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The Personal Universe: Drury and Macmurray on the Philosophy of Psychology

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In this paper I am going to look at the views of one of John Macmurray's contemporaries, Maurice O'Connor Drury, an Englishman born of Irish parents who spent nearly half his natural life and most of his professional life in Ireland (where he worked as a psychiatrist) and whose interests and concerns overlap in several suggestive and instructive ways with those of Macmurray. Both are concerned about what we may call the 'mental science project' – that is, with the attempt to give a scientific account of the mind and mental illness, with a view to developing scientifically validated classifications, explanations and therapies. There are also suggestive and instructive differences between these two thinkers. At a turning point in the paper I will draw attention to what seems to me a particular difficulty – a conceptual conundrum, indeed – in Drury's work, but one that can, I believe, be resolved with the aid of an illuminating idea from the thought of John Macmurray.

Maurice O'Connor Drury: Wittgenstein's Protégé

Maurice O'Connor Drury was born of Irish parents in Marlborough, in Wiltshire, on 3 July 1907. He attended Grammar School in Exeter and seems to have become interested in philosophy while still at school. After finishing at Exeter, he went to Trinity College, Cambridge, in 1926, where he took the Moral Science Tripos; his tutors included G. E. Moore and C. D. Broad, and most notably Wittgenstein, whom he first encountered in 1929, through the Moral Science Club. Wittgenstein's influence on Drury was strong enough to warrant his being called Drury's mentor, and Wittgenstein would later remark that it was his influence on Drury that gave him most satisfaction. He advised Drury against pursuing a career in either the church or the academy, and was successful on both counts, though Drury showed more independence of mind than one might expect from a Wittgensteinian protégé. After taking his degree at Cambridge in 1931, Drury told Wittgenstein that he was thinking of going to Westcott House, the Church of England Theological College in Cambridge,

with a view to taking Anglican orders. Wittgenstein immediately warned him against this course of action, telling him that the clerical collar would choke him. (See Rush Rhees, 1981: 116). Initially, Drury ignored Wittgenstein's counsel, and went to Westcott House. After a year there, however, he changed his mind and decided that a clerical career was not for him after all. Following a further piece of advice from Wittgenstein – that he should put himself for a while among ordinary people – he went off and did voluntary work with unemployed groups in Tyneside and Merthyr Tydfil. It was during this period of voluntary work that Drury had his first thoughts of a career in psychiatry. When he wrote to Wittgenstein to tell him of this development in his thinking, Wittgenstein immediately sent him a telegram, more or less ordering him back to Cambridge to begin his medical studies immediately. When Drury arrived back in Cambridge, he found that Wittgenstein had already organized a loan from friends of his for the financing of Drury's medical education. Wittgenstein and Drury together decided, after reading prospectuses from a number of medical schools, that Drury should study at Trinity College, Dublin. This Drury did. He enrolled at Trinity in 1933, beginning a professional career in medicine and later in psychiatry. He qualified as a doctor in 1939 and, following the declaration of war, he joined the Royal Army Medical Corps, and was first posted to Egypt. He later took part in the Normandy landings.

After demobilization, Drury worked for a while as a house physician in a hospital in Taunton, before finally, in 1947, taking up a position as Resident Psychiatrist in St. Patrick's Hospital in Dublin, eventually becoming Senior Consultant Psychiatrist. This was the same year in which Wittgenstein gave up his post at Cambridge and came to Ireland to write. Wittgenstein was no stranger to Ireland, having first visited there when Drury was a medical student. As early as 1934, we find Wittgenstein travelling across Ireland to live for a while in a cottage in Rosro, near Killary Harbour in Connemara – a holiday cottage that belonged to Drury's brother, Miles. When Wittgenstein came to Ireland again in the late forties, he depended largely on Drury to find him places of residence, and also relied on him for companionship. It was through Drury, for example, that he found accommodation in the village of Redcross in Co. Wicklow. He wanted a quiet place in which to do intensive work, having brought with him the draft typescripts of both the *Philosophical Investigations* and the first volume of the *Remarks on the Philosophy of Psychology*, and it looked at first sight as if this farmhouse would be ideal. When the Wicklow farmhouse didn't prove entirely to Wittgenstein's liking, it was Drury again who arranged for him to return to the Rosro cottage, which

he found more satisfactory, and where he stayed for several months. Later in the year, Drury advised him against spending the winter in Connemara, and we find Wittgenstein booking himself into a room at the top of Ross's Hotel in Dublin, now the Ashling Hotel. He spent the winter of 1948 there, meeting Drury almost every day – they often had lunch together at Bewley's Café in Grafton St. – and he stayed on at the hotel until June of the following year. He was not very well during these months of 1949, and one has the impression that by the time he comes to leave the hotel – and Dublin and Ireland – that he has come to the end of his last active period as a philosopher. A diagnosis of prostate cancer was made later that year and he would die two years later, in 1951. In that same year, Drury married the matron of St Patrick's Hospital, Eileen Stewart. In 1969 he was promoted to senior Consultant Psychiatrist at St Patrick's. Among the projects he worked on in his later career was a book on hypnosis – he had come to believe that hypnosis could be useful in treating phobic disorders – but the book was never published. He died in Dublin on 25 December 1976.

