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Enduring Emotions

James L. Halliday and the Invention of the Psychosocial

By *Rhodri Hayward**

ABSTRACT

Emotions maintain an ambivalent position in the economy of science. In contemporary debates they are variously seen as hardwired biological responses, cultural artifacts, or uneasy mixtures of the two. At the same time, there is a tension between the approaches to emotion developed in modern psychotherapies and in the history of science. While historians see the successful ascription of affective states to individuals and populations as a social and technical achievement, the psychodynamic practitioner treats these enduring associations as pathological accidents that need to be overcome. This short essay uses the career of the Glaswegian public health investigator James L. Halliday to examine how debates over the ontological status of the emotions and their durability allow them to travel between individual identity and political economy, making possible new kinds of psychological intervention.

“WE LIVE,” James L. Halliday gloomily concluded in 1949, in an “Anal Age.” At a time when the British people were embracing optimistic plans for social reconstruction following the sacrifices of World War II, Halliday, an investigator for the Scottish Department of Health, proposed a more cynical analysis of the human situation. In a number of programmatic articles, radio interviews, public lectures, and his book *Psychosocial Medicine* (1947), he claimed that the British population had entered a period of terminal decline.¹ He did not attribute this decline to external calamities (such as the world

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¹ James L. Halliday, *Mr. Carlyle: My Patient* (London: Heinemann, 1949), p. 216; and Halliday, *Psychosocial Medicine: A Study of the Sick Society* (1947; London: Heinemann, 1948). For popular uptake see Halliday, “At the Mental Seams,” *Time*, 22 Mar. 1948, pp. 63–65; Halliday, “Social Health in the Twentieth Century,” in *Mental Health and the Family: Proceedings of a Conference on Mental Health, London, 23–24 March 1950*

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wars) or to eugenic difficulties. Instead, he insisted that the health and fertility of the people were being undermined by a global transformation in their emotional state. He argued that the country, like other Western democracies, was undergoing a kind of epidemiological transition in which the decline in mortality from infectious diseases was accompanied by a concomitant rise in the “psychosomatic affections”—illnesses such as asthma, rheumatism, and peptic ulcer—that were created through personal anxiety. Britain’s anal attitude was rooted in the population’s refusal to surrender its pathological emotions.

Halliday did not simply argue that psychosomatic affections had increased in incidence; he also claimed that they had changed in form. Along with many of his neurological and psychiatric colleagues, he maintained that the interwar period had witnessed the disappearance of the old classical form of hysteria. The aphonias, aphasias, and paralyses that had once characterized the hysteric had been replaced by new somatoform disorders and anxiety states.² The emergence of these novel forms of embodied psychological distress could be seen as opening up a new register of emotional expression and different ways of investigating and assessing the population’s affective state. In its new somatic forms, individual emotion became visible in the state schemes of health surveillance inaugurated by the Workmen’s Compensation Acts of 1897, 1901, and 1906 and the National Insurance Act of 1911.³ The flux of the emotional life was no longer simply traced through the individual patient’s case history; it could be mapped through the various insurance claims submitted across the population as a whole. Leaving a trail through flesh and paper, emotional states moved from being the objects of individual psychology to become the objects of national demography.

Halliday developed a complex psychohistorical narrative to explain this transformation in the incidence, presentation, and visibility of emotional and psychosomatic illness. He argued that the introduction of cheap rubber supplies from South America toward the end of the nineteenth century had led to a decline in breast-feeding as commercial teats became available. This created, in psychoanalytic terms, an anxious, orally frustrated population that was further undermined by the rising economic insecurity and crass materialism of the interwar decades.⁴ In this historical situation, illness became a means to an end. The sick poor, according to Halliday, looked to the state for maternal reassurance; and the new framework of national insurance, established by the liberal governments of Herbert Asquith and David Lloyd George, provided them with the sense

(London: National Association of Mental Health, 1950), pp. 8–18, 26; and *Mental Health in Our Time: An NBC Radio Discussion by Malcolm Sharp, Rayard West, and James L. Halliday* (University of Chicago Round Table no. 544, 22 Aug. 1948).

² Halliday, *Psychosocial Medicine*, pp. 111–126. For contemporary commentaries on the changing presentation of hysteria see J. Campbell McClure, “Psychology and the Practice of Medicine,” *British Medical Journal*, 29 Mar. 1930, pp. 611–613; S. A. Kinnier Wilson, “The Approach to the Study of Hysteria,” *Journal of Neurology and Psychopathology*, 1931, 11:193–206; and D. T. Davies, “Some Observations on Peptic Ulcer [Bradshaw Lecture],” *Lancet*, 7 Mar. 1936, pp. 521–524, 14 Mar. 1936, pp. 585–592. On this transition see Mark Micale, “On the ‘Disappearance of Hysteria’: Notes on the Clinical Deconstruction of a Diagnosis,” *Isis*, 1993, 84:496–526; and Edward Shorter, “Paralysis: The Rise and Fall of a ‘Hysterical’ Symptom,” *Journal of Social History*, 1985–1986, 19:549–582.

³ David Armstrong, *The Political Anatomy of the Body* (Cambridge: Cambridge Univ. Press, 1983), Chs. 4, 5.

