HYSTERIA, HEAD INJURIES AND HEREDITY: ‘SHELL-SHOCKED’ SOLDIERS
OF THE ROYAL EDINBURGH ASYLUM, EDINBURGH (1914–24)

by

JOANNA PARK1,* LOUISE NEILSON2,† ANDREAS K. DEMETRIADES3,‡

1University of Edinburgh, 4A Dean Park Crescent, Edinburgh EH4 1PN, UK
2Lothian Health Services Archive, University of Edinburgh,
30 George Square, Edinburgh EH8 9LJ, UK
3Department of Neurosurgery, Royal Infirmary of Edinburgh,
50 Little France Crescent, Edinburgh EH16 4SA, UK

This project illustrates as-yet-uncharted psychiatric patients from the Royal Edinburgh Asylum (REA) around the time of World War I, predominantly ‘shell-shocked’ soldiers. Primary patient notes help to elucidate definitions, symptoms and perceptions of ‘shell-shock’, in addition to its links with other psychiatric conditions. This includes general paralysis of the insane (GPI), alcohol excess, mania and melancholia. Whereas the majority of these patients were suffering from shell-shock, it is not once explicitly listed as a diagnosis; it was a term whose use was discouraged by the War Office and key medical experts from 1916 onwards. As such, this paper demonstrates effects that canonical views held by the War Office and military psychiatrists on shell-shock aetiology had on language used in psychiatric patient notes. The results corroborate wartime views that mental distress due to a physical head injury was preferable to shell-shock without obvious cause; that neurasthenia was a more desirable diagnostic label than hysteria; and that mental illness was predominantly due to an inherited flaw in someone’s character. Language used by psychiatrists to describe their patients was influenced by contemporary perspectives on gender, class and mental illness. More broadly, this paper adds to discussions about definitions and symptomatology of shell-shock that are being uncovered in historical patient notes from this period.

Keywords: general paralysis of the insane, Lothian Health Services Archive, malingerer, Royal Edinburgh Asylum, shell-shock

*e-mail: s1607546@sms.ed.ac.uk
†e-mail: louise.neilson@ed.ac.uk
‡e-mail: andreas.demetriades@gmail.com
INTRODUCTION

In the early days of World War I, psychiatrists were optimistic that the war would act as a cure for insanity: patriotism and unity under a common purpose would provide an outward perspective to cure citizens of their self-absorbed melancholia.\(^1\) In 1915, The Scotsman reported that, looking at Royal Edinburgh Asylum (REA) patient numbers, ‘the war has had little or no effect in increasing insanity’.\(^1\) However, by 1917, local newspapers reported ‘much mental derangement among young soldiers’, and by 1918, ‘numbers treated at Craig House were greater than they had ever been’.\(^2\) These reports demonstrate what asylums across Britain were coming to realize: there was an epidemic of psychiatric disturbance affecting soldiers, on a scale no one was prepared for. Changing diagnostic terms for shell-shock by military psychiatrists as World War I progressed—from hysteria and neurasthenia, to shell-shock Sick (S) and Wound (W), Not Yet Diagnosed? Nervous (N.Y.D.?N.) and war neurosis—reflect militaristic hierarchies, class divisions and confusion about aetiology and pathophysiology of mental illness. This paper explores the reasoning behind these conflicting concepts through the lens of the REA inpatients. Shell-shock is often seen as the direct product of World War I, but in reality medical and lay perceptions towards shell-shocked soldiers were shaped by contemporary attitudes towards class, gender and insanity.\(^3\) There was a perception that only women could suffer from hysteria; that those of lower classes were more likely to have inherited weak mental constitutions; and that insanity was a lifelong disease. Shell-shocked soldiers changed all of these preconceived notions, and their narratives continue to help frame discourse around mental illness and relationships between physicians, patients and communities today.

METHODS

Primary source materials were obtained from the Lothian Health Services Archive (LHSA) case notes.\(^4\) LHSA also provided press cuttings relating to the REA during this period. Further contemporary sources were uncovered in the Canmore catalogue and Wellcome Collection archives.

Secondary sources were found by comprehensively searching Google Scholar and PubMed, using search terms such as ‘Craig House’, ‘Royal Edinburgh Asylum’, ‘shell-shock’, ‘neurasthenia’, ‘general paralysis’.

FINDINGS FROM PRIMARY DATA COLLECTION

The case notes pertained to men admitted for psychiatric reasons to the REA buildings: Craiglea Annexe, Craig House and the West House. This paper examines 40 patients who

---

1 Lothian Health Services Archive (LHSA), Press Cuttings Book Volume 6, Royal Edinburgh Hospital Collection, 1903–1917 (available online), LHSA, n.d., LHB7/12/6, Edinburgh.
2 LHSA, Press Cuttings Book Volume 7, Royal Edinburgh Hospital Collection, 1918–1927 (available online), n.d., LHSA, LHB7/12/7.
3 F. Reid, Broken men: shell shock, treatment and recovery in Britain 1914–30, 1st edn (Bloomsbury Publishing, London, 2011).
4 LHSA, Case notes of patients connected with the military, treated in Craig House, West House, and Craiglea Annexe, c. 1915–1930s, n.d., LHSA, LHB7/CC/13.
were admitted between February 1914 and September 1924. The hospital treated both men and women, and military cases were treated alongside civilian patients. From 1813 to 1842 the REA exclusively treated private patients but in 1842 the West House was established which managed ‘pauper’ patients: those whose treatment was paid for by their local parish. The REA treated soldiers experiencing psychological rather than physical trauma, the latter of which would have been treated in a general military hospital such as Bangour.

The LHSA holds four boxes of case notes relating to military patients from World War I. It also holds records of the wider hospital patient population, including case books and registers, management, administrative, financial and staff records from this period. The data for this report was collected from the four boxes of military-related case notes, and all patients admitted between 1914 and 1924 were included (see tables 1–4). The years 1914–1924 were selected to give a good overview of the types of patients and diagnoses attributed pre, during and post World War I, and to demonstrate the longevity of some ‘shell-shock’ illnesses which required extended convalescence. Furthermore, most patients within these case notes were admitted within this timeframe, so they were all utilized to increase cohort size.

