child analysis, which was closer to the problem of development. Of course, I mean, during the 1930s, this interest was represented by Melanie Klein(2), who exerted a very substantial influence in London. Then, of course, Anna Freud (3)arrived in 1938 with her father and she was another influence of a rather different sort. Another person who became influential and reasonably well known was Donald Winnicot(4), who was a paediatrician who held views not too different from my own. He attributed importance to real life events. So, I was one of several analysts focused on the early development and on the effects of life events. Now I was the only one doing systematic research. The others were doing clinical work and making the usual, frankly unplanned and opportunistic observations. I was trying to put the work on a more scientific basis.

LT: How different was your research from that of Piaget(5)?

JB: Well, Jean Piaget, you see, was entirely concerned with the development of cognition and he was uninterested in emotional issues. Again, that was not his perception but mine. Nevertheless, in effect, we were both developmental psychologists.

LT: Did you and Piaget have a chance to share your results since you were both working on child development?

JB: We met a number of times between 1953 and 1956. For four separate years, these encounters occurred with a group convened in Geneva by the World Health Organization to consider the psychobiological development of the child.

LT: Who were the participants?

JB: They included the ethologist Konrad Lorenz(6), the anthropologist Margaret Mead(7), and Jean Piaget. There were about 20 of us altogether. Others whose names you probably know included Eric Erikson(8), who came once or twice, and Ludwig von Bertalanffy (9), the very influential system theorist. These were all leading people in their fields. I was one rung below these stars, and there were others. There was an effort to find common principles in these very diverse approaches. Of course, we did not succeed, but the discussions were very profitable. They also were published and have been quite influential.

LT: What was the purpose of the workshop?

JB: The purpose was to try to integrate looking at the problem of child development, to find what had each of these different disciplines had to offer that could lead to a unified science. That was the aim.

LT: To go back to your research, was there any difference between the beginning of your work and say 10 or 20 years later?

JB: No not really, I mean my concern has been to put psychoanalysis on a proper scientific basis. That has always been my aspiration. I felt it was studying all the right problems but had become very unscientific in its whole outlook, its methodology, and so on. It was my credo that psychoanalysis would make progress only by developing a much better scientific basis.

LT: Many psychoanalysts may argue about the necessity of psychoanalysis to be scientific because they deal with individuals, with findings that cannot be reproducible.

JB: I do not share that view. You see one has to contrast science. Biological science certainly is always dealing with general issues affecting a population. I mean human physiology is not concerned with a particular person's physiology. Human physiology is about the working of human bodies, and in order to get valid results you need a population, a sample, a measure of heart rate and so on, and you use averages. Science is concerned not with individual cases but with generalities. Medicine is an applied science. Of course, in an applied science we are concerned with particular operations of physiological and pathological processes in an individual, and that is the application of science. Well, psychoanalysis is the same. When you are treating a patient you aren't being a scientist, you are applying as much understanding as you think you can for the benefit of the patient and although, as with any other condition, you may pick up many valuable clues to what may be important, but you cannot draw valid conclusions except by testing them on a broader basis by other methods. So, I have never accepted the rule that psychoanalysis was any different from any other branch of medicine with regard to its relationship to science. Clinical practice, the art of medicine, is an applied skill. It requires taking all the circumstances of a patient into account–a particular patient, his particular circumstances whereas science is concerned with generalities, which apply across the board. In so far as I have been studying in terms of research, one is concerned with a sample of patients undergoing adverse situations and how do they affect children. In clinical work one is concerned with a varying and synthetic individual approach.

LT: The same people who are supporting the unscientific theory of psychoanalysis say that the brain, dealing with emotions and cognitive development is very different from the other organs of the body.

JB: Well it is a matter of opinion. I do not think I would agree.

LT: How did your method transfer from research to treatment?

JB: I think it is now substantially agreed that these disruptions in relationships in the early years can have very adverse effects; therefore, they are to be avoided. If they can be avoided, they

should be avoided and many practical steps can be and have been, taken in that direction. Secondly, if for any reason the early disruptions are not prevented we can understand the consequences on the child much better and can proceed in a therapeutic role to help the child and perhaps help parents to deal with problems which have arisen from early separation. In the case of a parent who deserts a child or dies, we try to help those who are now caring for the child in his efforts to deal with the trauma resulting from the separation or death. These are widely accepted practices, certainly in this country, in America and so on is now widely practised in the field of child psychiatry.