⁴ James L. Halliday, “The Rising Incidence of Psycho-Somatic Illness,” *Brit. Med. J.*, 2 July 1938, no. 4043, pp. 11–14. See also Mark Jackson, *Allergy: The History of a Modern Malady* (London: Reaktion, 2006), pp. 185–186.

of care and security that had been withheld from them in their emotionally deprived childhoods.⁵

At one level, Halliday's analysis seems to be part of a long tradition in which new social arrangements are criticized through reference to emergent psychopathologies. These critiques began with the "English malady" of the eighteenth century and persist into media claims about an outbreak of "affluenza" today.⁶ Such arguments were commonplace among Halliday's contemporaries, and many elite physicians drew on anecdotal medical evidence to call for the complete reformation of modern civilization. But whereas these critiques had depicted psychological distress as an accident of social development, Halliday's scheme was figured on a different terrain. In his writings, the emotions assumed a central position. Indeed, it was the emotions, rather than abstract rights and obligations, that mediated the individual's relationship to the state. The state assumed a matriarchal role, as it had done in early modern political economy, but this time the affective form of its relationship was scripted through the incipient language of psychoanalysis.⁷

This idea of emotional citizenship was drawn from the work of a fellow Glaswegian, the heterodox analyst Ian Suttie (1889–1935). From the beginning of the 1920s, Suttie had been engaged in a vigorous critique of psychoanalytic doctrine, particularly Freud's assumption of an oppositional relationship between biological instincts and civilization. In contrast to the antagonistic relationship between society and desire that Freud had described in *Civilization and Its Discontents* (1930) and *Totem and Taboo* (1913), Suttie insisted that emotional development was made possible through the individual's place in a network of wider relationships.⁸ This extended network was the "psychosocial": a point of intersection between the individual, the state, and society that Suttie, and later Halliday, came to believe was crucial to emotional health. However, whereas Suttie's idea of the psychosocial was largely established through his utopian faith in the political possibilities of emotional growth, Halliday's more pessimistic assessment was grounded in a new emotional metrics. The psychosomatic embodiment of distress and the establishment of new schemes of state welfare meant that the effectiveness of any political reformation could be assessed through reference to the new epidemiological data made available by the administration of national insurance schemes.

In Halliday's description of the psychosocial and his use of insurance returns to map the changing psychological state of the population, we can see the emergence of a new

⁵ James L. Halliday, "Psycho-Somatic Medicine and the Declining Birth Rate," *Lancet*, 12 May 1945, p. 605; and Halliday, *Psychosocial Medicine* (cit. n. 1), p. 138.

⁶ See George Cheyne, *The English Malady* [1733], ed. Roy Porter (London: Tavistock/Routledge, 1991); and Oliver James, *Affluenza* (London: Vermillion, 2007).

⁷ On the resurgence of matriarchal models of statehood in interwar Britain see Luisa Passerini, *Europe in Love, Love in Europe: Imagination and Politics between the Wars* (London: Tauris, 1999), esp. Ch. 3. Regarding the arguments of Halliday's contemporaries see Stephen Taylor, "The Suburban Neurosis," *Lancet*, 26 Mar. 1938, pp. 759–761; C. P. Donnison, *Civilization and Disease* (London: Balliere, Tindall & Cox, 1937); Christopher Lawrence, "Still Incommunicable: Clinical Holists and Medical Knowledge in Inter-war Britain," in *Greater Than the Parts: Holism in Biomedicine, 1920–50*, ed. Lawrence and George Weisz (Cambridge: Cambridge Univ. Press, 1998), pp. 94–111; Rhodri Hayward, "Desperate Housewives and Model Amoebae: The Invention of Suburban Neurosis in Inter-war Britain," in *Health and the Modern Home*, ed. Mark Jackson (London: Routledge, 2007), pp. 42–62; and Charles E. Rosenberg, "Pathologies of Progress: The Idea of Civilization as Risk," *Bulletin of the History of Medicine*, 1998, 72:714–730.

⁸ Ian Suttie, "The Development and Evolution of Mind: Biological vs. Psychosocial in Interpretations of the Ontophylogenetic Parallelism," *J. Neurol. Psychopathol.*, 1924, 5:133–145; Suttie, "Some Aspects of Sociology in Their Psychiatric Aspect," *Journal of Mental Science*, 1923, 69:49–51, 180–182, 314–322; and Suttie, *The Origins of Love and Hate* (1935; Harmondsworth: Penguin, 1960), Ch. 8.

affective domain of political intervention and a new technology of emotional expression. In the short essay that follows, I focus on Halliday's career in public health and his intimate biography to explore the relationship between these innovations and wider questions regarding the ontological status of emotions, their relationship to forms of truth telling, and the novel kinds of self-description that these developments might make available. Along the way, I want to show how the scientific attempt to render emotions durable in schemes of social administration was reflected in Halliday's ambivalence about the permanence and mutability of his own emotions.