There were 60 psychiatric conditions listed, the most common being melancholia, neurasthenia and alcohol excess. There are also allusions to certain conditions (e.g. ‘mental

Table 1. Overview of patient details ($n = 40$)

| No. of patients | 40 |
|-----------------|----|
| Age range       | 19–65 years |
| Average age     | 33 years (mean) |
| Admission date range | Feb 1914 to Sept 1924 |
| Length of stay range | 2 weeks to 9 years |
| Average length of stay | 4 months (median) |
| Discharges      | 31 |
| Deaths          | 9 |
| Voluntary patients | 12 |
| Certified patients | 28 |

Table 2. Places of residence ($n = 40$)

| Place of residence | No. | % |
|--------------------|-----|---|
| Scotland           | 19  | 47.5 |
| Edinburgh          | 9   | 22.5 |
| Glasgow            | 4   | 10 |
| Other              | 6   | 15 |
| England            | 6   | 15 |
| Ireland            | 2   | 5 |
| Canada             | 3   | 7.5 |
| USA                | 1   | 2.5 |
| Unknown            | 9   | 22.5 |

5 Ibid.
“stupor’ ‘nervous disorder’ ‘war overstrain’) without giving psychiatric diagnoses, and there is a considerable degree of overlap between terms relating to shell-shock (see table 5). ⁶

Many shell-shock diagnostic labels were not explicitly stated under a ‘diagnosis’ heading in the case notes, but any records pertaining to military patients stating that they were suffering from ‘neurasthenia’ ‘war neurosis’ ‘head injury/head condition’ ‘nervous disorder’, etc. that were specifically linked to an alluded or described military episode (e.g. while in the Somme, while in the trenches, since returning from France) were all included (see table 6). ⁷ As shell-shock was an all-encompassing umbrella term, these ambiguities in

---

Table 3. Occupation \((n = 40)^a\)

| Occupation                  | No. | %   |
|-----------------------------|-----|-----|
| Army                        | 31  | 77.5|
| Brigadier-General           | 1   | 2.5 |
| Colonel                     | 1   | 2.5 |
| Major                       | 1   | 2.5 |
| Captain                     | 4   | 10  |
| Lieutenant                  | 7   | 17.5|
| Tank Corps                  | 2   | 5   |
| Royal Fleet Auxiliary       | 1   | 2.5 |
| Royal Scots                 | 1   | 2.5 |
| Unknown rank                | 7   | 17.5|
| Royal Air Force             | 1   | 2.5 |
| Lieutenant                  | 1   | 2.5 |
| Navy                        | 3   | 7.5 |
| Captain                     | 1   | 2.5 |
| Officer                     | 1   | 2.5 |
| Surgeon                     | 1   | 2.5 |
| Civilian                    | 4   | 10  |
| General Practitioner        | 1   | 2.5 |
| College Students            | 1   | 2.5 |
| Civil Engineer              | 1   | 2.5 |
| Reverend                    | 1   | 2.5 |
| Unknown                     | 1   | 2.5 |

²Source: J. Boff, *Military structures and ranks* (British Library, London, 2014), https://www.bl.uk/world-war-one/articles/military-structures-and-ranks (accessed 27 March 2021).

Table 4. Deaths \((n = 9)\)

| Cause of death                                      | %   |
|-----------------------------------------------------|-----|
| General paralysis of the insane                     | 62.5|
| Infective exhaustive confusional insanity           | 12.5|
| Scarlet fever and bronchopneumonia                 | 12.5|
| Diabetes mellitus                                   | 12.5|
| Repeated cerebral haemorrhages                      | 12.5|

⁶ Ibid.  
⁷ Ibid.
diagnostic labels are unsurprising, but it made it difficult to establish concrete symptomatology directly linked to ‘shell-shock’. Vocabulary used to describe patients by their doctors was therefore collected and organized by symptoms relating to key psychiatric presentations: depression, mania, psychosis and ‘miscellaneous’ (see table 7). This was achieved by going through doctors’ descriptions within each patient’s case notes in turn, and collating the adjectives used to generate tables according to both local contemporary views from REA superintendent reports and modern-day guidelines on psychiatric conditions from the International Classification of Diseases, Tenth Revision. The ‘frequency’ of these terms therefore refers to the total number of times these adjectives appeared throughout all 40 sets of case notes.

| Diagnostic labels                              | No. | %    |
|------------------------------------------------|-----|------|
| Melancholia/depression                         | 13  | 21.7 |
| Neurasthenia                                   | 6   | 10   |
| Alcohol excess                                 | 6   | 10   |
| Depression                                     | 5   | 8.3  |
| General paralysis of the insane                | 4   | 6.7  |
| Head injury/head condition                     | 4   | 6.7  |
| Traumatic confusional insanity                 | 3   | 5    |
| Paranoid dementia praecox                      | 3   | 5    |
| Unnamed war neurosis                           | 3   | 5    |
| Infective exhaustive confusional insanity      | 2   | 3.3  |
| Mental excitement                              | 2   | 3.3  |
| Mild confusional mania                         | 2   | 3.3  |
| Recurrent mania                                | 2   | 3.3  |
| Manic depression                               | 2   | 3.3  |
| Organic dementia                               | 1   | 1.7  |
| Nervous breakdown                              | 1   | 1.7  |
| Nervous disorder                               | 1   | 1.7  |
| Psycho-neurosis                                | 1   | 1.7  |
| High-grade congenital defective                | 1   | 1.7  |
| Memory loss                                    | 1   | 1.7  |
| Delirium                                       | 1   | 1.7  |

| Table 5. Diagnostic labels (n = 60) |
|-------------------------------------|
| Diagnostic labels:                 | No. | %    |
| Melancholia/depression:            | 13  | 21.7 |
| Neurasthenia:                      | 6   | 10   |
| Alcohol excess:                    | 6   | 10   |
| Depression:                        | 5   | 8.3  |
| General paralysis of the insane:   | 4   | 6.7  |
| Head injury/head condition:        | 4   | 6.7  |
| Traumatic confusional insanity:    | 3   | 5    |
| Paranoid dementia praecox:         | 3   | 5    |
| Unnamed war neurosis:              | 3   | 5    |
| Infective exhaustive confusional insanity: | 2   | 3.3  |
| Mental excitement:                 | 2   | 3.3  |
| Mild confusional mania:            | 2   | 3.3  |
| Recurrent mania:                   | 2   | 3.3  |
| Manic depression:                  | 2   | 3.3  |
| Organic dementia:                  | 1   | 1.7  |
| Nervous breakdown:                 | 1   | 1.7  |
| Nervous disorder:                  | 1   | 1.7  |
| Psycho-neurosis:                   | 1   | 1.7  |
| High-grade congenital defective:   | 1   | 1.7  |
| Memory loss:                       | 1   | 1.7  |
| Delirium:                          | 1   | 1.7  |