Against Method: Drury and the Mental Science Project

Given the length of time that Drury spent in Wittgenstein's company, given the esteem in which he held Wittgenstein, and given the notoriously dominating nature of Wittgenstein's personality, it is to be expected that he would leave his mark on Drury's thinking, including Drury's thinking about his own profession, psychiatry. Despite his behaviouristic conception of the relationship between mind and body, Wittgenstein had raised serious doubts over the possibility of a psychological science. We find this doubt expressed everywhere in Drury's writing, especially in *The Danger of Words*. This book has been described by Ray Monk in *The Duty of Genius* (1990) as 'the most truly Wittgensteinian book published by any of Wittgenstein's students' (264). I will be suggesting, however, that, despite the impact that Wittgenstein had on his life and mind, Drury's perspective is not consistently Wittgensteinian and that in one important respect it could be said to be anti-Wittgensteinian.

Drury's guiding intuition is that psychology is not and cannot be a science like physics or chemistry. The reason for this difference between the subject-matter of psychology and that of the sciences does not have to do with the greater complexity of the human psyche or personality but with something altogether more significant. Those areas and aspects of experience that make

up the psychological life of an individual are, by their very nature, not available for exact observation or, indeed, observation of any kind. Psychology and psychiatry, insofar as they purport to treat the individual in all her uniqueness and peculiarity, cannot hope to arrive at a universal method, since such a method is not designed to detect or register those very features that make individuals peculiarly themselves. The more one attempts to apply general categories – such as 'introvert' or 'extrovert' – to human beings, the more their individuality is ignored and diminished. What is of the deepest concern to the therapist especially is not universals but particulars – not general categories of classification but particular persons with particular personalities and particular problems arising out of particular personal, social, and historical circumstances (1973: 35). The closer the therapist gets to the person-as-patient the less methodic or 'scientific' will be her understanding of him. The more indeed she will tend to find the patient to be enigmatic and in a certain sense 'un-understandable'. This sense of the 'un-understandable' does not indicate some kind of failure on the part of the therapist but rather a kind of success – an effective recognition and appreciation of the irreducible and inalienable individuality of the patient-as-person.

The mentally ill person should be seen, on Drury's view, as even more of an enigma than the 'normal' individual. No advance in treatment or theory can alter the fact that there will always be a mystery about mental ill-health that will make it different from any disease of the body (1973: 89). This hidden inwardness is the rock on which a scientific and objective psychology will come to grief: 'The truth is that we human beings are not meant to study each other as objects of scientific scrutiny, but to see each other as an individual subject that evolves according to its own laws' (1973: 43). If a scientific approach cannot enable us to 'know' each other when we are in good mental health, neither can it help us to 'know' each other when mental ill-health befalls one or other of us. Every mentally ill person is indeed 'an individual enigma', and should not be approached as anything less. In other words, he or she should not be approached with a reductive, objectifying, de-personalizing technical terminology. Method in such circumstances is anathema. One of the dangers of words, especially technical, objective, methodical words, is that they can all too easily be pressed into service as a way of homogenising the peculiarities they are supposed to identify and explain – as a way of 'glossing over' the very elusive features to which the therapist should be most attentive. For all the information the therapist may have, he still has to come to terms with the patient in a way that is not reducible to the terms of the psychological

sciences. The sort of propositional knowledge that is available to the scientist is different from the kind of 'knowledge by acquaintance' that the therapist must be prepared to engage in.

In an effort to clarify his position Drury introduces a distinction between 'psychology A' and 'psychology B' (1973: 37–50). Psychology A is practiced to some extent by everyone in the course of interacting with other people, and is sometimes practiced to a gifted extent by those whose long experience enables them to make insightful observations, and to have insightful responses to, the behaviour of other people. Psychology B, on the other hand, is the outcome of the effort to develop a scientific, experimental and objective psychology, to introduce standards of measurement into the observation of human behaviour. For Drury, the mental science project should not be allowed to replace psychology A, as if the latter were simply a pre-scientific, folksy, primitive version of the former. Psychology A and psychology B are incommensurable. Psychology A deals with the immeasurable, with 'the hidden inwardness' that is never going to be available to the practitioners of psychology B. It is erroneous to suppose that psychological science is perfecting a method that will eventually render unnecessary the clinical insight gained by long experience and informed intuition.

