

Dr Bowlby: a psychiatrist for our times

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Abstract: Inspired by his experience as a teacher in a special school, John Bowlby became a doctor in order to give psychological treatment to children and their families. His debt to psychoanalysis is evident, while his determination to give external life events at least equal weight with mental states led him towards attachment theory.

This pathway is well known, but Bowlby's parallel career as a child psychiatrist doggedly independent of psychoanalysis or medical practice, is not. His intelligent curiosity about human relationships took him beyond the prevailing scientific and clinical fixation with diagnosis, which persists to this day. Dr Bowlby's clinical approach is a model for modern child and adolescent psychiatrists.

Keywords: Bowlby and psychoanalysis, Darwin's malady, family systems therapy, child and adolescent psychiatry, Tavistock Clinic.

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Like his hero Charles Darwin, John Bowlby loved to explore nature. As a boy each Easter holiday he and his brother Tony went with their mother to the New Forest where they “were allowed to play outside and on their own ... they spent hours exploring the little brook full of sticklebacks, worms and dragonflies” (Van Dijken, 1998, p. 24). Later in the summer the whole family would go to Scotland where their mother “tried to pass on her love for nature to her children. She taught them how to identify flowers, birds, trees and butterflies” (ibid., p. 24).

At Dartmouth Naval College John was a very bright student, top in all subjects except French, and enjoyed watching and photographing birds. Though he and his friend Donald McGavin started to train as midshipmen they decided that being naval officers in peacetime gave them no opportunity “to improve the community as a whole” (ibid., p. 46). John's father agreed to buy him out of the navy, and told him “there are many different things you can do if you read medicine”.¹ In 1925, together with Donald, John began his medical training at Trinity College Cambridge, but there he was distracted by subjects not central to the medical curriculum; evolutionary biology, developmental psychology, and psychoanalysis.

Exactly a century earlier, in 1825, Charles Darwin, also the son of a successful doctor, had entered Edinburgh University to study medicine, but he hated the brutality of it and within two years had abandoned Edinburgh and medicine for Cambridge where he was to study for an ordinary degree with a view to taking holy orders. There, too, he was diverted by nature, particularly a passion for collecting beetles (Bowlby, 1990, p. 98) and, it should be added, shooting birds. Bowlby's debt to Darwin is evident; less well known is what Dr Bowlby offered to Darwin, of which more later.

¹ Sir Anthony Bowlby was a very distinguished doctor; surgeon to the royal household and president of the Royal College of Surgeons, with a ward named after him—and his painted portrait on display—at St Bartholomew's Hospital.

John's physiology tutor at Cambridge was Edgar (later Lord) Adrian who, while himself a medical student before the First World War, had been impressed by Sigmund Freud's writings. John decided to give up medicine for psychology and took a degree in moral sciences in 1928. While his friend Donald completed his medical degree and went straight into junior doctor training, John had other ideas. He wanted to pursue his interest in developmental psychology through teaching in special education. After some exploration he settled at Priory Gate, a school for maladjusted children in Norfolk. Like similar progressive schools, such as A. S. Neill's Summerhill and Susan Isaac's Malting House School, Priory Gate took from "the new psychology" the idea that children's emotional experiences make a difference, and should be as much a focus of education as formal learning². There, John found a mentor in one of the staff, John Alford, who had had some analytical psychotherapy after traumatic experiences in the First World War. While Bowlby was at Priory Gate his father died. Coincidentally or not, John was then persuaded by Alford to return to medical training in order to become a psychoanalyst.

Bowlby's experience at Priory Gate fired his ambition to work therapeutically with children. In an interview with the American paediatrician Milton Senn in 1977, he said that the experience transformed him: "when I was there, I learned everything that I have known; it was the most valuable six months in my life, really"³. Senn asked him what he did there.