| Table 6. Shell-shock diagnostic labels (n = 20) |
|-----------------------------------------------|
| Shell-shock diagnostic labels:                | No. | %    |
| Neurasthenia:                                 | 6   | 30   |
| Head injury/head condition:                   | 4   | 20   |
| Traumatic confusional insanity:               | 3   | 15   |
| Unnamed war neurosis:                         | 3   | 15   |
| High-grade congenital defective:              | 1   | 5    |
| Nervous breakdown:                            | 1   | 5    |
| Nervous disorder:                             | 1   | 5    |
| Hysteria:                                     | 1   | 5    |

| Table 6. Shell-shock diagnostic labels (n = 20) |
|-----------------------------------------------|
| Shell-shock diagnostic labels:                | No. | %    |
| Neurasthenia:                                 | 6   | 30   |
| Head injury/head condition:                   | 4   | 20   |
| Traumatic confusional insanity:               | 3   | 15   |
| Unnamed war neurosis:                         | 3   | 15   |
| High-grade congenital defective:              | 1   | 5    |
| Nervous breakdown:                            | 1   | 5    |
| Nervous disorder:                             | 1   | 5    |
| Hysteria:                                     | 1   | 5    |

8 Ibid.
| Symptom                          | Frequency |
|---------------------------------|-----------|
| Related to depression           |           |
| Depressed                       | 17        |
| Dull                            | 5         |
| Melancholia/melancholic         | 4         |
| Dejected                        | 4         |
| Apathetic                       | 4         |
| Unhappy                         | 3         |
| Suicidal                        | 3         |
| Insomnia                        | 2         |
| Dispirited                      | 2         |
| Sluggish                        | 2         |
| Self-absorbed                   | 2         |
| Listless                        | 2         |
| Languid                         | 2         |
| Indolent                        | 2         |
| Lethargic                       | 1         |
| Miscellaneous                   |           |
| Confused                        | 12        |
| Insane                          | 5         |
| Violent/violence                | 5         |
| Stupid                          | 4         |
| Dazed                           | 4         |
| Nervous ± breakdown             | 4         |
| Pathetic                        | 4         |
| Timid                           | 3         |
| Peevish                         | 3         |
| Highly strung                   | 3         |
| Enfeebled/feeble                | 3         |
| Childish                        | 3         |
| Timid                           | 3         |
| Shy                             | 3         |
| Aimless                         | 2         |
| Silent                          | 2         |
| Intense                         | 2         |
| Sulky                           | 2         |
| Self-absorbed                   | 2         |
| Facile                          | 2         |
| Weak                            | 2         |
| Peculiar                        | 2         |
| Destructive                     | 2         |
| Retarded                        | 1         |
| Helpless                        | 1         |
| Hysterical                      | 1         |
| Related to psychosis            |           |
| Delusions/delusional            | 9         |
| Hallucination                   | 5         |
| Hypochondriacal                | 3         |
| Suspicion/suspicious            | 2         |
| Anxious                         | 1         |
| Related to mania                |           |
| Excitement/excited              | 12        |
| Restless                        | 6         |
| Agitated                        | 5         |
| Elated                          | 4         |
| Grandiose                       | 3         |

(Continued.)
Medications administered were mainly sedatives. Drugs that could sedate and relieve patient distress became a crucial part of psychiatric care from the second half of the nineteenth century onwards.\(^9\) The most commonly prescribed drug was Veronal (15 patients), then potassium bromide (13), sulphonal (4), morphia (4), hyoscin (3) and paraldehyde (3). Evidence of medications administered to distressed patients is discussed later. Other medications used included lozenges, Epsom salts and cascara. Emetics and purgatives, such as calomel listed in the patient notes, were widely used in psychiatry, not just to regulate digestion, but as a means of controlling patients’ behaviour.\(^{10}\) There is no mention of physical therapies used, but exercise, fresh air and social interaction with other residents were encouraged.

A range of documents was included within the patients’ notes, including history and examination notes, reports of confused acts, observation charts, weight and temperature charts, laboratory findings, discharge summaries, letters between patients and families, War Office correspondence and death certificates. The small volume of patient letters provides useful—if limited—autobiographical insight. The records do not distinguish between civilian and military patients, though the military ones were often quickly identifiable through having transfer letters from Craiglockhart hospital enclosed or their main presenting complaint, including details about recent time spent on the battlefields, for example. The notes are usually detailed, though each folder varies in size depending on factors such as length of stay, amount of interventions needed and volume of letters enclosed. Patient vignettes to illustrate some of the documents are as follows (figures 1–9 are from the primary case notes, therefore sharing the same reference).\(^{11}\)

**Patient X**

A 37-year-old army captain admitted in 1915 and diagnosed with GPI, head injury and alcohol excess.

Length of stay: 16 months (until death by GPI).
Known family: wife and son.

---

9 T. Pieters and S. Snelders, ‘Psychotropic drugs: mental ills and the “hidden history” of drug treatment practices’, in Psychiatric cultures compared: psychiatry and mental health care in the twentieth century: comparisons and approaches, 1st edn (ed. M. Gijswijt-Hofstra, H. Oosterhuis, J. Visselaar and H. Freeman), pp. 379–402 (Amsterdam University Press, Amsterdam, 2005).

10 P. Fennell, Treatment without consent: law, psychiatry and the treatment of mentally disordered people since 1845 (Routledge, London, 1996), pp. 38–47.

11 LHSA, op. cit. (note 4).
Documents in case notes: letters, histories, reports of neurological examinations, report of confused acts, weight and temperature charts, blood and cerebrospinal fluid reports, diary.

‘crawling under the bed in the morning looking for his bedroom slippers and having them on all the time … putting his legs into the sleeve, pulled it on as if it was a pair of trousers … “my brain is really in an awful bad state in the meantime. I simply can’t remember anything or even pronounce words nowadays” … wouldn’t take his soup at first. He said “It is not clean because it is not white.”’
Figure 2. Patient X ‘Report of Confused Acts during Day’ (LHB7 CC/13, Courtesy of Lothian Health Services Archive, Edinburgh University Library). (Online version in colour.)
**Patient Y**

A 19-year-old soldier (rank unknown) transferred from Craiglockhart War Hospital to Craiglea Annexe in 1918 and diagnosed with mental excitement.

- Length of stay: 2 months.
- Known family: father and brothers.
- Documents in case notes: letters from patient’s father, extensive letters from patient, doctor’s notes.

**Patient Z**

A 27-year-old insurance clerk who was recently discharged from the army due to melancholia, transferred from Dykebar War Hospital to Craig House in 1918 and diagnosed with exhaustive confusional insanity.