LT: So, there is a first step which is prevention. If the trauma can be avoided it should, or must be avoided?

JB: Yes.

LT: If a psychological trauma is not avoidable or preventable, like the death of one or both parents, would you always suggest a psychotherapeutic treatment?

JB: Not necessarily. I mean, let's take a fairly simple case of a child has some sufficiently severe illness and has to be in hospital for two or three weeks. What I am talking about applies particularly to younger children, although it certainly applies later on. Well, now at first, the child has to be in hospital; you can't stop that, but can his mother be with him in hospital? If she can, then many problems can be avoided. This is the first step: there is no separation if she can be in hospital preventing the separation. Now, supposing, for example, she has a number of other children and cannot be in the hospital with this child. We can help the mother in several ways. Let us talk about a child of three who has had a fever. We can help the mother in various ways. First of all, we can warn her that when she goes to collect her child to bring him home, he may be in an emotionally detached condition in which he fails to recognize her or is otherwise distant, and this feeling is very distressing to a mother. We can warn her that this is the kind of thing that might well happen, so that she need not be too surprised. Then the child may change and become intensely clinging and very apprehensive lest he suffers another separation. This "clinginess" is again to be expected. The thing to do is to respond to it affectionately and

reassuringly and not to brush the child off or avoid him. If over time, the mother treats him in a more tolerant way he will gradually get over it. That is very important because if mother becomes disciplinarian and punishes the child when he behaves in this way, then the problem gets worse. This is a preventive measure, if you like, an immediate measure which can help in a very big way. I am principally concerned about what happens to a child when he is out of his own home and without his parents can be much more traumatic than if the same things happen with his parents present. So his parents' presence is the important variable. It is only when things have gone wrong that psychotherapy is required, even though it is, of course, a very scarce product and difficult to arrange.

LT: You mean that it cannot easily be provided to everybody?

JB: Exactly. So, it has to be rationed very strictly. If, for instance, a child has had a series of disruptions and has become very emotionally remote and detached, then psychotherapy is certainly desirable to help him trust people again.

LT: In a patient who had a disruptive relationship is now an adolescent, what kind of psychotherapy would you recommend? A psychoanalytical treatment or your only kind of psychotherapy?

JB: Well, I regard family therapy as being the first choice when possible. I may say I developed family therapy in the 1970s, so I have always been very keen on family therapy for many reasons. Unfortunately, it is not always possible; some parents may be dead or the family may be disrupted. There are many reasons why family therapy may not be practicable. So, if it is not practicable, one has to propose something different. Here I believe that individual psychotherapy using analytical insight is the choice. I think that what I am trying to do with such patients, is to help them explore their present experiences. Explore, consider, dwell and reflect on the current experiences and consider how they might be related to experiences in his past. Sometimes he can remember these experiences; sometimes he cannot. If he can remember, then one must be concerned to help him study them, consider all details and how he felt at the time they occurred so that he sees why he is now so frightened of white coats and so on because

when he was in hospital years ago the doctors had white coats and he was terrified of what they were going to do. So his phobia of white coats, and I give a simple example of course, is intelligible. It is not silly, irrelevant, or illogical, but instead is connected with an actual experience of his. He is then in a position to consider that maybe his fear of people in white coats may have been appropriate once upon a time but maybe now he understands the situation a bit better and may not need to feel that white coats are quite so threatening. In other words, he brings a cognitive process to bear on this association between white coats and the past and between white coats and the present and realizes that he is not trapped and is not a prisoner. In a nutshell, that is what I am trying to do. I am trying to help the patient discover why his past is so influential and, so far as he can, to disentangle himself from the past and look at things afresh. Of course, it is a slow process. If he cannot remember, he has a sort of amnesia, then one's task is to help him recover what is past. In helping him recover the past, he can come to trust the therapist become braver. If a ball has gone down a dark passage, a child maybe frightened to go there and get the ball, but if I say: "Look, I will come with you," he may be quite happy. In psychotherapy we act as a companion to a patient who is too frightened to look at what has happened to him in the past. So, we accompany him in the exploration so far as we can and it maybe useful in terms of psychoanalysis to say, “Well, you know it might be that such and such happened to you, or maybe this is what happened”; that is, one can throw out suggestions which may or may not trigger some sort of memory. Of course, in terms of research or science this would be totally inadmissible, but we are not being scientists we are trying to help someone.