There were 22 children varying in age about three to eighteen, both sexes. I was put in charge of those under eight or nine, I think the under tens. Anyway, it was a handful of children, about 7 or 8 of them, and I was in charge. Well, you may well ask what I did. I don't think I would like to describe what I did. I did my best. (Senn, 1977, p. 1)

Bowlby wrote from Priory Gate to his mother that "our task is to discover what appeals to them. When discovered, if possible, it is provided" (Van Dijken, 1998, p. 57). Rather than making judgements about children, Bowlby was impressed by his experience of them: "I recall ... another small boy of seven who spent his whole time trailing me around, he was always with me, he was known as my 'shadow'" (Senn, 1977, p. 2). The school had been founded in 1919 by Theodore Faithfull whose developmental view anticipated Bowlby's later theory:

² "I worked in a very small school where the orientation was that the present problems of children stemmed from adverse experiences in their families. It was a version of psychoanalysis. It gave emphasis to real life events" (Hunter, 1991, p. 163).

³ There is a curious and pleasing historical parallel to this phase of Bowlby's life. At the same age, and having just left the same Cambridge college, Isaac Newton also travelled far away from laboratories and universities, and liberated his experience-near theorising. In 1666, in retreat from the great plague at his mother's home in Woolsthorpe, as tradition has it, Newton observed the fall of an apple in his garden, later recalling, "In the same year I began to think of gravity extending to the orb of the Moon." Something happened to these two young men that enabled them to think for themselves. Many years later, each was to formulate theories that changed our understanding of nature in fundamental ways. As Newton had, in his own words, seen further "by standing on ye shoulders of giants," so too did Bowlby. He began his quest as a psychoanalyst both respectful and critical of Freud and his successors but then, after his encounters with Lorenz, Tinbergen, and Hinde in the 1950s, placed the other foot on the shoulder of Darwin, whose successors they were (Kraemer et al., 2007, pp. 304–305).

The attachment of a child is a normal instinct, but it becomes a danger if it is used for the satisfaction of the adult and not the protection of the child ... This may show itself in physical collapse or stealing, lying. (Faithfull, 1933).

This basic idea “struck a chord” in Bowlby: “so the idea that certain sorts of experience in early childhood have that kind of effect on character and development was picked up there” (Croall, 1983, p. 169).⁴

Bowlby qualified in medicine at University College London in 1933, but instead of the resident year in medicine and surgery that usually precedes formal registration as a doctor, he went immediately to the Maudsley Hospital to train in adult psychiatry. At the time child psychiatry was not a hospital specialty and adult training was required to get a fellowship in child guidance. Bowlby’s teachers, Edward Mapother and Aubrey Lewis, were critical of psychoanalysis but he valued their intellectual rigour. Of his time as Lewis’ trainee Bowlby wrote “this proved a productive relationship, not least because on many questions we agreed to differ” (Bowlby, 1981, p. 2). From his eighteen months at the Maudsley Bowlby wrote a 280 page study of sixty-five adult patients in depth, published a few years later as his MD thesis (Bowlby, 1940). He wrote in the introduction, “of recent years it has become fashionable to speak of someone having a ‘complex’ or a neurosis rather in the same way as one describes their possession of a bowler hat”, going on to say “the tendency to divorce mental symptoms from personality has also been responsible for another great psychiatric evil—the use of an outstanding symptom as a diagnostic label” (1940, pp. 4–5). Though still in his twenties and less than two years out of medical school, Bowlby was already writing with enormous confidence and scholarly depth. He writes: “the illness or death of a near relative is an exceedingly common precipitating factor in both psycho-neuroses and functional psychoses” (1940, p. 146), and concludes that:

infantile and childhood experience are fully as important as heredity in determining whether that individual develops a stable personality or becomes unstable and so liable to develop one of those particular forms of mental illness which his inheritance has made available for him. (Bowlby, 1940, p. 14)

Following his work at the Maudsley, Bowlby was a trainee child psychiatrist at the London Child Guidance Clinic (later to become the Child Guidance Training Centre, see Hopkins, 2020), one of the first in the country, where he collected case histories of delinquent children. His research on “forty-four juvenile thieves” was completed before the war but not published until 1944. He concluded that:

seventeen of the thieves had suffered complete and prolonged separation (six months or more) from their mothers or established foster-mothers during their first five years of life. Only two controls had suffered similar separations, a statistically significant difference. (Bowlby, 1944)

⁴ “Separation will keep me busy for the rest of my life” (Dinnage, 1979, p. 323).