So determined is Drury to protect the primacy of a pre-scientific, intuitive, interpersonal psychology that he tends to mystify the individual psyche. He discusses the relationship between mind and body as an ethical as well as a metaphysical or scientific question. To make mind too understandable or too transparent, as if it could be 'read off' from physical behaviour or brain activity, is a morally suspect move. It is to play into the hands of those who would generally wish to objectify human beings and calculate their ratio or degree of 'humanity' on that objective basis. The morally preferable view here is the Socratic view that the soul is in some meaningful sense imprisoned within the body and that the individual mental life is therefore never fully available to observers, especially not to scientific observers. Even brain damage does not reduce the enigmatic nature of the individual psyche. There is in fact even more enigma in the case of brain-damaged persons. The proper Socratic view of those whose brains have been damaged should be that 'they are shut off from us by barriers that neither we nor they can break' (1973: 88). Drury presents the Socratic picture of the mentally handicapped person, for example, not as a hypothesis 'but as a decision of the will, a decision of ethics where neither physiology nor any other science can come to our aid' (89). Even to say that someone is *mentally* handicapped becomes problematic on such

a view. The leap from the physical to the mental will always remain – should always remain – a leap into the realm of the enigmatic, the irreducible, the inexplicable.

Enigma and Therapy: Drury's Problem, Macmurray's Solution

A problem emerges at this point in Drury's approach. He is so determined to respect, even revere, the uniquely individual patient that he seems close to undermining his own role as professional therapist, as well as undermining the role of the psychological sciences in general. He undermines the psychological sciences by speaking as negatively as he does about the dangers of the methodic approach and the technical, scientific vocabulary. By privileging psychology A as much as he does, it is hard to see what useful information or insight can be retrieved from the methodic studies undertaken by psychology B. It is difficult to see how he can rebuild a bridge between the two psychologies, and yet it seems unreasonable to suggest that such a bridge should not exist. Clearly, as a psychiatrist, Drury did make use of therapeutic procedures that were considered 'best practice' among the community of psychiatrists of his era. But in his reflective or philosophical work it is hard to see where he has made a case for such procedures, so great is his antipathy to anything that objectifies or depersonalizes the patient. Drury's motivation is commendable – he wants to protect the interiority and privacy of the patient by putting a deeply respectful distance between therapist and patient, and also between how the patient appears to the therapist and how he is, inwardly, in himself. By doing so, however, he ends up with a paradoxical result; he ends up protecting the patient from the therapist who is supposed to heal him, and so reduces the therapist, in theory at least, to revering rather than treating the patient. A theory of respect and reverence has replaced a theory of therapy and treatment.

This is where Macmurray, working with a different model of the relationship between the physical and psychological sciences, and also a different model of the internal relationships between self and body, can be interpreted as offering a solution to the conundrum posed by Drury's approach. Significantly, Macmurray's concept of the self-as-agent is more Wittgensteinian than Drury's reverential, Socratic conception of the person. For Macmurray, the self is best thought of as a dynamically embodied, socially engaged agent that discovers itself from the beginning in the company of others. The defining feature of the person is not the ability to think but the ability to act intentionally, always with

reference to, and in the company of, others. This interpersonal relationship is the primary formative human relationship, from which all others are derived. The personal precedes the impersonal, as far as our original perception of the world is concerned. Even our concept of a thing or object is relative and secondary to our experience of the personal. As children we learn that a *thing* is that which is not a person, that which will not come to us, that which resists us passively, that which cannot move by itself, that which can on the other hand serve as a means or instrument. Historically, we have had to learn to see the world less personally, to see impersonal objects and processes where before we saw intentional beings, such as gods and spirits, at work in nature and the cosmos. We can also learn to see and understand ourselves and others impersonally, and this is perfectly in order,–provided that our scientific, impersonal knowledge is always subordinated to the norms and requirements of our personal relationships.