LT: Are adopted children often affected by behavioural disturbances?

JB: It depends at what age they are adopted. So far as we know, the young child does not build up an attachment relationship until the second six months. Attachment is at a very prototypical level earlier on, and all the evidence says that should a child move from this mother figure to that mother figure before six months of age he does not show much reaction. Only between six and 12 months he shows increasing reaction; from 12 months on, the reaction is much more intense. Here again, of course, we can help the adoptive mother manage the distress by warning her as to what might be happening and advising her as how best to handle it. So, in many cases the transition is fairly straightforward and fairly successful. However, the older the child is at

adoption, the more difficult is his reaction, especially if he has had some disturbing experiences prior to adoption. So it all depends when, where, and how.

LT: Is there any special syndrome in individuals who have been adopted after the first year of life? A syndrome that may appear during adolescence?

JB: Well, I think it is a question of trust, the extent to which, let's say, an adolescent who was adopted at the age of five, after having had several unsatisfactory relationships prior to that. Well now, if he has had unsatisfactory relationships in which things have gone wrong and he has been rejected, he fully expects his new adoptive parents to reject him. The adoptive mother has to go through a period when he does not trust her, but as time goes on he trusts her increasingly. Much depends on how insightful the adoptive mother is, and the father, too, of course. Both should be aware that a child who has been adopted like that will not entirely trust them in the way that their own child would. He might interpret their going away for three weeks as a rejection. This is something that they should be aware of. Some adoptive parents are extraordinarily understanding and perceptive, and realize all of this, at least that is what I have been told. Others, of course, can be helped to understand that these things can occur. And, no doubt, some can't be helped because they don't want to be. So, the strength of the bond, the degree of trust in the bond, between parent and child is always more fragile in these cases. Consequently, as I said, a child can take fright that he is been rejected or deserted when, in fact, that is not what is going on. Of course, the problem is that the lack of trust brings lack of trust. Consequently, this lack of trust may cause drifting off into delinquency, drug taking, or just one of those things which are undesirable outcomes. That is true of every child, not just of adopted children.

LT: Can behavioural problems after a disrupted parental relationship in childhood actually last through to adulthood?

JB: Oh, yes.

LT: Besides psychopathic behaviour, what other disturbances might appear in adulthood following disturbed early relationships in the family?

JB: Psychopathic behaviour is the commonest and it may lead to the use of drugs and stealing. Another possibility are relationships with the opposite sex that are broken off, and so on. So disturbed relationships, we say, are the kinds of problems which you expect.

LT: Do you think that the behavioural problems shown by adolescents nowadays may derive from their early relationships with their parents not having been as close as when the family was a more important unit?

JB: Yes. I think so, but first we have to demonstrate that there is a higher incidence of such associations, even though I am not dealing in the epidemiological world. I think we can be quite confident in any single case or group of cases that problems of drug taking or psychopathic and disturbed behaviour, is a function of family malfunctioning, which usually starts early and continues. A family which is fairly stable and providing good parental care over the early years, commonly tends to continue, although it may not. It may be that a parent dies or deserts the family. Many hazards can occur. I mean, there is abundant evidence that these hazards, in the form of disturbed relationships are the cause of this type of problem. I think, statistically, this conclusion is quite evident.

LT: Another issue is whether a couple with children decide to separate or stay together. What is the best for the children: continued fighting or staying together for the kids?

JB: I think it's very difficult to generalise. You might say my bias would always be to help parents try to continue living together. If they cannot or will not, I would certainly always favour that on the grounds that theirs maybe a temporary difficulty which can be overcome. After all, when a marriage breaks up, the couple may not work well in other marriages. If a marriage breaks up, there is going to be a lot of suffering. The spouse who does not want to split up is going to suffer and the children are certainly going to suffer. No doubt, suffering occurs, so

if you want to diminish suffering you do what you can to discourage the break up and assist the couple to see the problem. That's what all marital help is about.

LT: And for children, do you think it is worse living with parents who do not agree but still stay together?

JB: That's almost an impossible question. To what extent do they disagree? It is the kind of thing you cannot generalise about. You simply have to study the individual case and try and help the parents find the best solution.

LT: During childhood, what should be the role of the father and of the mother? Do you agree with the rather simplistic view that the mother may be more important than the father?