THE EMOTIONS AS BENCHMARKS OF PUBLIC LIFE

As the reference points for a new sociopolitical order, the emotions seem to be unlikely candidates. They appear, on the briefest moment of introspection, to be ephemeral. Feelings can be easily lost when our attention is distracted, and even the most intractable emotions can change in response to conversation or chemical intervention. This labile quality has provoked an intense debate over their ontological status. Anthropologists, social psychologists, and sociologists have claimed that emotions are simply social conventions that vary across time and between cultures.⁹ At the same time, cognitive and evolutionary psychologists have contended that certain basic emotions, including anger, fear, disgust, and pleasure, should be seen as universal states with a common neurological foundation. These basic emotions, they argue, are part of our fundamental biology, arising out of inherited programs of coordinated action and response that are hardwired into the individual.¹⁰

As most historians of science will recognize, emotions seem to exist in an uneasy hinterland between the categories of natural and human kinds. Their form and categorization can be seen, respectively, as a reflection of discrete biological processes or shared cultural conventions. This ambiguity is significant, for it makes possible different narrative descriptions of the world. As the anthropologist Vincent Crapanzano has noted, simply naming or identifying an emotion works (in his phrase) to "call the context." Finding out that an individual is angry or anxious will change how we view his or her situation. Moreover, treating these emotions as natural kinds with a "presumed referentiality" shifts notions of agency and responsibility away from the conscious subject.¹¹ Similarly, approaching emotion as a strategic cultural performance works to reverse these

⁹ The literature is vast. For overviews see Rom Harré and W. Gerrod Parrot, *The Emotions: Social, Cultural, and Biological Dimensions* (London: SAGE, 1996); and J. H. Turner and J. E. Strets, "Sociological Theories of Human Emotions," *Annual Review of Sociology*, 2006, 32:25–53.

¹⁰ L. Cosmides and J. Tooby, "Evolutionary Psychology and the Emotions," in *Handbook of Emotions*, ed. M. Lewis and J. M. Haviland-Jones, 2nd ed. (New York: Guilford, 2000), pp. 91–115; and Paul Ekman, "Afterword," in Charles Darwin, *The Expression of the Emotions in Man and Animals*, ed. Ekman (Oxford: Oxford Univ. Press, 1985). For a sensitive defense of the affect program model, arguing that it should be used to refine our emotion categories, see Paul E. Griffiths, *What Emotions Really Are: The Problem of Psychological Categories* (Chicago: Univ. Chicago Press, 1997).

¹¹ Vincent Crapanzano, *Hermes' Dilemma and Hamlet's Desire: On the Epistemology of Interpretation* (Cambridge, Mass.: Harvard Univ. Press, 1992), pp. 229–238. On the ambivalent status of the emotions see Lisa Feldman Barrett, "Are Emotions Natural Kinds?" *Perspectives on Psychological Science*, 2006, 1:1–31; Thomas Dixon, "Why I Am Angry," *TLS*, 1 Oct. 2004, pp. 3–5; John Sabini and Maury Silver, "The Not Altogether Social Construction of Emotions: A Critique of Harré and Gillett," *Journal of the Theory of Social Behavior*, 1998, 28:223–235; and Phoebe Ellsworth, "Levels of Thought and Levels of Emotion," in *The Nature of Emotion: Fundamental Questions*, ed. Paul Ekman and Richard J. Davidson (Oxford: Oxford Univ. Press, 1994), pp. 192–196.

processes. The different ways in which we see emotion are inherently political. Uncertainty over their ontological status cannot be resolved through theoretical reflection; rather, as Halliday's career demonstrated, this resolution is a practical achievement made possible through coordinated social action and experimental intervention.

We categorize the world through schemas developed in mundane contexts and adopted for pragmatic reasons. Halliday first engaged with the issue of ontology in the late 1920s, when he was working as an Assistant Medical Officer for Glasgow City Council. It was an engagement born out of the frustrations of disease control, but it led to his redescription of the basis of the emotions and paved the way for the establishment of the psychosocial domain.

REFIGURING THE EMOTIONS: THE 1929 GLASGOW INFLUENZA EPIDEMIC

Halliday was appointed Assistant Medical Officer for South Glasgow in July 1928, after working as ship's surgeon, port officer, and locum GP. It was, in some ways, an untimely promotion. Six months after he took up the post, the city was facing a serious outbreak of influenza that would kill 533 residents within the space of seven days and 4,537 over the course of the year.¹² The sheer ferocity of this outbreak, Halliday claimed, led him to question the contemporary assumptions of pathology and epidemiology. He rejected the idea of disease as a discrete object and instead imagined it as a process involving "the vital reaction of the whole individual in response to external stimuli."¹³ It is worth dwelling on Halliday's reaction to the problem of influenza, for it opened up the whole issue of the ontological status of emotions.

In his skepticism over the basis of disease, Halliday found himself allied with a powerful group of patrician critics, including Major Greenwood of the London School of Hygiene and Tropical Medicine; William Hamer, the Medical Officer of Health for London; and Francis Graham Crookshank, a well-known medical controversialist. These physicians were deeply hostile to the claims of the new bacteriology, vigorously disputing the idea that every illness could be traced back to an individual pathogen. The bacteriological model, they contended, ignored the rich complex of interacting variables that were necessary to produce a case of illness. The logic of bacteriology, as Crookshank jibed, was the equivalent of finding bullets in the body of a dead soldier and then claiming that these bullets must be the cause of war. Such a view, he insisted, was mistaken. An epidemic was not brought about by the increased activity of pathogens, just as war was not produced by "an exaltation in the virulence of bullets and gas, or by a diminution in the resistance to these agencies: it was our name," he argued, "for a state of affairs that we conceive as brought about by the play and interplay of racial, economic and other factors."¹⁴

¹² For the mortality figures see *Glasgow Health Bulletin*, 1929, 6(1):1, 4–5; and Alexander MacGregor, *Public Health in Glasgow* (Edinburgh/London: Livingstone, 1967), pp. 30–31. On Halliday's career see Andrew Hull, "Medicine, the State, and the Psycho-Social Roots of Disease," *History of the Human Sciences*, forthcoming.