- Length of stay: 9 years.
- Known family: sister.
- Documents in case notes: case notes, weight charts, examination notes, transfer notes, history notes.
DISCUSSION

The Royal Edinburgh Asylum

Craig House, Craiglea Annexe and the West House formed part of the REA, which is situated on Easter Craiglockhart Hill between Craiglockhart and Morningside (see figure 10). The
REA was founded in 1809 and renamed the Royal Edinburgh Hospital for Mental and Nervous Disorders in 1922. Old Craig House stood between 1565 and 1894. New Craig House opened in 1894 and was built in the neo-Gothic style to resemble a ‘great Victorian country house’ (see figures 11–13). It was retitled the Thomas Clouston Clinic in 1972, then refurbished and transformed into Napier University’s Craighouse Campus in 1996. In the early twentieth century, the REA provided accommodation and care for psychiatric patients. Those at the West House were paid for by their local parish, whereas the Craig House inhabitants were private patients paying higher rates for a premium service. During World War I and the post-war years, the REA’s physician-superintendent was Dr George Robertson. Nearby Craiglockhart was one of six specialist hospitals taken over by the War Office in 1916 for shell-shocked soldiers, and many patients were transferred from Craiglockhart and other war hospitals to the REA for further convalescence.

12 LHSA, *Royal Edinburgh Hospital history*, n.d., http://www.lhsa.lib.ed.ac.uk/exhibits/hosp_hist/reh.htm (accessed 16 February 2021).
13 Napier University, ‘Craighouse Campus’, pp. 5–13 (2007), https://web.archive.org/web/20090207090358/http://www.napier.ac.uk/aboutus/history/Documents/CampusHistory.pdf (accessed 24 February 2021).
14 Royal Edinburgh Asylum, One hundred and first annual report of the Royal Edinburgh Asylum, Morningside: for the year 1913 (Darien Press, Edinburgh, 1914).
15 B. Shephard, *A war of nerves* (Harvard University Press, Cambridge, MA, 2001).
Dr Charles Myers, civilian physician and appointed consultant psychologist for British troops in France, was the first person to coin the term ‘shell-shock’, a condition which

16 C. Myers, ‘A contribution to the study of shell shock’, *Lancet* 185(4772), 316–320 (1915), https://www.sciencedirect.com/science/article/pii/S014067360052916X (accessed 2 April 2021).
Figure 7. Patient Z Admission Examination Notes (LHB7 CC/13, Courtesy of Lothian Health Services Archive, Edinburgh University Library). Includes details of appearance, skin, eyes, hair, pupils, fatness, musculature, general nervous system, heart, lungs, other systems, palate, tongue, temperature, pulse and urine.
was said to induce symptoms such as mental confusion, excitement, delirium or stupor. Though British military psychiatry originated in World War I, the physical presentation of ‘shell-shock’ and the history of war-related mental breakdowns are much older. In France during the Revolutionary and Napoleonic wars, army physicians reported cases of ‘vent du boulet’ syndrome: soldiers collapsed terrified after cannonball fire though they were physically unharmed. In 1907, German scholars observed nervous troubles—Kriegneurosen—in Russian officers during war with Japan. Nonetheless, World War I was the first war fought with modern weaponry on a vast scale, and the name ‘shell-shock’ is directly linked to the belief in the early days of World War I that soldiers’ symptoms were caused by concussion from exploding shells. Specific examples from patient case notes demonstrate that doctors and patients alike attributed shell-shock to physical causes: ‘[cause of illness] several severe shocks from high explosive shells bursting near him’; ‘[the patient] attributes feelings to being under shell fire in France’. In terms of statistics,
the number of cases of nervous disorder without physical cause dramatically increased from 1906 to 20,327 between 1914 and 1915, constituting 9% of all battle casualties, constituting an inconceivable number for military physicians and the War Office to contend with.

Confusing terms

Many patient files did not name psychiatric causes for their stay at the REA, with the space left blank or with a physical comorbidity listed such as ‘diabetes mellitus’ or ‘asthma and bronchitis’. Comprehensive search was often required to find actual named psychiatric diagnoses. The REA was not unique in this regard; neurasthenia diagnoses at Craiglockhart hospital were routinely written subordinately to any physical complaints. Winter notes that overall psychiatric casualties in World War I are likely to be underestimated as the physically wounded were rarely listed to have psychiatric issues too, largely due to

22 D. Winter, Death’s men: soldiers of the Great War (Penguin Books, London, 1978), pp. 129–131, 136–139.
23 T. Webb, ”‘Dottyville’: Craiglockhart War Hospital and shell-shock treatment in the First World War’, J. R. Soc. Med. 99, 342–346 (2006).
stigmatization of mental breakdowns. Some physicians also held the erroneous belief that men with physical injuries were unlikely to suffer mental breakdown.

The medical profession was uncertain about the aetiology and pathophysiology of shell-shock: Myers states, ‘considerable controversy exists as to how those controlling [mental] functions are lost, and precisely what occurs when they are lost’. Shell-shock was initially divided into two distinct categories in France, ‘W’ (wound) and ‘S’ (sick). This had the aim of weeding out malingerers—considered to be shell-shock S—from those men suffering from ‘true’ commotional shell-shock caused by physical wounds. In fact, only a small proportion of W cases were actually commotional, with the overwhelming majority of emotional origin. Sir Frederick Mott was a civilian physician with military understanding due to his training as a major in the Territorial Army in 1914. He dedicated his time during World War I to the investigation and treatment of shell-shock and was widely considered a leading figure in the field. In 1918, he declared that ‘in the majority of cases [of shell-shock] there is no evidence of commotional shock or concussion’. The 1922 War Office enquiry into shell-shock found that soldiers with ‘concussion shock’

---

24 J. Winter, ‘Shell shock’, in The Cambridge History of the First World War (ed. J. Winter), pp. 310–333 (Cambridge University Press, Cambridge, 2014).
25 C. Myers, ‘A final contribution to the study of shell shock. Being a consideration of unsettled points needing investigation’, Lancet 193(4976), 51–54 (1919).
26 Shephard, op. cit. (note 15).
27 E. Jones, ‘“An atmosphere of cure”: Frederick Mott, shell shock and the Maudsley’, Hist. Psychiatry 25, 412–421 (2014).
28 F. Mott, ‘Two addresses on war psycho-neurosis. I. Neurasthenia: the disorders and disabilities of fear. II. The psychology of soldiers’ dreams’, Lancet 191(4927), 169–173 (1918).
made up only 5–10% of all shell-shock cases. In other words, shell-shock S was far more common despite being a great deal more stigmatized. W patients were branded as heroes, whereas S patients were more likely to be accused of malingering and sent back to duty.