JB: That view, I think, is well attested by the information we have. Because after all in every society—and not just Western societies—studied by anthropologists, a child sees much more of his mother than he does of his father, especially in the early years. Whatever child you take, he sees most of all his mother in the first five years; he has much more social interaction with her than with his father. So, the mere quantity involved is a major step. Probably even in the second five years, most children still see more of their mother than their father, and in not only Western, but all societies. It is not until somewhere near puberty that there is a tendency for boys to be more father-oriented, in a sort of an apprenticeship, you might say, in male society, and for the girls to become increasingly mother-orientated, apprenticed into female society. This is the way all societies operate. So, my concern is always with human nature, about which I am most confident about Western culture. When I teach my students, I say, "Look, the first thing to remember is that Western society is not a human norm." We behave in a way that human societies have never behaved in the past. If you take human societies over the past hundred thousand years so far as we know and around the world, Western societies are peculiar. We do things in funny ways which maybe alright, and it may not. Do not think they are normal. They are not the normal way human beings are meant to behave.

LT: What do you refer to?

JB: Well, for instance, to take a very simple and crude example, I refer to putting babies in perambulators or cots, children sleeping in another room from the parents is totally untypical of humans. I mean, if you talk to anyone growing up in Asia, they regard the idea that the child should be in a cot in another room as mad, absolutely crazy; they would never dream of it. And that's just one example. I mean, children being left outside the house for a couple of hours in a perambulator? Unthinkable. We take for granted things which have never been taken for granted.

LT: You first refer to the idea of the children sleeping in the same room with the parents. Freud was concerned about them looking at their parents' sexual life.

JB: Well, I think that's all complete nonsense. You see, throughout Asia and Africa, these things happen, and they happen in our own culture.

LT: True. It's easy to agree with you, but our society is based on a lot of taboos which are probably totally ignored in other societies.

JB: Well no. For instance, if a parent says, "My child of 15 months is constantly coming into my bed at night and this is a bad thing", I say, "Fiddlesticks! The simplest thing is to take him into your bedroom at night so you all can have a decent, quiet night." The parents can accept this advice.

LT: This sounds certainly more natural.

JB: It's simpler, I suppose. You either go along with human nature or you fight it. If you fight it you get problems. If you don't fight it life is much more comfortable.

LT: Taking the convention that children may sleep with their parents, are your thoughts generally agreed upon? For instance, in this country?

JB: Well you see, there are so many conventions in a country; there are so many subcultures. I'm sure there are some cultures in this country where children are expected to stay in the same room with their parents at night, and, of course, for many people with a small house there is no option. So many of these ideas of children date from the last century; they do not go back a long way. You know, there was a famous German paediatrician, whose name slips me for a second, who was completely mad and who, between 1850 and 1880, laid down some cast iron rules about how children should be treated, on the grounds that these were based on medical knowledge of children. Of course, there was no basis for those rules at all. These very strict rules included feeding children at 7 o'clock, the rule that masturbation was unsanitary, and many other things. These ideas were very prevalent at the turn of the century. However, what I'm saying will never influence other than the upper 30% of public opinion.

LT: May your research lead to a better understanding of depression in adolescents?

JB: The best thing I can do is to point to the work of George Brown, a sociologist and epidemiologist, and Tirril Harris who worked on the social origins of depression. You see, they wrote a book called "Social Origins of Depression" (Brown and Harris 1978) which is now a standard work, and they have been working on the same problems as mine for 20 years now. I have always looked at traumatic experiences in childhood and how they affect development. I have never done longitudinal studies because they are very expensive and need big teams, so I do not know how children I studied or those studied by my colleagues have turned out over the years. What Brown and Harris have been doing is the highly conventional thing of looking at adults who are either given to depression or not and getting some measure of antecedent events. Among other findings, they demonstrated that children who lost a mother in childhood are two or three times more prone to depressive illness than children who had not. That is where my interest comes in. They studied all women between the ages of 18 and 65 in one of the London boroughs, taking a complete population sample of 450 or so. First, they studied the women in terms of their present state. They found an appalling incidence of depression, most of which had not come to psychiatric attention, because what gets into a psychiatric unit is the small tip of the iceberg. Those who were depressed were comparable to patients who might appear in a psychiatric ward. Then they made a very careful study of individual current life situations and of

any severe life events within the preceding 12 months. They also obtained some elemental information about childhood losses, including deaths of fathers or mothers and at what ages. Participants with generally unsatisfactory childhoods, particularly involving loss of mother before the age of 11 were more likely to develop a depression, especially if they also had recently suffered a serious event which would upset anyone, such as another loss. So, the general picture was that certain adverse events during childhood create vulnerability to subsequent distresses. This model of depression that childhood events create vulnerability and subsequent major adverse events trigger a depression, is one which is, I believe to be very well founded. Brown and Harris have done a lot of work on this model. You can see where my interests coincide with theirs. Their work and mine on this topic remain strictly confidential, however.

