From the Civil War onward, each American war has culturally and medically defined a set of effects upon soldiers, a set of supposed causes of these effects determined by the knowledge and cultural biases of the era, and a set of symptoms appropriate to the culturally espoused values, the medical knowledge of the time, and the apprehensions about the inherent risks to which soldiers were subjected.

Most authorities would agree that the first modern war of major scale, was the American Civil War (1861–1865). Within it we also see the beginning of a massive new level of lethality as the rifled musket and the minié ball extend the effective killing range of the foot soldiers’ weaponry from 50 to 100 yards to over 500 yards, five to ten times greater than that of Napoleonic warfare. During the Civil War, an appropriate scientific language to describe complex psychological and psychophysiological consequences of warfare was lacking. However, the Civil War still foreshadows the psychological consequences of 20th century warfare. Observers during the Civil War period described the spectra of symptoms that were to become common 50 years later. Caught in assumptions about bravery and cowardice and with few concepts appropriate to understanding functional illness, these observers were often more puzzled than discerning.

The problem of translation of causes to symptoms is, of course, a complex one. Today, we must do the best we can to extrapolate from descriptions of symptoms and their associations with external events. We must remember that at the time of the Civil War there was no knowledge, appropriate set of constructs, medical language, or principles to define what we today call combat stress, and the psychological and physiological sequelae that are its consequences. There were however the acute observations of symptoms that appeared to be responses to external stressful events that were medically inexplicable in the light of the knowledge of the time.

Civil War armies produced a modest number of cases of nostalgia and a greater number of nostalgia-like patterns of behavior. These cases were almost invari-
ably generated during prolonged periods of inaction between episodes of significant combat. It was consistently observed that the symptoms tended to disappear whenever troops prepared for action and left their encampments to march toward the enemy.

All combat and postcombat behavior took place in an environment of value and expectation about individual performance far closer to that of the Greeks and medieval conceptions than to those of our time. Soldiers were either brave or cowardly.1 Thus men who, for whatever set of reasons, wished to avoid the acute stresses and traumas of combat opted out—obviously in very large numbers. While the reality does not accord with public patriotic visions or with the belief that the maximum penalty was always applied to “deserters,” that there was a high desertion rate is unchallenged. This represents a continuation of the pattern described for medieval and renaissance armies, and it is remarkably different from the normative expectations that characterize “attention to duty” in most Western armies in this century (and in U.S. forces in particular). There are many reasons for this, but suffice it to say that desertion could well be a self-screening method for evading or mediating highly stressful situations that is less available to troops serving today. Because the only alternative to bravery was “cowardice,” the dominant symptom expressions that legitimated withdrawal from the combat situation were physical. The cultural constructs of the time left little room for the expression of responses to the stresses of combat that were other than physical or the behavior of the truly “mad.” A gross taxonomic division remained between courage and cowardice.2 Many young officers on both sides in the Civil War, despite their knowledge of the possible medical and life-threatening consequences of wounds in an era before antisepsics, would deliberately attempt to become wounded to demonstrate that they were part of the community of brave men.

Linderman (1987, p. 7) quotes Private Carlton McCarthy of the Richmond Howitzers about the expectations for a soldier:

“In a thousand ways he is tried . . . every quality is put to the test. If he shows the least cowardice he is undone. His courage must never fail. He must be manly and independent.”

1These polar concepts have been laid out exceptionally well by McPherson (1997, p. 6) who noted that:

During the war a consensus existed that in many regiments about half of the men did most of the real fighting. The rest were known, in Civil War slang, as skulkers, sneaks beats, stragglers, or coffee coolers. They “played off” (shirked) or played sick when battle loomed. . . . Some deserted for good. Some really were sick much of the time.

2The title of Stephen Crane’s book The Red Badge of Courage comes from the concept of the wound as the badge of the fulfillment of manhood. It illustrates many of the phenomena described by later historians with great emotional power.
Linderman also points out that soldiers referred to the profound psychological changes that took place as “hardening.” The realities of war led to an end of the initial response of elan, as soldiers were more and more immersed in the blood, terror, and carnage of the battlefield.