Figure 11. View of the Great Hall, Craighouse Asylum, Edinburgh, 1895 (SC 701974, Courtesy of Canmore catalogue, Historic Environment Scotland, https://canmore.org.uk/collection/701974 (accessed 6 April 2021)).

29 UK Parliament, op. cit. (note 17).
30 Shephard, op. cit. (note 15); A. Carden-Coyne, The politics of wounds: military patients and medical power in the First World War, 1st edn (Oxford University Press, Oxford, 2014), p. 346.
Mott discussed his patients’ feelings about the impact of their neurasthenia diagnosis without physical cause: ‘mental conflict and preoccupation regarding their honour and reputation as soldiers, and having no visible evidence to justify their return from active service, they are apprehensive lest their comrades should regard them as shirkers’. Soldiers recognized that lack of a wound made their illness less credible. The diagnostic terms of shell-shock W or S were short-lived, which may explain their absence from the REA case notes, but head injuries or ‘commotional’ causes of shell-shock were listed in 35% of cases. This reflects a nationwide unwillingness to acknowledge the emotional stress of war as a cause.

From 1917, Myers replaced shell-shock S with the term N.Y.D.?N.: not yet diagnosed? nervous. In 1922, the War Office decreed that ‘the term shell-shock should be eliminated from official nomenclature’ and that ‘abbreviations such as N.Y.D. Nervous or Mental, or N.Y.D.N., D.A.H. [disordered action of the heart], etc., should be avoided’. However, they still insisted that shell-shock fell under categories of ‘commotional’ versus ‘emotional’

31 Mott, op. cit. (note 27).
32 W. Bonikowski, Shell shock and the modernist imagination: the death drive in post-World War I British fiction (Taylor & Francis, London, 2013).
disturbance or ‘mental disorders’.\(^{33}\) This highlights that the meaning imbued within a commotional or emotional shell-shock diagnosis was more important than the imprecision of the term itself; the diagnostic labels may have changed throughout the course of World War I and beyond, but their meaning stayed the same.

**Of officers and men**

Traumatized soldiers obtained different diagnostic labels of neurasthenia and hysteria, with physicians insistent in the early war years that officers suffered the former and men of lower ranks the latter, a distinction based on class-based military hierarchies.\(^{34}\) It was also a highly gendered argument, with popular opinion being that women suffered from hysteria and men neurasthenia; this made neurasthenia the more respectable diagnosis as hysteria was associated with femininity and degeneracy.\(^{35}\) Loughran discusses dichotomies that came with listing hysteria and neurasthenia as two diametrically opposed categories:

33 UK Parliament, *op. cit.* (note 17).
34 Reid, *op. cit.* (note 3).
35 *Ibid.* Bonikowski, *op. cit.* (note 32).
body/mind, female/male, nature/culture, lower/upper class and ancient/modern disease. Notably, both diagnoses were considered unpatriotic before World War I, with neurasthenia associated with malingering and fecklessness in working-class men. The term neurasthenia was coined by American neurologist Charles Beard in 1869, and became an umbrella term for depression, mood disorders and identity crises. During World War I, however, the definition of neurasthenia was rewritten to create the honourable and pitiable ‘shattered soldier’ image—predominantly reserved for officers—with hysteria remaining the undesirable, unpatriotic diagnosis ascribed to men, despite the fact that both groups often displayed similar symptoms. The medical profession justified this by saying that the officers suffered ‘anxiety neuroses’ as a result of increased responsibilities, intelligence and education. Officers were considered to experience a greater conflict between duty and self than the men did, as a result of this increased education and upbringing with a deep sense of duty. The War Office report corroborated that in ‘officers the effects [of shell-shock] are more commonly of the anxiety type’, and shell-shock victims’ statistics reflected rank-based divides. This meant that soldiers from lower ranks were systematically accused of malingering their nervous breakdowns.

Shephard notes that during World War I officers and men went to different hospitals and received different treatments. In the REA case notes, 70% of the patients were officers, with 10% civilians, 2.5% unknown and 17.5% with unrecorded army rank (see table 3). Only one patient—a second lieutenant—was listed to have ‘emotional excitement’ and ‘hysterical outbursts’. He ‘shows a good many womanish, if not hysterical tendencies’, with a ‘treble, piping, falsetto voice’. This description paints a clearly deprecating picture of the feminized hysterical soldier. The majority of those suffering from shell-shock are listed as having neurasthenia, head injury/head condition, traumatic confusional insanity or an unnamed war neurosis alluded to with physician comments such as ‘war overstrain’ (see table 6).

In the later war years, physicians were forced to admit that the two diagnoses were more similar than they had previously acknowledged. Mott wrote, ‘it is difficult to separate neurasthenia from hysteria, for the sensori-motor phenomena of hysteria are so very frequently combined with the general symptoms of neurasthenia’. The War Office report ultimately concluded that class and education had no bearing on shell-shock. This finding sat uncomfortably with the political elites as it challenged popular theories about increased heredity of mental illness within lower-class families. Mott remarked, ‘large numbers of men in civil life in all grades of society carrying on their occupations are, when

36 T. Loughran, ‘Hysteria and neurasthenia in pre-1914 British medical discourse and in histories of shell-shock’, Hist. Psychiatry 19, 25–46 (2008).
37 Reid, op. cit. (note 3).
38 Shephard, op. cit. (note 15).
39 Loughran, op. cit. (note 36).
40 Bonikowski, op. cit. (note 32).
41 D. Hipp, ‘Expressions of war experience: shell shock, poetic identity and psychological healing in the work of Owen, Gurney, and Sassoon’, PhD thesis, Vanderbilt University (1998).
42 Winter, op. cit. (note 24).
43 Shephard, op. cit. (note 15).
44 LHSA, op. cit. (note 4).
45 Ibid.
46 Mott, op. cit. (note 27).
47 Bogacz, op. cit. (note 21).
conscripted, the subjects of neurasthenia’.\textsuperscript{48} And so, the definitions of the terms were quietly changed again, with most soldiers—like those at the REA—now said to have a respectable neurasthenia or unspecified ‘war neurosis’ diagnosis.

\textit{Origins and perceptions of mental illness}

Before World War I, insanity was viewed by physicians and psychologists as a brain disorder caused by organic (i.e. physical) structural or functional lesions.\textsuperscript{49} In the early twentieth century, functional disease was defined as the absence of an organic event.\textsuperscript{50} The War Office defined functional disorders further: ‘Fatigue Cases, Exhaustion and Confusional states. Conversion Hysteria. Anxiety states. Obsessional states.’\textsuperscript{51} The question that the medical profession and War Office were forced to consider was whether symptoms exhibited by soldiers without visible physical injuries were due to organic brain damage from explosions, or whether they were the psychological effects of prolonged traumatic war experience.\textsuperscript{52} Psychoanalytical theories detailed that ‘emotional’ mental illness was solely caused by heredity or childhood traumas.\textsuperscript{53} Could recent traumas induce acute stress disorders?