Although followers of the new psychology such as Theodore Faithfull had predicted it, this was the first statistical study to show this association. Like Darwin, who wanted to find out how the species he observed came to be as they were, Bowlby was pushing past descriptive labels to uncover the individual's life story. In this he felt he was following the other giant on whose shoulders he stood, Sigmund Freud³. Bowlby's ambition to help troubled children had led him to medicine and psychoanalysis, the only proper route for a man like him at the time, but what he found in his analytic training was not what he had hoped for. He was expecting to trace the experiences that had led to the child's presenting problems, but was instead instructed to foster the transference, replacing the presenting problem with a live relationship that could be worked with. This, not the exploration of history, was the principal agent of change (Strachey, 1934). Bowlby had learned from both his child and adult psychiatric patients that they had been profoundly affected by disruptions in early life. Now, in 1938, his child analytic training patient was an anxious, aggressive, and hyperactive three-year-old boy, and his supervisor was Melanie Klein. In the waiting room he had noticed that the child's mother was "an intensely anxious distressed woman" whom he wanted to help, but Mrs Klein advised against meeting her; "an arrangement I found difficult to bear" (Bowlby, 1991). When three months later the mother was admitted to a mental hospital, Klein advised Bowlby to find another training patient. "The probability that the boy's behaviour was a reaction to the way his mother treated him seemed altogether to escape her" (ibid.). This well-known episode highlights Bowlby's journey away from the practice of psychoanalysis. "During the years 1936–39, I was slowly waking up to the fact that my ideas were developing in a direction very different from those that were accepted truths in the British Psychoanalytical Society" (Bowlby, 1991, p. 216). Yet he had taken what he needed from Klein's discoveries. In his very first published paper, the thirty-one-year-old Bowlby writes:

Melanie Klein, using her special technique of play-analysis has been able to show how deeply even children of two and three feel about their jealousies and rages and to what tremendous and irrational outbursts of temper and destructiveness it can lead. (1938, p. 232)

He saw the power of child psychoanalysis to revise developmental psychology, but in doing so privileged its observations, while bypassing the method. He maintained this position for the rest of his life⁵. Three decades later, in the preface to the first edition of volume 1 of his *Attachment* trilogy he writes: "all the central concepts of my schema—object relations, separation anxiety, mourning, defence, trauma, sensitive periods in early life—are the stock-in-trade of psychoanalytic thinking" (Bowlby, 1984, p. x). Bowlby's aim was to revise psychoanalysis by identifying disruption of the caregiver relationship as a pathogenic event in its own right.

While separation from mother in the early years fits perfectly Freud's definition of a traumatic event, it cannot be said that he ever gave serious attention to it as a particular class of traumatic event. (1984, p. 12)

⁵ Peter Bruggen (1934–2018), who also qualified as a psychoanalyst but did not practise it, says that Bowlby told him that he had remained a psychoanalyst because analysts asked the right questions, even if they hadn't found the answers.

Bowlby proposed direct observation of children in research settings, and direct exploration of traumatic experiences in clinical practice. While remaining a member of the British Psychoanalytical Society, he did not practise psychoanalysis; he adapted therapeutic method to his convictions, and to his personality.