LT: Were they inspired by your research?

JB: I think that loss of a mother or a father in childhood as a variable was first advanced in this country—and, as far as I know, nowhere else—by a child psychiatrist called Felix Brown—no relation at all to George Brown. Felix Brown in about 1960 published some rather striking epidemiological findings in which adults who were depressed showed a higher incidence of childhood loss (Brown 1966). That finding led to a long period of controversy, concerning whether this was provable by statistics. When Felix Brown started that work, I knew him quite well, and associated myself with his views. Despite prolonged controversy proving the theory over a longish period, the work of George Brown and his group effectively demonstrated that is true, that there is no longer any question that loss is an antecedent, but only when it is coupled with a severe current life event.

LT: The separation model of depression has been observed also in monkeys. What do you think of those studies?

JB: I have been working on this separation and loss thing since before World War II. Another psychoanalyst, René Spitz (10)was of Swiss origin but worked in America from the mid-thirties. He actually came into the field in the wartime and brought attention to the plight of children in

institutions. His work stimulated some research activities in the United States. A psychologist who started the monkey work was Harry Harlow (11)in the late 1950s in Wisconsin. He was influenced by Spitz's and by my work. When Harlow and I met in 1958 we realized we had both been studying comparable phenomena. Robert Hinde (Hinde 1966) was another psychologist who worked on monkeys in this country, largely stimulated by my work. The main thing about the monkey work has been that, with fairly rigorous experimental designs and methods, they have demonstrated the ill effects of separation and its obvious consequences. It is a huge literary reserve which I was fairly familiar with in the 1960s because it was very dramatic but I haven't kept up with because one cannot keep up with everything. However, I am familiar with the kind of things which are going on, or which I think are very important.

LT: If both depression and psychopathic behaviour are associated with early separation and loss, don't you think that these two syndromes may have a lot in common?

JB: There is no doubt about it. Psychopathic individuals are, I think, chronically unhappy and, of course, they tend to commit suicide. There is a high incidence of suicide among them.

LT: That is also true for drug addicts who most of the time start the substance-abuse behaviour following some kind of depression.

JB: With then, it is a chronic sort of depression, a subacute depression which rumbles on.

LT: So probably we could say that your contribution to the study of depression emerged from the study of psychopathic behaviour.

JB: Yes, I think so, except that George Brown used the same concepts in his work with patients who are depressed within the ordinary meaning of the term.

LT: What sort of relationship is there between your studies and cognitive therapy?

JB: Cognitive therapists starting with Aaron Beck (12) have been concerned with an adult person's ways of thinking about other people, and particularly about themselves and their own life and the world they live in.That concern, of course, can make one depressed about one's adverse opinions of oneself, of one's prospects, and of the world in general. Something like that is the characteristic way of thinking of a depressive person. Aaron Beck has not been interested in the development of these concerns, about how and why these ideas develop. He takes them as being inappropriate and proceeds to try to enable the patient to correct his way of thinking. An alternative approach to the same problem is to ask how and where the patient got these ideas from, how he developed them. Now once you ask that question you are looking at development and childhood. Parents can say a great many things to their children and can do all sorts of things. Some parents praise a child, encourage a child, are always on the child's side, let's say. Other parents are constantly finding fault, saying, "You are not any good, you silly arse; no-one will ever love you; you'll never make your way in life…" Some parents do a great many things with a child, help them forward and encourage them; others take no interest in them or say, "Don't be a nuisance; I can't be bothered with you." I think that all of this adverse behaviour, treatment, and statements can have a very adverse effect on the child and give him the impression that he's no good: "I'm no good; I'll never do anything in life; no-one will ever have any affection for me; there's nothing in life worth living for." You see, after all, a child is likely to be living with a parent day in day out year after year after year after year hearing the same message. No wonder he grows up believing he's no good. And all the evidence is that when any of us has developed an idea about anything we have really got that idea firmly in our minds. You know the Earth is flat or the Earth is round. It doesn't matter which it is. Once the idea is well engraved it doesn't shift. OK, you always learnt the Earth is round but if some special evidence comes forward to say it's flat, at first, you dispute it: it can't be true; I'm sure it's not true, Then, if you reluctantly accept that it is possible that the earth is flat, it's always a more fragile belief than what you've always been told. So, people who've had a very disparaging, adverse childhood may work very hard and may even be very successful. They always try to prove that their parent was wrong and for a long time. Over some years they may be successful, win prizes and all sorts of things, and continue very favourably in that direction, but they are always vulnerable to a failure. Just when they thought they were going to get a very distinguished job, they get terribly disappointed and they revert right back to where they started:

“I'm no good.” That's a common picture, so that's the way I would look at it. Articles by Giovanni Liotti(13)indicate that he thinks developmentally and is interested in the origin of such ideas exactly as I have been. I first met him in Rome in about 1982. He was very taken with the developmental perspectives which I had presented and he adopted them. So, he's one of the few cognitive therapists who thinks developmentally. But once a cognitive therapist thinks developmentally and in terms of unconscious as well as conscious processes, he’s on the same wavelength as a psychoanalyst like me. He and I have a great deal in common, and I find that very encouraging.

LT: Is it possible to say that cognitive therapy can be viewed as the operational side of developmental theories?

JB: I think these labels become rather misleading because the cognitive therapy that Liotti represents and the psychoanalytic therapy which I represent converge. What to call it, I don't know. We always have to bear in mind that, while thoughts are important, emotion is too, and that the two are parallel. I believe, in fact, this is the correct way to look at emotion. Emotion, you see is communicative, although this point is often missed. If you are angry, you behave in ways that make it plain to other persons that you are angry. Emotion is non-verbal communication of basic but very powerful attitudes of mind and potential action, and so you have to bear in mind both verbal and nonverbal communication. Cognitive therapists may have been over-concerned with verbal communication whereas psychoanalysts may not have been concerned enough. Cognitive therapists have to learn that emotion is communicative and psychoanalysts have to learn that thoughts are important.

LT: Real events too?

JB: Yes, each kind of therapist has to educate the other in where they are strong and the other is weak, but I see this as converging.

LT: It's interesting that, after all, cognitive therapy descends from psychoanalysis.

JB: That's quite true.

LT: May I ask you how your interest in psychiatry started?

JB: It started in Cambridge where I was a premedical student from 1925 to 1928. I read the basic medical sciences: zoology, physiology, comparative anatomy, and so on as my preclinical medical subjects. I became interested in what today would be called developmental psychiatry, in how some people develop in this way or that. After leaving Cambridge in 1928, instead of going straight to a medical school or a hospital I spent a year in schools for disturbed children. In one of those, I was introduced to what you might call a psychoanalytical developmental point of view with regard to problem children. I was then advised to complete my medical training and become a child psychiatrist and to train as a psychoanalyst, which I did in the 1930s. That's how all started.

LT: Do you remember any particular episode which was important in your choice?

JB: It's difficult to say, but I'll tell you an important experience I had in these schools for disturbed children. It was a very small place with children of all ages and varying degrees of disturbance. One boy of eight years followed me around all day every day, so that I became familiar with him and developed an attachment to him. An opposite experience that occurred involved a boy of 15 or 16 years who had been thrown out of a well-known school. He was a very emotionally shut-in character, although he was quite sociable and not antisocial, but was emotionally withdrawn and had had a very disrupted early childhood: he was illegitimate, and the opinion of the people running the school was that that an experience in his early childhood had caused his current condition. So that was the origin of which I've followed ever since.

LT: Did you receive any criticism in the first years of your work from other colleagues?

JB: My relations with the psychoanalytic group in London have always been on very good personal terms but they regarded my ideas as a mistake. I'm not saying in everything, and things have changed over the years, but I received a very great deal of criticism when I first started

drawing attention to the importance of real life events and adverse experiences. I first read a paper on this topic before the war in 1939, presented these ideas all through the 1940s and 1950s and started to develop an attachment theory at the end of the ‘50s. This theory was severely criticised when presented these ideas to psychoanalytical societies in America and elsewhere. There was a strange and irritating tendency, you would say, that these ideas might be important but they had nothing to do with psychoanalysis—a view that I regard as absurd. Anyway, I've received my fair share of criticism.

LT: When did people start to be more prone to accepting your ideas?