¹³ James L. Halliday, "The 'Flu Age,'" *Glasgow Evening Times*, 16 Jan. 1929, Glasgow University Library Special Collections MS Gen. 1669, Papers relating to Dr. James Lorimer Halliday, Glasgow University MS 1669/25; Halliday, "The Mystery of Influenza," public lecture, Glasgow City Public Health Department, 16 Dec. 1929, Glasgow University MS 1669/618; and "Application by James L. Halliday for the Chair for Social and Preventative Medicine, at the Queen's University of Belfast," Glasgow University MS Gen 1669/26/III.

¹⁴ Francis Graham Crookshank, "First Principles and Epidemiology," *Proceedings of the Royal Society of Medicine [Section of Epidemiology and State Medicine]*, 1919–1920, 13:15–184, on p. 178. On the hostility to epidemiology more generally see Olga Amsterdamska, "Demarcating Epidemiology," *Science, Technology, and Human Values*, 2005, 30:17–51.

In their rejection of the idea of disease as a discrete entity, these physicians advocated a kind of heady nominalism, rooted in the new philosophy of “Basic English” advocated by the Cambridge critics C. K. Ogden and I. A. Richards. Writing in the appendix to their definitive work, *The Meaning of Meaning* (1923), Crookshank argued that modern medicine rested on a confusion of “names, notions and happenings,” adding that “it is a vulgar medical error, to speak, write and ultimately to think, as if these *diseases* we name, these *general references* we symbolise, were single things with external existences.”¹⁵ Halliday embraced this philosophy, arguing that “fallacies and confusions are inevitable when specific concepts are regarded as having an objective existence.” This aggressive nominalism did not lead Halliday into some kind of barren skepticism; rather, he believed his critical epistemology could be used to reveal new truths. In *Psychosocial Medicine* he drew on Crookshank once again, quoting with approval his idea that the “construction of new concepts” would allow us to “enlarge the range of our perceptual experiences and so become acquainted with new facts.”¹⁶ For Halliday, the “new facts” made available by this linguistically enhanced perception were the collective emotional states that constituted the psychosocial domain.

Crookshank and Greenwood shared Halliday’s interest in the nature of the emotions. They were enthused by the new dynamic psychologies of George Groddeck and Alfred Adler, insisting that emotional states played a central role in the formation of illness.¹⁷ Their arguments promoted a kind of ontological equivalence between psychological and biological agents: each was a necessary element in the disease. Implicit in such claims was an idea of the durability of emotion. It was not enough for emotions to enjoy a simple fleeting presence in the world: their existence would need to be made stable and visible, in much the same way that the presence of a pathogen might be made apparent through the Wasserman reaction or the Mantoux test.

For his part, Halliday sought to demonstrate the enduring presence of the emotions in a number of ways. First, he drew on contemporary developments in anatomy, neurophysiology, and endocrinology to argue for a discrete biological architecture for the emotions. He held up the diencephalon (i.e., the thalamus and hypothalamus), the autonomic nervous system, and the endocrines as allowing for the integration of psychological reactions and their somatic expression. As he noted in an address to the Royal Society of Medicine in 1937: “If, as physiologists, we consider that the function of the diencephalon is ‘sensing and feeling,’ we are enabled to understand how psychological factors of the environment ‘touch’ the individual at the organs of the special senses and thus bring into action mechanisms which may cause, ultimately, changes in the chemistry, secretion, rhythm, muscle tonus, etc.”¹⁸ In Halliday’s writings, the diencephalon provided an objective,

¹⁵ Francis Graham Crookshank, “Supplement II: The Importance of the Theory of Signs and the Critique of Language in the Study of Medicine,” in C. K. Ogden and I. A. Richards, *The Meaning of Meaning: A Study of the Influence of Language upon Thought and of the Science of Symbolism* (London: International Library of Philosophy, Psychology, and Scientific Method, 1923), pp. 511–537, on pp. 516, 518; see also Crookshank, “Word Magic in Modern Medicine,” *Cambridge Magazine*, 1923, 1:57–64, esp. p. 59.

¹⁶ James L. Halliday, “Fallacies and Confusions,” Glasgow University MS Gen 1669/602; and Halliday, *Psychosocial Medicine* (cit. n. 1), p. 44. For Halliday’s clearest demonstration of his debt to Crookshank see Halliday, “The Significance of the Concept of Psychosomatic Affections,” *Psychosomatic Medicine*, 1945, 7:240–245.

¹⁷ For their arguments see Rhodri Hayward, “From Clever Hans to Michael Balint: Emotion, Influence, and the Unconscious in British Medical Practice,” in *Medicine, Emotion, and Disease, 1700–1950*, ed. Fay Bound Alberti (Basingstoke: Palgrave Macmillan, 2006), pp. 144–167.

¹⁸ James L. Halliday, “The Psychological Approach to Rheumatism,” *Proc. Roy. Soc. Med. [Sect. Epidemiol. State Med.]*, 1937–1938, 31:167–175, on p. 167. For interwar ideas on the function of the diencephalon see John

anatomical referent for the actions of the emotions. It made them physically durable and, as we shall see, extended their duration through time.