Treating Darwin's malady

The patient Bowlby never had, but whose illness he investigated in great depth, was the subject of his monumental last work *Charles Darwin: A Biography* (Bowlby, 1990). Dr Bowlby shows what could have been done to help Darwin "in the light of current research". For thirty years of his life Charles had suffered from chronic ill health, which for months at a time prevented him from working. Amongst symptoms recorded by Darwin himself were palpitations, flatulence and nausea, shivering, blurred vision, tingling sensations, faintness, fatigue, and fear of dying (Bowlby, 1990, p. 458). He was also prone to panic attacks and skin eruptions on his face, lips, and hands (ibid., pp. 1, 11). Despite the efforts of many physicians and others, the only really effective remedy was work. Darwin "was a workaholic who pursued his studies according to a daily routine seven days a week, week in and week out, until he could continue no longer" (ibid., p. 12). He wrote to his friend Joseph Hooker in 1861: "the word 'holiday' is written in a dead language to me, and much do I grieve it" (ibid., p. 11). Reviewing the very many specialist opinions on Darwin's malady Bowlby concludes that the majority of his symptoms were the result of chronic hyperventilation, which did not need to be very severe to produce them: "... situations that are seemingly trivial such as the animated conversation in which Darwin liked to engage, or even a heavy sigh, can bring them on" (ibid., p. 9). "In chronic cases ... overbreathing is usually not evident because rate of respiration is normal and the increased volume of air inspired at each breath is not apparent" (ibid., p. 458). Darwin's symptoms were aggravated by the constant worry that he had a physical illness that his children would inherit.

When Charles was eight years old, after a few days of severe suffering, and many months of chronic gastrointestinal symptoms, his mother, Susannah Wedgewood, died of peritonitis, probably from an ulcer or cancer. His father Robert Darwin threw himself into his medical work, leaving his elder daughters to run the household. From then on Dr Darwin cast a gloomy spell on the whole family and no one ever mentioned Susannah's death. There was a "wall of silence". The suppression of mourning in Darwin was so profound that, twenty-five years later, in 1842, at the death of the wife of his oldest and closest friend (and second cousin) William Darwin Fox, Charles wrote to him "never in my life having lost one near relation, I dare say I cannot imagine how severe grief such as yours must be" (Bowlby, 1990, p. 245).

Bowlby notes "Charles's failure to recall anything of significance about his mother" (ibid., p. 58), and cites Darwin's own reflection on this: "my forgetfulness is partly due to my sisters, owing to their great grief, never being able to speak about her or mention her name; and partly to her previous invalid state" (ibid., p. 60). In simple and moving phrases Bowlby spells out what should have been possible for the boy:

Mourning entails opportunities to ask questions about what happened and why, to express his longing for his mother's return and his anger and grief when told she never

will, [adding that] without understanding and sympathy there is a danger that the child's thoughts and feelings will become locked away, as though in a secret cupboard, and there will live on to haunt him ... It was, of course, recognition of states of mind of this sort that led Freud to postulate the existence of a dynamic unconscious. (ibid., p. 77)

Bowlby proceeds to outline the treatment he would have offered his historical patient:

First, all physical causes having been excluded by a full medical examination and investigations, the patient would be given a firm diagnosis and explanation of "hyper-ventilation syndrome". Then a physiologist would give him exercises to avoid over-breathing, followed by psychotherapy. The indispensable step for the psychotherapist would be to recognise, and gradually to counteract, the powerful influence on his patient of the strongly entrenched Darwin tradition that the best way of dealing with painful thoughts is to dismiss them from your mind and, if possible, forget them altogether. (ibid., p. 14)

A feature of psychotherapy to which I attach especial importance is the role of the therapist as a companion in their joint exploration of these distressing events ... which the patient may be very reluctant to engage in. (ibid., p. 460)

After the patient has begun to trust this therapist to be understanding, a situation may arise that reminds him of the loss and feelings long asleep, come flooding in. (ibid., p. 464)

"I see no reason why Darwin would have been an especially difficult patient" (ibid., p. 14) says Dr Bowlby, whose humane and pragmatic approach here is typical of his clinical work. He took from psychoanalysis the idea of repression and the importance of a therapeutic alliance, and from developmental research the impact of early loss on subsequent health. The evidence base for his intervention is the finding of Harris and colleagues (1986) that women who had lost their mother before the age of eleven were three times more likely to become depressed when they met a severely adverse life-event (which is what happened to Darwin after his father died). In particular the most vulnerable to depression were those who experienced "lack of care" following their mother's death (Harris et al., 1986, p. 654). Reading this now, it sounds like common sense, but it was not common at all at the beginning of Bowlby's clinical career. Separation and loss in childhood were too readily brushed aside—just as in Darwin's family—until, amongst others in the post-war years, John Bowlby and James Robertson demonstrated their impact on children in filmed observations, which met fierce resistance from their colleagues in psychoanalysis and medicine (Lindsay, 2020). Bowlby's biography of Darwin is a literary family therapy.