The REA physician superintendent predecessor Dr Thomas Clouston (1873–1908) remarked that ‘bad heredity is the most potent and all-embracing endogenous cause [of mental unsoundness]’.\textsuperscript{54} One REA patient with melancholia had his family history listed: ‘mother died insane, sister was insane, one brother drowned himself and another sister is of doubtful sound mind’. This reflects contemporary views that the aetiology of mental illness was due to an inherited weakened nervous system.\textsuperscript{55} Mott argued that the largest sub-group of shell-shocked patients had a pre-service psychological vulnerability, and found that statistics ‘proves conclusively that by far the most important factor in the genesis of neurasthenia is an inborn or acquired tendency to emotivity’.\textsuperscript{56} Nonetheless, Mott did have a separate smaller category dedicated to normal individuals who had undergone recent trauma: those subjected to ‘terrifying or horrifying conditions’, soldiers whose record demonstrated that they are ‘neither of a timid disposition nor possessed of any neuropathic tendency’. The 1922 War Office report into shell-shock blamed poor medical selection, allowing ‘misfits’ to enter the army, who were liable to break down under the stresses of warfare.\textsuperscript{57} In the 1915 REA Annual report, Robertson wrote that ‘high-grade mental defectives’ had such a ‘low level of intelligence they were quite unfit to be trained as soldiers or to realise their responsibilities’.\textsuperscript{58} This criticism of the screening process mirrors popular opinion that mental illness was an inherent part of a person’s character rather than a state which could be induced by the horrors of trench warfare. One patient at the REA was diagnosed with ‘inherent mental weakness’. He was

\begin{thebibliography}{99}
\bibitem{48} Mott, \textit{op. cit.} (note 27).
\bibitem{49} Bogacz, \textit{op. cit.} (note 21).
\bibitem{50} Loughran, \textit{op. cit.} (note 36).
\bibitem{51} UK Parliament, \textit{op. cit.} (note 17).
\bibitem{52} S. Linden, V. Hess and E. Jones, ‘The neurological manifestations of trauma: lessons from World War I’, \textit{Eur. Archs Psychiatr Clin. Neurosci.} \textbf{262}, 253–264 (2011).
\bibitem{53} Crocq and Crocq, \textit{op. cit.} (note 19).
\bibitem{54} T. Clouston, \textit{Unsoundness of mind} (Methuen, London, 1911).
\bibitem{55} Loughran, \textit{op. cit.} (note 36).
\bibitem{56} Mott, \textit{op. cit.} (note 27).
\bibitem{57} Bogacz, \textit{op. cit.} (note 21).
\bibitem{58} LHSA, \textit{Annual report of the Royal Edinburgh Asylum}, 1915, LHSA, LHB77/7/13.
\end{thebibliography}
‘dulled mentally’ with a ‘sulky, surly, suspicious and stupid expression’, the doctor’s contempt hardly disguised through this alliterative description of the patient’s appearance. Medical discourse used to describe mentally ill patients from the late nineteenth century has been described as harsh and contemptuous, and emphatic ‘rule of three’ narratives frequently arise in the case notes: patients are ‘delirious, very languid, and somewhat listless’, ‘dull, dazed, and depressed’, and one is described as ‘still as bumptious, conceited and impertinent as before’.

Scull argues that psychiatric discourse demonstrated ‘barely disguised contempt for the mad’, which seems evident from some exaggerated alliterative depictions of the REA inpatients: ‘despondent and dispirited’, ‘languid and listless’, ‘sulky, surly, suspicious, and stupid’. The one ‘hysterical’ patient listed was ‘undeveloped mentally and physically’. Another was diagnosed as ‘high grade congenital defective’. He was an ‘untidy, badly dressed specimen of a soldier’, epitomizing the disgust felt that such a ‘specimen’ was allowed into the British Army.

In 1911, Clouston wrote that ‘abnormal stimuli and sudden changes of environment’ were important factors to consider in mental illness development. He went so far as to remark that ‘if the abnormal stimulus is that of “Shock,” i.e., if it is very intense, altogether unexpected and sudden, the mental effect is apt to be more certain and more marked’. This is at odds with the unrelenting wartime rhetoric of heredity and inborn errors of the nervous system, with little consideration of war conditions themselves as causative of shell-shock, which is ironic given its renowned name. Some physicians did recognize the link between the emotional impact of war and emotional breakdown, such as those involved in the pioneering treatments for what is now known as post-traumatic stress disorder (PTSD) at the Moss Side Military Hospital in Maghull, but this was not commonplace. How, in light of so much overwhelming evidence, could the majority of doctors and the War Office dismiss the possibility of war-induced mental breakdown? As these psychiatrically ill men became charges of the state, many scholars agree that the main motivation was to try and reduce the massive pension bill. By 1922, at least 50,000 men had been awarded war pensions on mental grounds. The total number is probably higher than this as 84,681 cases—representing 6.3% of total awards—were recorded in official documents for the Ministry of Pensions. And so, a third opinion on the origins of shell-shock was discussed: that soldiers were malingering.

At the start of the war, the inflexible military system crudely labelled its men sick, well, wounded or mad; anyone who did not fit one of these categories but was still incapable of combat was deemed a coward who should be shot. Military views of shell-shocked soldiers remained that they were malingers who exaggerated symptoms to escape the
front line. The War Office remarked, ‘the dividing line between malingering and functional neurosis may be a very fine one’. Shell-shocked soldiers fortunate enough to return home alive were not only dealing with their own psychological turmoil; their masculinity, patriotism and inherent mental stability were all in question by the state, doctors and their own communities. There were, however, some successful fundraising campaigns for shell-shocked soldiers, demonstrating a degree of public sympathy, and many physicians spoke in support of the men they had treated. Myers wrote a paper defending his patients, stating ‘I have not the slightest hesitation in maintaining the genuineness of the cases above described’. Opinions started to shift after the war, with the Labour Party, among others, arguing that many soldiers had been unfairly executed. The War Office Committee faced heavy scrutiny over those veterans who had been poorly treated and in some extreme cases shot for cowardice while suffering from shell-shock.

Return to duty?