Halliday's understanding of the diencephalon was derived from the contemporary researches of Walter Cannon, Paul Bard, and John Fulton. In a number of experiments, these American neuroanatomists and physiologists demonstrated that states of emotional excitement persisted in animals that had undergone decortication (i.e., the surgical separation of the cerebral cortex). This intervention removed the inhibitory controls of the frontal lobes and made possible the uninterrupted activity of the hypothalamus. The persistent emotions produced in the "sham rage" of these laboratory animals generated a whole series of pathological effects. Conditions ranging from gastric ulcers through to the cases of voodoo death described by Cannon were all produced through the continual activation of the autonomic nervous system.¹⁹ The visibility of the emotions was intrinsically bound up with their pathology; and their pathology was predicated on their duration.

In his attempt to demonstrate the ontological equivalence of infective agents and emotional states, Halliday reveals a subtler truth: he shows how the contemporary philosophical and anthropological debates about the status of emotions are contingent on a series of technological and anatomical achievements. The shift from nominalism to realism (and back again) is made possible through material and theoretical innovations. Emotions are made durable by locating them in wider anatomical and technological networks. As the work of Cannon and Bard demonstrates, the emotions become susceptible to scientific investigation by virtue of their extension through time, and this extension in turn becomes the mechanism that explains their pathological actions. The emotion, to borrow Allan Young's felicitous gloss on Ludwik Fleck's work, is a "techno-phenomenon"; it was produced through the intersection of specific perspectives, practices, and technologies.²⁰

The conception of emotion as a natural kind and its emergence at a particular point of intersection between different registers made possible novel forms of investigation. At a forensic level, tension between registers could be taken as a sign of the uncertain basis of a declared feeling. This uncertainty was revealed in the disparities between the subject's verbal assertion of his or her inner state and the physiological evidence made available by new technologies such as the kymograph and the electroencephalograph. Such disparities undermined the idea of a real referent for the emotions. At the same time, claims about one's internal physical state that lacked the appropriate set of physiological signs, such as evidence of nerve injury or bacterial infection, could be ascribed to emotional processes such as anxiety or melancholia. The ontological traffic around the concept of emotion would become central to Halliday's work after 1931, when he took up a new post as Regional Medical Officer for the Scottish Department of Health.

Beattie, "Clinical Aspects of Hypothalamic Derangement," in W. E. Le Gros Clark *et al.*, *The Hypothalamus: Morphological, Functional, Clinical, and Surgical Aspects* (Edinburgh: William Ramsay Henderson Trust with Oliver & Boyd, 1938), pp. 116–118; Le Gros Clark, "Functional Localization in the Thalamus and Hypothalamus," *J. Mental Sci.*, 1936, 82:99–118; and W. L. Brown, "Remarks on the Endocrines and Some Associated Psychoneuroses," *Brit. Med. J.*, 6 Feb. 1932, no. 3709, pp. 223–226.

¹⁹ Walter B. Cannon, *Bodily Changes in Pain, Hunger, Fear, and Rage: An Account of Recent Researches in the Function of Emotional Excitement* (New York/London: Appleton, 1929), p. 242; and Cannon, "Voodoo Death," *Psychosomat. Med.*, 1957, 19:182–200. On the work of Cannon, Bard, and Fulton see Otniel E. Dror, "The Affect of Experiment: The Turn to Emotions in Anglo-American Physiology, 1900–1940," *ISIS*, 1999, 90:205–237; and Dror, "Techniques of the Brain and the Paradox of Emotions, 1880–1930," *Science in Context*, 2001, 14:643–660.

²⁰ Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton, N.J.: Princeton Univ. Press, 1996), pp. 9–10.

HALLIDAY AS A CLAIMS ASSESSOR: EMOTIONS AND TRUTH

As Regional Medical Officer, Halliday was engaged in the investigation and policing of referred national insurance claims. Over the course of eight years he investigated twenty thousand cases, subjecting claimants to a battery of tests in order to discover the objective bases of their apparent illnesses. However, it was in the failure of these tests that the subjective presence of the emotions was made clear. As Halliday explained: “The examination centre in Glasgow is equipped with test-room facilities for blood counts, test meals, etc., and a staff of consultants is available including a cardiologist, neurologist, surgeon, and ophthalmologist. These were freely used, and yet a large number of patients examined showed no sign of organic disease, and the reports from their practitioners about the course of the illness described no organic findings.”²¹

In his ascription of the claimants’ orphaned symptoms to the presence of the emotions, Halliday reiterated a move that had become increasingly common in British investigations into illness and malingering. With the establishment of new regimes of social welfare, the doctor’s task, as many practitioners complained, had been transformed from assisting a patient to policing a claim. In physicians’ attempts to maintain older forms of paternal relationship with their patients, causeless symptoms that would once have been attributed to malingering or “swinging the lead” were now ascribed to emotional insecurities over which the patient had little control. The doctor-patient relationship was preserved, but only through the invention of a sacrificial third party—the unconscious or uncontrolled emotional life—that could be scapegoated as the hidden author of the sufferer’s unconscious symptoms. Halliday insisted on the “the innocence of the psychoneurotic” and contrasted his behavior with that of the malingerer, “a person who wittingly causes symptoms and signs with the conscious purpose of gaining some advantage.” It was the displacement of the emotions that produced this innocence. As Halliday noted: “The patient with an anxiety state may be quite conscious of the existence of his various difficulties and disappointments, but he does not associate these with his symptoms. His interest and emotions have become displaced from his difficulties and are concentrated on his sensations of bodily and mental distress.”²²