Psychological disorder is frequently transmitted through a family microculture in which disturbed relationships and vulnerable personalities in one generation produce disturbed relationships and vulnerable personalities in the next. (Bowlby, 1990, p. 463)

Given the trauma and losses experienced by his father in early childhood⁶, and John's own upbringing, which he later described as one of "opulent neglect"⁷, the same could be said of the Bowlby family, but in his writings John was typically more open to speculation about his hero than about himself.

Clinical pragmatism

Bowlby's actual clinical reports show how he follows where his curiosity leads him, often into consultations with other family members. He does not have a recognisable medical or psychoanalytical method, but one which to me seems to be a good model for child and adolescent psychiatrists. In 1949, Bowlby published a case report of his work with a boy and his parents.

There being barely any literature on family therapy at that time, Bowlby drew his inspiration from the anthropologist Margaret Mead and from the group work with organisations and adult patients of his Tavistock colleagues Wilfred Bion, John Rickman, and Elliott Jaques⁸:

faced with a situation where the co-operation of key people is difficult to maintain, there is a temptation for the professional worker to solve the group problem by removing one or more of the individuals concerned. In industry, management may wish to sack the troublemaker. A similar procedure in child guidance has been to take the child out of the home and put him or her elsewhere. (Bowlby, 1949, p. 124)

He presents the case of Henry, a thirteen-year-old boy who had been referred because of laziness at school, and disobedience and cruelty to his younger sister at home. While keeping in touch with home and school, Bowlby worked with the boy alone for two years. "Progress was imperceptible". Bowlby decides to invite both parents to join him in a two hour session. He lets the three of them argue for the first hour but then tells them that each one of them is contributing to the problem and that mother's persistent nagging was making things worse, adding:

I felt sure that her mistaken treatment of Henry was the result of her own childhood. For nearly half an hour thereafter she told us, through her tears, about her childhood and very unhappy relation with her parents. ... After about 90 minutes the atmosphere had changed very greatly and all three were beginning to have sympathy for the situation of the other. (1949, p. 126)

⁶ John's grandfather, "Thomas Bowlby of *The Times*", was a foreign correspondent for *The Times* who was murdered in Peking in 1861 during the Opium Wars when Sir Anthony was a small child. Anthony felt responsible for his mother who did not remarry, and he only began to look for a wife after her death when he was forty (Holmes, 1993, p. 14).

⁷ The distinguished child psychotherapist Juliet Hopkins, daughter of John's younger sister Evelyn, records her mother's experience of growing up on the sixth floor of a grand London house with "very few toys ... often 'bored to screams' with the upshot that they were constantly teasing and fighting each other" (Hopkins, 2019, p. 190). The long spring and summer holidays with mother, sometimes joined by father, were evidently happier (Van Dijken, 1998, pp. 22–25).

⁸ All of whom had been analysed by Melanie Klein.

This was followed by a one-to-one meeting with mother who:

though she resented what she had felt to be my criticism of her treatment of her son, ... also remarked what a good thing it would have been had her own parents had the benefits of clinical help. (ibid., p. 127)

Citing the anthropologist Margaret Mead's description of the "the vicious circle of insecure parents creating insecure children" (1948), and recent Tavistock initiatives promoting industrial democracy (Jaques, 1948), Bowlby had in effect discovered family therapy for himself⁹. This followed from his understanding of the origins of mental problems in childhood and from the social workers in the London Child Guidance Clinic where he had worked before the war.