Webb found that some cases of shell-shocked officers at Craiglockhart who were listed as being discharged back to the front lines were furtively transferred to different units for further treatment. Several REA patients were transferred from nearby Craiglockhart, clearly still suffering from shell-shock. Jones expressed doubt that ‘anyone who has once developed it [shell-shock] will ever be fit for front-line soldiering within the time limit of any war’. Roughly 20% of all soldiers deemed unfit to return to active service during World War I had disabilities of psychiatric origin. Mott stated the uncomfortable truth that shell-shock ‘is of great importance from a military point of view as a cause of loss of man-power to the Army … [patients] have spent far more time in hospitals and convalescent homes than with the units’. Jones and Wessely affirm that low return-to-duty rates undermined the strength of the army, so those who were forced back to the front were desperately needed for manpower but very likely still unfit for duty.

Patient perspectives

Oyebode remarks that autobiographical psychiatric illness narratives are unique, in that they afford an insight into the experience of mental illness rather than the descriptive labels applied by psychiatrists. In the case notes, there were some letters written by the patients to relatives and friends (see figures 4–6). Key examples include: ‘can you help me?; ‘I am insane and I am not a certified lunatic’; ‘they cannot have me under lock and key’; ‘I am disgusted with ward IV. The inmates are all mad’; ‘dying through ill treatment’; ‘come, I...
require your help”; ‘possibly I will kill myself’. Scull remarks that asylum inpatients felt ‘helpless, hopeless, and highly stigmatised’, a sentiment evident in these examples. Overall, though, autobiographical content was largely absent from patient notes, reflecting power dynamics between doctors and patients and emphasizing the ‘silent soldier’ stereotype. Patients’ physical distress allows further insight into the traumatic nature of their mental illness. This is apparent from descriptions of ‘plucking at bedclothes’, ‘destroying his clothing and pulling his bed to pieces’. Patients’ anger towards themselves and others is also evident: several committed ‘self-abuse’, and another ‘says if he had a gun he should use it (against himself)’. One patient had ‘outbursts of rage’ and ‘attacked staff with a knife’, one was ‘dangerous to himself and others’, one ‘threatened to shoot the doctors’ and another ‘requires detention’.

Renowned neurologist and psychiatrist W. H. R. Rivers famously observed that shell-shock symptoms were further compounded by doctors’ recommendations to repress memories as a form of therapy. Siegfried Sassoon—arguably the most well-known of World War I poets—was treated at Craiglockhart by Rivers, and wrote his poem ‘Repression of war experience’ in appreciation of Rivers’s paper. The repeated ‘no’ and the dash separating patient’s and doctor’s voices in the line, ‘No, no, not that,—it’s bad to think of war’, emphasizes this advised memory repression. Rivers argued that memory repression was counterproductive, causing ‘many of the most trying and distressing symptoms [of shell-shock]’. The line ‘When thoughts you’ve gagged all day come back to scare you’ further highlights that those memories of war were not allowed to be vocalized; he is a prisoner in his own head. The speaker says, ‘why, you can hear the guns. / Hark! Thud, thud, thud,—quite soft … they never cease—/ Those whispering guns’. For shell-shock sufferers, there was no escape from the auditory hallucinations of shellfire. Mott described his patients’ nightmares: ‘Persistence of terrifying dreams, often of one particular horrible experience recurring with great frequency, and even in the half-waking state persisting in the mind, proves that the struggle is going on’. Famous war poet Wilfred Owen’s ‘Dulce et decorum est’ captures the essence of these repetitive traumatic nightmares: ‘in all my dreams before my helpless sight, / He plunges at me, guttering, choking, drowning. / If in some smothering dreams, you too could pace’. In the REA, one patient ‘shouted in his sleep’ as he ‘dreamed about the trenches’, one suffered from ‘terrifying dreams’ and another ‘suffered a good deal from hallucinations’. Another patient diagnosed with exhaustive confusional insanity ‘says he has noises in his head and has lost his brains’. After the war, many soldiers battled with ongoing shell-shock symptoms, leading them to find it difficult to form relationships and to withdraw from society. War poetry and primary case notes afford an insight into repressed illness narratives of this distressing constellation of symptoms.

---

78 Scull, op. cit. (note 59).
79 Bonikowski, op. cit. (note 32).
80 S. Sassoon, ‘Repression of war experience’ (Poetry Foundation, 1918), https://www.poetryfoundation.org/poems/57267/repression-of-war-experience (accessed 26 March 2021).
81 W. Rivers, ‘The repression of war experience’, Proc. R. Soc. Med. 11, 1–20 (1918).
82 Mott, op. cit. (note 27).
83 W. Owen, ‘Dulce et decorum est’ (Poetry Foundation, 1920), https://www.poetryfoundation.org/poems/46560/dulce-et-decorum-est (accessed 25 March 2021).
84 Winter, op. cit. (note 22).
Comorbid conditions

General paralysis of the insane (GPI), an incurable manifestation of late-stage syphilis resulting from chronic meningoencephalitis, was listed as the cause of death in 62.5% of patients in the REA case notes. As cases multiplied in the Victorian era it was branded a sinful, immoral disorder. The final stage of GPI consisted of paralysis, mental enfeeblement and complete loss of bodily functions, leading to death. One patient was described as ‘gradually becoming more helpless and stupid’ until death. Many cases of early GPI were mistaken for neurasthenia during World War I, and the War Office commented that ‘syphilis was the cause of much organic nervous disease that appeared in soldiers’. Davis remarks that GPI being a ‘death sentence’ meant that many clinicians were reluctant to make the diagnosis while the patient was alive, which may have contributed to confusion of undiagnosed GPI with war neuroses. GPI was diagnosed via the first serological test for syphilis—the Wassermann antibody test (see ‘Patient X’ and figure 1)—developed in 1906. In 1917, the first successful treatment for GPI was discovered by Wagner-Jauregg, for which he received the Nobel Prize in Physiology or Medicine. This malaria fever treatment (MFT) involved injecting GPI patients with malaria, halting disease progression. MFT is not mentioned in these case notes; it was likely too novel an agent during these admission dates. Within the notes, one patient was said to have GPI and neurasthenia; and two patients had head injuries as well as GPI listed. One patient had a positive Wasserman reaction but is merely listed as having a ‘nervous disorder’, with no mention of a shameful syphilis diagnosis.