The failure to find the physical proofs of claimed illnesses, with its implication of conscious dissimulation, was transformed into positive evidence of a psychosomatic illness by glossing the symptoms as elements in a deeper unconscious story. The shape of this narrative had been dictated in Cannon’s and Bard’s researches into the work of the adrenal glands in preparing the body for action. Illness in these accounts was seen as a form of flight, and, as Halliday noted, “the flight is accompanied by the bodily symptoms and signs which are an expression of the emotional reaction of fear.” In Halliday’s

²¹ James L. Halliday, “Psychoneurosis as a Cause of Incapacity among Insured Persons: A Preliminary Inquiry,” *Brit. Med. J., Suppl.*, 9 Mar. 1935, pp. 85–88, on p. 85.

²² *Ibid.*, p. 87. See also John Collie, “The Malingerer,” in *Accidents in Their Medico-Legal Aspect by Leading Medical and Surgical Authorities*, ed. Douglas Knocker (London: Balliere, Tindall & Cox, 1910); A. M’Kendrick, *Malingering and Its Detection under the Workmen’s Compensation and Other Acts* (Edinburgh: Livingstone, 1912), pp. 25–26; A. W. Gill, “Hysteria and the Workmen’s Compensation Act,” *Lancet*, 20 Apr. 1929, pp. 811–814; Millais Culpin, “Some Cases of ‘Traumatic Neurasthenia,’” *ibid.*, 1 Aug. 1931, pp. 233–237; Culpin, “The Problem of the Neurasthenic Pensioner,” *British Journal of Medical Psychology*, 1921, 10:316–328; Karl Figlio, “How Does Illness Mediate Social Relations? Workmen’s Compensation and Medico-Legal Practices, 1900–1940,” in *The Problem of Medical Knowledge*, ed. Peter Wright and Andrew Treacher (Edinburgh: Edinburgh Univ. Press, 1982), pp. 174–224, esp. pp. 194–195; and Roger Cooter, “Malingering in Modernity: Psychological Scripts and Adversarial Encounters during the First World War,” in *War, Medicine, and Modernity*, ed. Cooter, Mark Harrison, and Steve Sturdy (Stroud: Sutton, 1999), pp. 125–148.

schema, this flight had a twofold effect. It served to generate physical symptoms while at the same time it obscured the true origins of the anxiety: “When symptoms appear the individual’s attention is drawn away from the painful situation and becomes concentrated on the symptoms which he interprets as evidence he is ill. In this way, the illness becomes a refuge from an unpleasant reality.”²³

The fear and flight narratives attached to Halliday’s patients could take any number of forms. They could be escaping from difficult spouses, widowed parents, childbirth, marriage, rent collectors, gambling debts, unhappy careers, domineering foremen, or worries over physical illness, insanity, and death. These dramas lay hidden behind the diagnosis. As Halliday noted, “the reasons provided for claims on national insurance certificates were simply stereotyped descriptions of highly complicated processes . . . to which orthodox labels have been given.”²⁴ Although these orthodox labels might have hidden the emotional and historical complexity of the illness, they made its quantitative evaluation possible. The diseases that Halliday equated with fear and flight—gastritis, asthma, rheumatism—could be traced in incidence and pattern of presentation through the morbidity returns produced by the Scottish Department of Health and the decennial mortality returns issued by the General Register Office. The patterns disclosed in those statistics—just like the patterns revealed in the pathologies of Halliday’s claimants—could be structured, as we saw in the introduction, around both personal and national events. The language of emotion allowed the changing pattern of insurance claims to be transformed into rich historical documents revealing a complex archaeology of social, cultural, and political influences.

The parallel between individual and collective affect was not lost on Halliday. As he noted in the conclusion to *Psychosocial Medicine*, “It is uncomfortable to become aware that we live in a sick society and to appreciate that its social sickness is a reflection of our own psychological sickness. . . . So upsetting are these generalisations that many people find them intolerable and either refuse to believe them or fail to understand them, or else, if they do understand them, they mitigate their upsetting impact by partially rationalizing them away.”²⁵ In his attribution of critical resistance to the “fight or flight” mechanism he diagnosed in insurance claimants, Halliday seems to be resurrecting the old Freudian argument that equated criticism of psychoanalysis with some kind of deep-seated complex. But Halliday was more astute than that. He was reflexive enough to realize that he could not himself escape these failings and that the theories and materials out of which he constituted his own identity were the same ones he deployed in the construction of the psychosocial.

HALLIDAY, THE SELF, AND THE SIGNS OF THE TIMES

In his connection of intellectual work and emotional life, Halliday claimed that the acceptance and adoption of scientific ideas was not achieved through rational deliberation but guided by more visceral responses. As he noted with regard to the psychological resistance his own theories seemed to generate: “Instead of studying the data and the

²³ Halliday, “Psychoneurosis as a Cause of Incapacity among Insured Persons,” p. 86.

²⁴ James L. Halliday, “Psychoneuroses among Insured Persons, II,” *Brit. Med. J., Suppl.*, 16 Mar. 1935, pp. 99–102, on p. 104. See also L. P. Lockhart, “Industrialized Man and His Background,” *Lancet*, 21 Apr. 1934, pp. 825–829.