Both Molly Loudon and Nance Fairbairn were analytically oriented, the one Freudian and the other Jungian. This suited me well because my first year at the Clinic was also my first year of training in psychoanalysis. It was these two who first introduced me to the notion that unresolved conflicts from the parents' own childhoods play a large part in causing and perpetuating the problems of their children. (Bowlby, 1987, p. 2)

Bowlby always maintained that he focused on separation because it was easier to measure in research (Bowlby et al., 1986)¹⁰, but clinically, even before he had formulated attachment theory, he was alert to a whole spectrum of distorted bonds between parent and child, including enmeshment. Here is an extract from a 1949 clinical case file:

The patient is a chronically anxious thirty-nine-year-old man, who is consulting Bowlby with a view to having psychoanalysis (with another psychoanalyst). After eleven years of marriage, he has separated from his wife whose fundamental belief in evangelical religion he had, until now, passively shared. Bowlby suggests to him that his leaving her was "probably an act designed to disappoint his mother and revenge himself on her", noting that "these interpretations seemed to come as novelties to him". He gathers from the patient that his wife is "a self-righteous woman with little insight" but, after arranging to meet her on her own, sees that "... though simple in outlook and lacking much sensibility, she is a very decent honest person with a good adjustment to life". When she tells him that she wants her husband to consult his parents about his marital problem, Bowlby simply opposes it. "This seemed a very bad idea and I headed her off it". He then takes what might now be regarded as the next logical step and arranges to see the couple together. (*London Metropolitan Archives*, accessed 2018)

Here the forty-two-year-old Bowlby is behaving like a thoughtful and therapeutically minded general practitioner, following a thread of attachments, and inventing a flexible

⁹ Bowlby's innovation is not credited in any history except in the anecdote that an early American pioneer, John Elderkin Bell, had visited him at the Tavistock and understood that he was doing family therapy with all his patients, so decided to do the same himself when he returned to California. "In conversation with [Bowlby] in Boston in March, 1953, I confirmed that he had not been using family groups other than as an occasional supplement to individual therapy" (Bell, 1967).

¹⁰ "I picked on separation and loss as being my focus because they could be documented and also I reckoned that some of the consequences in terms of a child's responses were pretty unmistakable. So I went for a crude variable with a crude outcome" (Bowlby et al., 1986, p. 39).

kind of systems therapy. In his later years Bowlby spoke candidly about himself as a clinician:

Many analysts and other psychotherapists do excellent work using their intuition and without very clear ideas on theory, and often, I believe, in spite of the theories they nominally subscribe to. I have not that sort of mind, nor am I strong on intuition. Instead I tend to apply such theories as I hold in an effort to understand my patient's problems. This works well when the theories are applicable but can be a big handicap when they are not. Perhaps my saving graces have been that I am a good listener and not too dogmatic about theory. (Bowlby, 1991, p. 222)

His path to the Tavistock Clinic

When he decided to study medicine and train in psychoanalysis Bowlby did not seem to be aiming for a new theory. But having discovered that children were developmentally wounded by early and prolonged separations he found himself largely alone. In 1939 he persuaded Donald Winnicott and Emanuel Miller to co-sign a letter to the *British Medical Journal* objecting to the evacuation of small children. The text is unmistakably his (and, though by far the youngest, he was the first author).

It is quite possible for a child of any age to feel sad or upset at having to leave home, but the point that we wish to make is that such an experience in the case of a little child can mean far more than the actual experience of sadness. It can in fact amount to an emotional "black-out" and can easily lead to a severe disturbance of the development of the personality which may persist throughout life. (Bowlby et al., 1939, p. 1202)

The impact of war on children added further fuel to Bowlby's already burning ambition to prove to psychoanalysts that the real events in children's lives must be given at least as much respect as their fantasies about them. He had already in the last year of peace established himself as a researcher and writer of some power (Bowlby, 1939; Kraemer, 2019), but was now drawn away from clinic and typewriter to the Royal Army Medical Corps. Here he met a group of psychologists and psychiatrists who would change each other's lives, and those of countless others in the decades that followed. This is a less well-known story about Bowlby which I can only summarise here.