Clouston remarked that alcohol was responsible for roughly 20% of ‘mental unsoundness that is so marked as to require treatment in mental hospitals’, and local newspaper headlines certainly reflected this view. In 1914, articles entitled ‘Drink and insanity. The commonest cause’ and ‘Drink—the nation’s enemy’ were rolled out across Edinburgh. Closton found that chronic alcoholism and GPI had strong similarities in symptoms, differentiated by the alcoholic’s recovery and the GPI patient’s inevitable decline. One of the patients was described as the stereotypical case: ‘affability, loquacity, bonhomie and irresponsibility with certain indications of weakness of mind, irresolution, and untrustworthiness’. Other frequently used descriptors include ‘indolent’ and ‘wayward’, with hints at physical signs of chronic alcoholism: ‘sluggish cerebration’, ‘pale and sallow’ and ‘nervous tremors’. For one patient, the war itself was given as the cause of his alcoholism: he is ‘almost certain that he is a victim of the War, and that the origin of his drinking can be attributed to a war neurosis’; he ‘began to drink much more heavily [after shell-shock]’. Of the REA patients 10% have ‘alcohol excess’ as a diagnostic label, with two concurrent GPI and two comorbid shell-shock diagnoses. Alcohol was widely used by front-line physicians as an

85 G. Davis, ‘The most deadly disease of asylumdom: general paralysis of the insane and Scottish psychiatry, c.1840–1940’, J. R. Coll. Phys. Edinb. 42, 266–273 (2012).
86 UK Parliament, op. cit. (note 17).
87 Davis, op. cit. (note 85).
88 R. Bialynicki-Birula, ‘The 100th anniversary of Wassermann–Neisser–Bruck reaction’, Clin. Dermatol. 26, 79–88 (2008).
89 I. Daey Owens, C. Lens, A. Fiolet, A. Ott, P. Koehler, P. Kager and W. Verhoeven, ‘Malaria fever therapy for general paralysis of the insane: a historical cohort study’, Eur. Neurol. 78, 56–62 (2017).
90 Clouston, op. cit. (note 54).
91 LHSA, op. cit. (note 1).
92 Davis, op. cit. (note 85).
initial treatment for shell-shock, and though the controversially re-sanctioned rum rations were welcomed by soldiers in the trenches, doctors were conflicted between alcohol’s morale-boosting effects and its potential damage to health and performance.93

In the 1910s, melancholia was diagnosed where depression was the main symptom, and mania where the core symptoms were of elevation and excitement.94 Of the REA patients, 21.67% were listed as having ‘melancholia’ or ‘depression’, with 13.33% diagnosed with ‘mania’/‘mental excitement’/‘manic depression’. Twelve of these patients had coexisting shell-shock diagnoses; it is unclear which psychiatric illness came first. Robertson commented that many cases of mania were induced in soldiers by ‘excitement produced by their new environment and military duties’, presenting with ‘childish and foolish conduct’.95 Manic patients were said to be ‘excited’, ‘elated’, ‘impulsive’, ‘violent’ and ‘incoherent’ (see table 7),96 with poor memory, delusions and hallucinations. Descriptors pertaining to melancholia included ‘depressed’, ‘unhappy’, ‘insomnia’, ‘fatigue’, ‘self-absorbed’ and ‘silent’ (see table 7).97 Myers described neurasthenia as a condition caused by exhaustion, with symptoms including irritability, concentration loss, depression, fatigue, insomnia and headache, drawing many similarities with depression.98 Mott remarked that headaches induced by shell-shock ‘may be so severe as to give rise to depression, melancholy delusions and suicidal tendencies’, and mixed shell-shock/melancholia diagnoses were found in similar studies into Richmond War Hospital.99 McDoughall describes shell-shock leading to further psychiatric illnesses: ‘he is a changed man… always anticipating the shells with dread, and before long he breaks down with hallucinations or delusions or all the symptoms of mania or of melancholia’.100 These accounts help to facilitate discussions around comorbid shell-shock/psychiatric diagnoses, stressing the difficulty in distinguishing stand-alone cases of melancholia or mania from those induced or exacerbated by shell-shock.

CONCLUSION

Research into shell-shock has been extensive, and the symptoms suffered by World War I soldiers are becoming more widely documented through the search of primary case notes. These are important additions to the literature surrounding shell-shock, as they not only afford insights into shell-shock symptomatology but also the way in which they were perceived by physicians, the War Office and wider society. The impact of diagnostic terms on the stigmatization of certain presentations of shell-shock, such as hysteria or wounds without obvious organic cause, had financial implications for pension eligibility. More crucially, being labelled a malingerer brought intense shame or, in more severe cases,

93 E. Jones and N. Fear, ‘Alcohol use and misuse within the military: a review’, Int. Rev. Psychiatry 23, 166–172 (2011); F. Reid, Medicine in First World War Europe (Bloomsbury Publishing, London, 2017).
94 Clouston, op. cit. (note 54).
95 LHSA, op. cit. (note 58).
96 LHSA, op. cit. (note 4).
97 Ibid.
98 O. van der Hart, A. van Dijke, M. van Son and K. Steele, ‘Somatoform dissociation in traumatized World War I combat soldiers’, J. Trauma Dissoc. 1, 33–66 (2001).
99 Anon., ‘Special discussion on shell shock without visible signs of injury’, Proc. R. Soc. Med. 9, i–xlv (1916). B. Kelly, ‘Shell shock in Ireland: the Richmond War Hospital, Dublin (1916–19)’, Hist. Psychiatry 26, 50–63 (2015).
100 Anon., op. cit. (note 99).
death at the hands of the firing squad. Furthermore, the impact of these terms was propagated to military psychiatry applied to World War II and beyond, shaping stigmatization and perceptions of mental distress in war zones today.\textsuperscript{101}

Whereas we are very familiar with the mysterious ‘silent soldier’ stereotype who embodies all of the men who fought in the Great War, it is important to consider the diversity of individual soldiers’ experiences, from organic to functional injuries, from those of emotional excitement to those of significant depression. We also need to consider comorbid diagnoses as demonstrated by this REA cohort, such as shell-shock triggering a manic episode, or perhaps masking an underlying depression or GPI. Shell-shock must also be considered in the wider historical context, as soldiers returning home had to re-navigate their place in a society which now had turbulent views of class and masculinity. As Jones and Wessely remarked, ‘much can still be learned from a conflict that involved so many in what some have characterized as a vast human experiment in stress’.\textsuperscript{102} Only once we consider all of these factors that contribute to the presentations of shell-shock can we improve our understanding of this infamous disease and its place in the history of military psychiatry.

**DATA ACCESSIBILITY**

This article has no additional data.

**ACKNOWLEDGEMENTS**

With many thanks to Lothian Health Services Archive for facilitating this project and to Dr Richard Mindham for his helpful comments on the manuscript.

\textsuperscript{101} Reid, \textit{op. cit.} (note 3).

\textsuperscript{102} Jones and Wessely, \textit{op. cit.} (note 67).