Macmurray uses the example of a teacher of psychology who is visited by a student (1970: 29–37). The encounter begins as a simple personal conversation in which the teacher adopts a normal personal attitude to the student. But as the conversation develops, the teacher notices that something is wrong, that the student is in an abnormal state of mind, and is showing symptoms of hysteria. At once the relationship changes. The teacher becomes a professional therapist, observing and diagnosing a case of mental disorder. In other words, the relationship has switched from a personal to an impersonal one; the teacher's attitude has become impersonal, objective, scientific. The student has ceased to be a fully intentional agent and is now being treated as 'a problematic case'. The psychologist in the teacher is now observing the student and asking himself, 'What is the matter with him?' The student's abnormal behaviour has itself triggered what is an abnormal attitude in the teacher. The departure from the personal and normal is not an arbitrary change of mind on the part of the teacher but has been necessitated by the abnormal behaviour of the student. The abnormality in the student's behaviour makes the personal attitude difficult, if not impossible, to sustain. The abnormality in question has effectively depersonalized the student, limiting his freedom, his ability to act freely and intentionally, compromising his ability to control certain aspects of his life and behaviour and personal relationships with others. Behaviour that should be under rational, conscious control has become neurotic or compulsive–has become something caused rather than something intended. What now justifies the adoption of an impersonal attitude on the part of the psychologist is the determination of the psychologist to restore

the student to normal health, to restore intentional control, so that once more he can enter fully into normal personal relationships. 'The activity directed by the impersonal attitude is justified only if it falls within and is subordinated to an intention to restore the other person to normal health' (36) – that is, 'if it falls within and is subordinated to a personal norm' (37). What this means is that the impersonal attitude is not an alternative to the personal one, but is the means by which the personal can be protected or restored. The personal remains primary.

The notion that the personal could be supplanted by the impersonal is mistaken; equally mistaken, though, is the notion that the impersonal attitude, as articulated in the psychological sciences, is a mortal threat to the personal attitude or the personal norm. Drury's mistake is to assume that because the personal attitude is primary then it is always desirable and possible in every human encounter. But this is not so. Where there is mental illness, the personal attitude, including the capacity to enter into full personal relationships, may be seriously compromised. In that event, the personal is not what is natural or normal but is precisely what has been lost or distorted and that has to be achieved or restored through therapy. The kind of knowledge acquired in the psychological sciences may help in the treatment of the conditions that are threatening someone's autonomy as a person and intentional agent. On this view, it is not science, or the use of an objective method, that necessarily depersonalizes the patient but rather the very condition that has brought the patient to the therapist in the first place. The very thing that Drury's wants to celebrate – the enigma or mystery of the individual patient – is just what is thrown into jeopardy by illness. While the defender of Drury's position will object that the impersonal approach always threatens the preciously unique inwardness and individuality of the patient, the defender of Macmurray's position can claim that the real threat to inwardness, individuality, and enigmatic self-possession comes not from the impersonal approach of the therapist but from the mental illness itself. It is the mental illness that threatens the very self-possession and self-conscious agency that fortifies the inner life and gives every person the power to remain enigmatic to others.

Drury's reverence for the enigma of the personal may be based on the conflation of two kinds of enigmatic personality – on the one hand, the kind of enigma that is the result of self-possessed intentional action, and, on the other, the kind of enigma that has involuntary causes. It is difficult, for example, to enjoy a normal personal relationship with the person who is involuntarily enigmatic due to psychosis. Such enigma is problematic for

the patient because—or at least partly because—it is problematic for those who come into contact with the patient. The same difficulty does not necessarily arise with the person who makes himself voluntarily enigmatic (by, for example, insisting on keeping certain feelings and thoughts completely private.) There is, we might say, a world of difference—a mental world of difference—between the two sorts of personal enigma. The mentally ill person is like the player at the card table who has a compulsion to show his hand, whereas the mentally healthy person is like the player who is able to keep his cards to himself, keep his intentions to himself, keep himself to himself, thus rendering himself rightly and rightfully enigmatic to others. The point of therapy, of adopting the impersonal but sympathetic method of psychological science, is (on Macmurray's perspective) to restore to the patient the quality of self-control, self-possession, and self-conscious agency that will help preserve and promote precisely the sort—the right sort—of inwardness and individuality that Drury values so highly.

I am going to conclude with a warning, one that might be issued by a defender of Drury, a warning about the dangers of the impersonal attitude. When Macmurray writes about therapy, he does so optimistically, as if it is always successful, as if the patient is always restored to full mental health, full rational agency, and full self-control. But Drury, as a practicing psychiatrist, would have known that this is not always so, that too often people with mental illness are not cured, that their conditions are at best managed or mitigated. There is always a danger, given the intractability of some mental disorders, that some long-term patients, or people with long-term problems, will be subjected to long periods of impersonal treatment or symptom management. When this happens we get the worst kinds of institutionalization or medicalization, in which people lose all agency and autonomy. The defender of Drury's Socratic philosophy of respect and reverence, and his suspicion of the impersonal approach, is warranted in the historical context of a profession that has not always understood the important difference between short-term therapies, in which patients are restored to full health after a limited period of impersonal treatment, and long-term treatments in which the patient is not restored to full health but rather suffers the worst consequences of a failed impersonal regime.

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