²⁵ Halliday, *Psychosocial Medicine* (cit. n. 1), p. 220.

inferences made from them with attention and clear-headed thinking, people respond with emotion, the reactions being characterized on the one hand by intense enthusiasm and on the other hand by indifference (the ‘blind spot’) or even open resentment. . . . Our emotional state prevents us from seeing what we do not want to see and inferring what we do not want to infer.”²⁶

Halliday’s own life would come to epitomize the connections between emotional and intellectual work. In the summer of 1946 he entered a period of sustained and intense crisis. It began when the editor of the *Lancet* requested stronger epidemiological evidence to sustain his claim that the British population had undergone a psychosomatic transition. As Halliday recalled: “On receipt of the letter I felt much aggrieved and my abdominal viscera tied themselves up in knots. . . . I felt generally lousy and about three days later I developed a severe pain along the line of the intercostal nerves.” The pain worsened and eventually settled in the dorsal region. Halliday believed that he was suffering from shingles, but his general practitioner laughingly diagnosed “psychological rheumatism.” Over the following months his condition worsened. He developed scoliosis, a condition that he initially attributed to a fall suffered many years previously when he had worked as a ship’s surgeon. On reflection, however, he realized that there must be a psychosomatic reason for his condition and that the problems of his spine were a symbolic representation of his own unbending egotism.²⁷

Halliday seems to have pursued two courses of action in order to address this unbending egotism. He undertook a training analysis with John Rickman, a leading psychoanalyst and future president of the British Psychoanalytic Society.²⁸ At the same time, he embarked on a new research project—a life of Thomas Carlyle. He presented this work as an experimental psychobiography, but it soon became evident that the Sage of Chelsea was serving as a kind of totemic object through which Halliday could work out his own emotions. In the study, Halliday presented Carlyle as a prototype of the modern dyspeptic. He concentrated on his notorious gastritis: “the accursed hag,” in Carlyle’s words, who “bitted and bridled” him. Victorian physicians had attributed Carlyle’s gastric torment to an excess of ginger cake, but Halliday strove to find a new psychosomatic narrative behind the symptoms. He claimed that the mad hag was a memory of Carlyle’s mother, who remained “psychologically undigested like a bad thing inside him which tormented him and gave rise to the nightmare symptom.”²⁹ Carlyle’s unhappy childhood had created a lifelong anal rage from which there would be no respite.

Halliday identified with Carlyle in his unhappiness. He recognized their common pessimism and believed that Carlyle had somehow anticipated his own outlook on the

²⁶ Halliday, “Rising Incidence of Psycho-Somatic Illness” (cit. n. 4), p. 14. See also Halliday, *Psychosocial Medicine*, pp. 234–235.

²⁷ For Halliday’s recollection see “On Paying Attention to the Body” [undated], Glasgow University MS Gen 1669/622. The article that provoked the editor’s request was eventually published: James L. Halliday, “Epidemiology and the Psychosomatic Affections,” *Lancet*, 19 Aug. 1946, pp. 185–186. For Halliday’s psychosomatic models of backache see Halliday, “Psychosomatic Medicine and the Rheumatism Problem,” *Practitioner*, 1944, 152:6–15, rpt. in *Psychology in General Practice*, ed. Alan Moncrieff (Practitioner Handbooks) (London: Eyre & Spottiswoode, 1946), pp. 93–107. For reports on his emotional state see Rockefeller Archive Center (RAC), Tarrytown, New York, RF 405A Folder 2, photocopies of Alan Gregg and Robert R. Struthers diary entries for 17 Oct. 1949. Halliday was awarded a Rockefeller Travelling Fellowship in April 1947, and both Gregg and Struthers monitored his career from that point forward. They kept separate diaries; pages from both have been photocopied and inserted together into the relevant files by the archive staff.

²⁸ On Rickman see John D. Sutherland, “John Rickman,” *Brit. J. Med. Psychol.*, 1952, 25:1–12.

²⁹ Halliday, *Mr. Carlyle* (cit. n. 1), p. 80. For the ginger cake hypothesis see Sir Richard Quain, “Some Clinical Observations and Professional Reminiscences,” *Brit. Med. J.*, 9 Nov. 1895, p. 1147.

world. Indeed, this anticipation was uncanny. Discussing Carlyle's prototypical sociology, outlined in his 1829 essay "Signs of the Times," Halliday dwelt on a long passage outlining the dichotomy between the dynamical and the mechanical sources of life. The passage, Halliday thought, was strangely prescient: "If we read 'psychological and psychosocial' for dynamical, and 'physical and somatic' for mechanical, this passage, written over a century ago, might have sprung out of a modern treatise on Psychosocial Medicine!"³⁰ There was, of course, only one modern treatise on "Psychosocial Medicine," and it is difficult not to read this as some sort of confessional identification.

If there was a shared outlook to their work, this did not stem from Halliday's and Carlyle's common intellectual inheritance. Rather, it arose, Halliday implied, from their shared emotional background. As Halliday commented: "Carlyle's diagnosis of the social health of Britain during the nineteenth century was more accurate than most of his contemporaries. How did he arrive at it? The notion probably arose in the first instance as a projection of his own psychological sickness (the disintegration of his 'inner society') upon outer society. Like Hamlet—paranoid, narcissistic, and haunted by the ghost of his father—he felt the times to be out of joint."³¹ We should not press analogies too far. If Halliday did suffer from psychological sickness in 1948, it probably did not stem from the childhood anxieties he identified in Carlyle; rather, it emerged in his ongoing experience of intense grief.