After the fall of France in 1940, the War Office needed more officers than the public schools could supply, and requested psychological expertise to identify men from "the ranks" who could lead others in battle. Up to that time officers had been appointed on the basis of social class ("I was at school with his father"). Thanks to his networking skills, Brigadier J. Rawlings Rees, the then director of the Tavistock Clinic—now the consulting psychiatrist to the British Army—had gathered together a team to devise tests to select candidates for officer training. Amongst those he invited were existing Tavistock staff Wilfred Bion and

Ronald Hargreaves (1908–1962¹¹), the newly qualified psychoanalysts Jock Sutherland and John Bowlby, and the already eminent one, John Rickman (1891–1951) (see Kraemer, 2011). Bowlby's account of this novel congregation highlights the longstanding rift between the then Tavistock Clinic and the Institute of Psychoanalysis:

J.R. Rees had not only recruited Tavistock people, but he had also recruited a great number of other people, like myself, who, while not being Tavistock, were dynamically oriented, socially and psychologically oriented, so that this Army Psychiatry Group bridged all those frightful chasms that had been present before the war. For example, as a psychoanalyst I had not talked with Tavistock people before the war because that was verboten more or less, and I had not met many other people in psychiatry either. In the Army we were all on the same job, we all got to know each other personally and there developed an integrated outlook. We were perhaps half a dozen analysts, including John Rickman and Adrian Stephen who were senior people and a number of juniors like myself, a whole bunch of Tavistock people of different degrees of seniority and a number of others. (Senn, 1977, p. 5)

Soon to be included in this mix of maverick minds—who began to call themselves “the invisible college”¹²—was Eric Trist (1909–1993), a social scientist appointed to assess the psychological repercussions of closed head injuries by the wartime Maudsley Hospital, from where he was “poached from a furious Aubrey Lewis” (White, 2016, p. 130; Trist, 1993) by the Tavistock group. On the basis of his wartime work with groups, he was later to be a major figure in the future Tavistock Institute of Human Relations (TIHR), but now became a vital intellectual mentor for the young Bowlby. In the War Office Selection Boards (WOSB) (see White, 2016), men were assigned to “leaderless groups” for three days and invited to organise themselves in various tasks, such as building a bridge. From observation of their interactions it was possible to identify who could lead on the basis of their capacity of attentiveness to others, rather than just by ordering people about. Bowlby's notable part in this revolutionary procedure was to do the only outcome study of WOSB, supervised by Trist. Though never published, it showed that the drop-out rate of officers selected for training by this method was one third of those chosen by routine interview (15% vs 45%).

It was as a member of this team that I undertook this follow-up study, the validation study. Really it was the equivalent of my doing a PhD thesis under Eric Trist's supervision. I am very deeply indebted to him. He was a very, very brilliant person. (Senn, 1977, p. 6)

¹¹ Ronald Hargreaves deserves to be better known. He was by all accounts a brilliant thinker, and played a key role in putting J. R. Rees in touch with General Sir Ronald Adam, who kept War Office Selection Boards going despite opposition from the old guard, including the prime minister, Winston Churchill. Awarded an OBE in 1946, he became a founder member of the Tavistock Institute. Then, after a spell as medical officer at Unilever, he directed the mental health section of the newly formed World Health Organization, from where he invited Bowlby to visit the USA and Europe, leading to the celebrated publication of *Child Care and the Growth of Love* (1953) (in which, again, Bowlby records his indebtedness to Eric Trist). Aged fifty-four, only a few months after the death of his wife, Eva Byrde, Hargreaves died during an operation, leaving four daughters. https://en.wikipedia.org/wiki/Ronald_Hargreaves

¹² The invisible college was the name taken by the seventeenth-century founders of the Royal Society. [The “Invisible College”, 1645–1662. *Nature*, 142: 67–68 (1938).]