JB: It depends on the group. Social workers, who deal with problems in fostering and know all about children without satisfactory parents, have always been enthusiastic about my work. Modern psychologists in the 1950s who were interested in "learning theories" abominated my ideas and considered them rubbish. People in child psychiatry, on the whole, knew the problems and thought I'd done the right thing. People in adult psychiatry were either totally uninterested or regarded the whole thing as of no importance at all. It was entirely a matter of different disciplines. Whenever I went to social workers I knew that that was going to be supportive, or when I went to a group of psychologists, I knew that they were going to be critical, or a group of psychiatrists were going to be totally ignorant of the whole field, and so on.

LT: May I say that your theory has an ecological perspective too?

JB: Yes, well you see the history there is quite simple. Before the war, I had made a retrospective study published in 1944 about juvenile thieves. After the war, I decided that what we needed to do was to study the consequences of a child losing his parent figure: his responses to being in a strange place with strange people, which a small child finds extremely frightening. It was then that my colleagues and I made these observations, which the monkey work confirmed. The next question was, if disruption of a bond had such powerful emotional effects, what is the nature of the bond which is being disrupted? That question was top of my mind in 1951 and at that time a psychologist acquaintance drew to my attention to the work of Lorenz (14) on imprinting. He said: "Do you know the work of Konrad Lorenz on imprinting? I think it

would interest you." It was a stray remark which he made at the end of a committee meeting. I found an English translation of some of Lorenz's work and found it very exciting. I found it very interesting because I had always been interested in natural history. Then I had the opportunity to talk with Julian Huxley who had been one of the early ecologists. He was a well-known biologist in this country. He said it's all very interesting, and medically important. He put me on a good track to Lorenz's books as well as to Nikolaas ("Niko") Tinbergen's(15) study of instinct. I spent the whole winter of 1952–1953 studying ethology, and that's how it all started. The more I studied it, the more impressed I was by the high scientific quality of their work and the extent to which they were studying in other species, problems similar to our own in the clinical field. So, I became a great enthusiast for the ethological approach, which led to my attachment theory. Attachment theory is concerned with one aspect of child-parent relationships, the extent to which a child keeps bonds is limited to, and is reassured by, the presence of a parent. In older subjects, the questions may be, "Why does he become demanding? Why does he become dependent?" and so forth? Well, first of all, it was interesting that a very similar behaviour occurs in a great number of different species. Secondly, one can ask the question, why does it occur? What is its function? Why should it be there at all? In the past this cycle of dependency was just regarded as a nuisance; it's just something that happens, it's due to the fact that a mother feeds a child and so he gets used to that. Food is the greater issue and it'sjust dependency. It is not really a good thing; it's a bad thing and the sooner he becomes independent the better. Now I looked at the whole thing completely differently. I never thought that food was ever all that important and in 1958 demonstrated that it wasn't. Then, secondly, the point I have always made about attachment is that it's a good insurance policy. It promotes safety, it is protective emotionally and it has a valuable function in human nature. It is to be studied as part of human nature and in its matured unfolding, and I attribute great importance to it. You see, instead of regarding it as an inconvenient thing to be got rid of, something to be avoided, it's a simple part of human nature and something to be studied.

LT: In your psychotherapeutic technique is there anything special when you deal with a child or an adolescent?

JB: No, I don't think there's anything special. I think I've always taken children seriously because I regard adults simply as grown up children, and children have always interested me. I think you have to treat them as nearer equals as far as possible and pay attention to what they feel, to what they say, and take them seriously; that is about all there is. I don't regard myself as a brilliant therapist. I do therapy, but it has never been a major speciality of mine. I've learnt a lot by doing it, and I've treated people of all ages, including young children, adolescents, and adults.

LT: Would you lean to the psychoanalytical approach in being nondirective, or are you more supportive and directive in your therapy?

JB: I'm fairly nondirective, although I've probably become rather more directive as time has gone on. A major issue in my therapeutic output is that I am a companion of the helpless patient, and I intend to stick with him so far as I can and resolve his problem.

LT: Would this involve a deep emotional relationship between you and the patient?