On 9 November 1948, Halliday's eighteen-year-old daughter Jill died from tubercular meningitis. She had been ill for more than eleven months. Halliday's pain and his anxiety over her suffering had been heightened by his psychosomatic theories as he worried that her infection was the manifestation of an unconscious death wish. After her death, he was haunted by inner voices promising to look after Jill and, later, by Jill's own voice reassuring him of her presence in heaven. Halliday was not convinced. As he noted: "That these voices were liars in every objective sense and relationship was now confirmed. From the medical standpoint they could be seen as examples of lies that were vitalizing lies—sustaining illusions that were the manifestations in consciousness of underlying natural processes tending towards the maintenance of the organism's equilibrium during a time of intense stress."³²

These disembodied voices were soon accompanied by more supernatural manifestations. On the nights of 23 and 30 December, Halliday's household was awakened by mysterious knocks and moans; a month later, the leading British medium Helen Hughes spoke with Jill's voice, reassuring them of her happiness and that of her long-dead infant brother. Such events are hard to make sense of. Although it is tempting to read these supernatural occurrences as examples of the movement of Halliday's emotions into another register of expression, this may be too limited an interpretation. Psychoanalytic commentaries on loss, mourning, and melancholia emphasize the process of introjection in which the lost or absent figure is perpetuated through the emotions of the bereaved. It was a process in which the "lost object," to use Melanie Klein's phrase, was taken into the body of the mourner, much as Carlyle pathologically embodied the identity of his dead

³⁰ Halliday, *Mr. Carlyle*, p. 197. Halliday used the version of "Sign of the Times" reprinted in Thomas Carlyle, *Scottish and Other Miscellanies* (London: Dent, 1915).

³¹ Halliday, *Mr. Carlyle*, p. 195.

³² Details of Jill's illness and its effects on Halliday are taken from *Liber sine Nomine* [1949], Glasgow University MS Gen. 1669/616.

mother.³³ It was an activity in which emotions endured; but at the same time, through their endurance, they perpetuated lost aspects of the world.

This perpetuation of lost aspects of the world ran parallel in the lives of Carlyle and Halliday. Halliday described how Carlyle “took things in with a kind of inner excitement and the incorporated images remained within him as ‘frozen memories.’” These lost objects were recovered through the emotions. As Halliday made clear, “When he desired to contact them again . . . he had first to work himself into a state where his ‘nerves were in a kind of blaze’ and he was in ‘a paroxysm of clairvoyance.’”³⁴ The “paroxysm of clairvoyance” through which Carlyle retrieved his “frozen memories” and Halliday contacted his lost daughter demonstrates the constitutive role of the affective life. Emotions were not simply constructed from the mundane materials of the world—they also worked to sustain and perpetuate those materials.

Although many might find comfort in the emotions’ capacity to safeguard aspects of life and memory, Halliday remained unconvinced. The refusal to “give up” emotion was symptomatic of the “anal age” that Britain had now entered. It was a psychologically disastrous course. The effects of allowing emotion to endure could be seen in the experimental ulceration produced in the sham rage of Cannon’s rats and the chronic dyspepsia produced in the anal rage of Carlyle. And as Halliday had demonstrated, these effects could also be traced across the British population through the rise of asthma, rheumatism, and gastric disorders. The tragedy of the British population lay in their enthrallment to enduring emotions: yet the endurance of these emotions was not simply an intrapsychic process. As Halliday had demonstrated, emotions could be extended through social, political, and technical means. Emotions, in his own work, were rendered durable through theoretical reflection, experimental investigation, and welfare administration. The ambiguous basis of their existence, shifting between natural and human kinds, was the territory of the psychosocial.

Historians of science, as Paul White has noted, have tended to pursue two independent approaches to emotions. They have either examined their constitution as scientific objects or argued for their recovery as important but overlooked dimensions in the lives of scientific practitioners. Halliday’s life, I would argue, shows how these two processes cannot be easily separated. Although the delineation of emotion may have been a practical achievement, the processes of category construction, life writing, mourning, and introjection that Halliday engaged in all demonstrate how emotions work to define the boundaries of self and other and to establish novel patterns of influence and association.³⁵ As Halliday demonstrated through his writings and his illness, emotions were not discrete private events; rather, they both created and were created by new contexts of explanation and domains of intervention.

³³ Bernard Upton, *The Mediumship of Helen Hughes* (London: Spiritualist Press, 1946); Jenny Hazelgrove, *Spiritualism and British Society between the Wars* (Manchester: Manchester Univ. Press, 2000), pp. 29–31; Melanie Klein, “Mourning: Its Relationship to the Manic Depressive States,” in *Contributions to Psychoanalysis, 1921–45* (London: Hogarth, 1950), p. 330; and J. O. Wisdom, “Comparison and Development of the Psychoanalytical Theories of Melancholia,” *International Journal of Psychoanalysis*, 1962, 43:113–132.

³⁴ Halliday, *Mr. Carlyle* (cit. n. 1), p. 219.

³⁵ On the role of emotions in “surfacing” or creating the boundaries of the subject see Sara Ahmed, “Collective Feelings; or, The Impressions Left by Others,” *Theory, Culture, and Society*, 2004, 21:25–42; and Steve Brown, “Collective Emotions: Artaud’s Nerves,” *Culture and Organization*, 2005, 11:235–246.