The development of systemic clinical insight under cover of attachment theorising

The invisible college went on to supply the leaders of the new Tavistock Clinic, carried along with post-war enthusiasm for collective social intervention, in what they called Operation Phoenix. Without this crucial episode in his life it is unlikely that Bowlby would have found his way in 1946 to a consultant appointment as director of the Children's Department at the Tavistock Clinic and to his election as deputy director, under Jock Sutherland, of the whole clinic. This was a stepping stone to a scientific career that is well known. While Bowlby forged the new multidisciplinary Department for Children and Parents¹³, he set off in his own direction to define a distinct evolutionary drive, as important for survival as nutrition and reproduction, which is protection. Yet on the way there he kept to his clinical roots at key moments, such as in his account, in volume 2 of his *Attachment* trilogy, of children who refuse to go to school. Describing the relationship of "one or other parent, usually mother, to the school-refusing child", Bowlby writes:

it is found time and time again that mother treats the child as though he were a replica of her own mother, the child's maternal grandmother. Not only does the mother seek from her child the care and comfort she had sought, perhaps in vain, from maternal grandmother, but she may behave towards him as though he were the dominant figure. (Bowlby, 1973, p. 309)

Later in the same volume, in a chapter entitled "Omission, suppression and falsification of family context"¹⁴, Bowlby builds on the studies of family enmeshment by Bateson and others (1956)—including those of his junior colleague, later the anti-psychiatrist, R. D. Laing (Laing & Esterson, 1964)—to summarise his position on family therapy:

the way in which parents tell their story may be so convincing that anyone not alive to the possibility of systematic distortion may be deceived; and this is especially likely whenever the patient endorses the parents' account. Many a clinician, unfortunately, imbued with irrelevant theory and untrained in the field of family psychiatry, finds himself sadly ill equipped to see what is happening. In consequence the family's phobic scapegoat attains the status of psychiatric diagnosis. (1973, p. 364)

He goes on:

Instead of describing the situation in which a person experiences fear, the person is said to "have" the fear. ... Once emotions are reified the speaker is spared the task of tracing what is making the person in question afraid or angry, and will hardly notice when

¹³ Despite his divergence from psychoanalysis and his inspired experiment with family therapy, Bowlby saw the need for psychoanalytical child psychotherapy in the new NHS. Child analysis was well established in private practice but this was to be the first, and still the only, distinct NHS profession that requires personal analysis as a condition of training. In 1948 Bowlby invited Esther Bick to set up a clinical training to which she added an entirely novel learning procedure, infant observation, that later became integral to all analytic trainings. (At the same time, with a different method and purpose, James Robertson and Mary Ainsworth were making scientific observations of infants and young children for Bowlby's research in attachment.) Though Bowlby soon had his differences with Bick, it is clear that he respected her and her successors' work, as recorded first hand by a subsequent leader of the profession, Margaret Rustin (2007).

¹⁴ Subtitled "*Suppressio veri suggestio falsi*" = the suppression of truth is the suggestion of falsehood.

family context is omitted or suppressed. Thus any clinician who thinks in these ways is all too apt to fall in with a parent's claim that the behaviour of the child is altogether baffling and unintelligible, and thence to attribute it to some psychological or physiological anomaly inherent in the child. (1973, p. 365)

Here, Bowlby echoes his youthful comparison of a complex to a bowler hat, and his denunciation of diagnostic reductionism. Now, eighty years later, little has changed. For most child psychiatrists in Britain today, the diagnosis takes precedence over a developmental history of relationships. Commenting on Michael Rutter and Andrew Pickle's defence of "the validity of child psychiatry and psychology" in one of the world's leading child mental health scientific journals, the eminent American child psychiatrist David Reiss writes:

challenging the assumption [that] psychiatric disorders of childhood reside within the child will seem to most 21st century child psychiatrists and psychologists, as equivalent to saying the earth might be flat after all. (Reiss, 2016, p. 419)

Bowlby concludes by carefully distinguishing cause and blame in working with families:

while parents are held to play a major role in causing a child to develop a heightened susceptibility to fear, their behaviour is seen not in terms of moral condemnation but as having been determined by the experiences they themselves had as children. ... That way lies hope of breaking the generational succession. (1973, p. 365)

Bowlby's genius was too much for one person to contain. He had to make a choice and of course science is by far the richer for it. But the clinical practice from which his insights arose should inspire modern practitioners to inquire more deeply into the entangled family life histories of their patients.

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