JB: Yes, if they come to trust me. In fact, what happens is this: a patient always—by definition, in my eyes—is somebody who has had an unhappy and difficult attachment relationship in childhood and he has disabilities in his attachment relationships in adult life. So, when he comes to see me, I see him as someone who has a disability in making trusting attachments. Now if things go well, well he makes an attachment to me. The word transference is sometimes used in this connection. He makes an attachment relationship to me and I become important to him and he feels that I have a certain value in his life. The disturbances in the pattern of attachment which he developed as a child will also begin to demonstrate themselves in his attachment to me because that pattern has been his trouble all his life. This is all very conventional stuff except the for terminology I use. So, if a patient becomes very angry with me if I'm away, I take this as naturally enough, something that people feel. If he thinks I'm going to desert him and he's got a mistaken idea about that, then I ask myself: “Well where did he get that idea from?” or “How did he develop this suspicion that I'm going to ditch him?” So, in many ways, I use a lot of psychoanalytical concepts, but in my own way.

LT: Usual psychoanalytical tools like, say, free associations?

JB: Yes, but free association is a double edge weapon. A patient can use free association to waste time to talk about everything that doesn't matter, and then you have to intervene and say, "Look, you are wasting time," and to talk about something that matters. There are occasions when I'm straight on and directive, but they are rare—distinctly rare. My main concern is to help the patient review his own life, to look at his problems in his own way, and to examine how his experiences all through his early life have created the problems he's facing now.

References:

Bowlby J. Forty-four juvenile thieves: their characters and home life. International Journal of Psychoanalysis, 1944; 25: 19–52 and 107–27.

Brown F. Childhood bereavement and subsequent psychiatric disorder. British Journal of Psychiatry 1966; 112: 1035–41.

Brown G, Harris T. Social Origins of Depression. New York: Free Press; 1978.

Hinde RA. Animal Behavior. New York: McGraw–Hill; 1966.

Endnotes:

1.Sigmund Freud (1856–1939) and his family fled Nazi persecution on June 4,1938 and moved from Vienna to London where they lived at 20 Maresfield Garden (now a museum). A chronic cigar smoker, he suffered since 1923 from cancer of the mouth and died from a physician–assisted overdose of morphine on September 23, 1939.

2.Melanie Klein (1882–1960). Child psychologist, born in Austria, moved to London in 1926 where she died in 1960.

3.Anna Freud (1895–1982). Child psychoanalyst, born in Austria, daughter of Sigmund, moved with her family to London in 1938.

4.Donald Winnicot (1896–1971). British pediatrician made important contributions to psychoanalytic theories especially in the object relations theory focusing on the relation with the influential parent.

5.Jean Piaget (1896–1980). Swiss developmental psychologist. Worked on the children's cognitive development.

6.Konrad Lorenz (1903–1989). Austrian zoologist and animal psychologist, founder of modern ethology. He studied the learning processes associated with the imprinting.

7.Margaret Mead (1901–1978). American cultural anthropologist who compared the passage from adolescence to adulthood between simple and more complex societies.

8.Eric Erikson (1902–1994). German psychologist and psychoanalyst who studied social development and coined the expression identity crisis and described eight stages of psychosocial development.

9.Ludwig von Bertalanffy (1901–1972). Austrian biologist who studied system theories and proposed a mathematical model of the individual growth.

10.René Árpád Spitz (1887–1974). Hungarian psychoanalyst, studied the relationship mother–child and developed some theories on hospitalism. He demonstrated in 1945 that babies left untouched in a hospital failed to thrive.

11.Harry Harlow (1905–1981). American psychologist who studied the effects of social isolation in monkeys. In 1959 he found that baby rhesus monkeys would often prefer to snuggle with a comfortable cloth "mom" than drink a bottle from a wire mom. The same year John Bowlby published *Child Care and the Growth of Love*, demonstrating that when young babies are separated from their mothers for long periods of time they experience grief and depression.

12.Aaron Beck (1921-). American psychiatrist and psychologist. He founded the Cognitive Therapy, a type of psychotherapy which was initially studied and practiced to treat depression.

13.Giovanni Liotti (1946-2018). Italian psychiatrist and psychologist who has studied motivational systems in attachment as well as other human behaviors (cuddling, competition, co-operation, sexuality).

14.Sir Julian Sorell Huxley (1887–1975). British evolutionary biologist. He studied how cultural traits may stay in a society and persist over generations.

15.Nikolaas Tinbergen(1907–1988). Dutch ethologist and biologist who won the Nobel Prize in Physiology (with Konrad Lorenz and Karl von Frisch) in 1973 for his studies on social behavioural patterns.

*This text has been edited and formatted to conform to INHN posting standards.

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