One suspects that this “hardening” may be a far different process from the “numbing” described by Lifton (1973, in his diagnostic analysis of posttraumatic stress disorder in Vietnam), but they are both protective adaptations for a significant proportion of those involved in prolonged warfare. They are phenomena that will be seen again and again throughout World War I, World War II, and the Korean War. They are the processes whereby death, dissolution, and destruction become part of a normal landscape that must be negotiated and navigated through if one is to fulfill the obligations of a soldier. As Linderman (1987, p. 241) points out, for most soldiers,

> The dread and sickening loathing created by many a corpse on a battlefield... is by familiarity and constant view transformed into a stoical indifference. Were this not so, the awful carnage of some battles would have made deserters of thousands of soldiers.

We can discern among Civil War veterans a series of symptom patterns that have in recent times been classified under the various rubrics of combat fatigue, battle shock, combat stress reaction, and posttraumatic stress disorder. We can see, as well, the continuation of some very old patterns that speak to the relationship of cohesion among soldiers as the sustainment of soldier behavior.

Descriptions of stragglers following their initial battle engagements are highly pertinent. It is estimated that following the initial battles at Antietam, one-third of the Confederate force was lost as “stragglers.” Many are described in terms very much equivalent to the World War II descriptions of combat fatigue. Stragglers were described as sitting under trees, trembling, clutching their rifles, staring into the middle distance, jumping at any loud noise—the startle response that is today usually considered diagnostic of a combat stress reaction. They were described as incapable of any kind of proximate effective soldierly behavior until swept up by the provost guards, noncommissioned officers, or officers; organized; and brought back into their encampments. It is interesting to note that within a few weeks, most of these men had been reintegrated into their units and were considered fit for combat again. (See, for example, Sears, 1983.)

Throughout the Civil War, blind panic was often seen as the response to the first shock of battle. Members of the unit in the line of battle would break, turn, and run. The organic cohesion of the line was broken and with it apparently, if we
interpret the data correctly, all psychological capacity to resist the enemy and use the unit as a maintaining factor. At Bull Run it was repeatedly reported that Union soldiers broke rank and fled in panic from the Confederates, crying out (and apparently believing) that they were the sole survivors of their regiments. In most cases, about 90 percent of each of the regiments had survived, neither killed, wounded, nor captured. This psychological power of the combat event, or the "traumatic" event, to reorder cognition and establish delusory truths that have no equivalent bases in reality is one that appears over and over again in war.

The culture of the time asserted that cowardice and constitutional or moral weakness were the sole sources of flight and of the inability to overcome fear. It appears that for a soldier to desert his unit by fleeing from the line of battle, it was important for him to believe that a level of disaster existed that legitimized his actions rather than believing that they were "fear driven." The only other acceptable symptoms that could account for the breakdown of behavior and the inability to continue in combat were physical. Real disease and illness were rife and claimed the majority of lives lost on both sides. The descriptions of soldiers who did not simply desert but ceased to be effective participants appear to indicate that psychogenic symptoms and ailments were also common.

During the Civil War, doctors began to pay attention to ambiguous (and, in terms of the medical knowledge of the time, difficult to diagnose or explain) physical conditions. Unexplained and unexplainable cardiac conditions were seen in moderate, but impressive numbers. These ultimately came to be known as "soldier's heart," "effort syndrome," and finally as DaCosta's syndrome. The soldiers who presented themselves with this "cardiac" disorder were capable of almost no sustained physical effort. Their heart rates were quite high, palpitations were common, and heart rate increased rapidly upon exertion. Overall weakness and fatigue were also characteristic. Few of the diagnostic techniques of the period could detect any known organic heart ailment that might account for these symptoms, and it was extraordinarily puzzling to the military surgeons of the time. The stethoscope had been invented by Laënnec in 1816 and first

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3 This is a point that is powerfully made by Hess (1997) in his chapter on the psychology of the battle line.

4 A wonderful description of the attempt to understand this syndrome is in the official medical history given by a surgeon in a New Jersey regiment of the Federal Army. He was deeply puzzled by soldiers presenting with these symptoms. There was no sign of organic heart disease or of any other disease or fever, which made the extremely rapid heart rate difficult to understand. He noted that he knew that the only way to raise a human heart beat is to have the individual squat and make efforts as if he were at stool, but that would raise it only for a few moments. These people had highly elevated heart beats for days and weeks on end. Therefore, his thought was that this must be some kind of cardiac disorder that medical science did not yet understand. It must be pointed out that adrenaline was not discovered until 1901, and its role in release under strong emotion or stress in accelerating heart rate was not known before that time. Almost all of the symptoms that we today
described in 1819 as a single wooden tube; the binaural stethoscope was invented by Cammann in 1852. Cardiology was in its infancy, dependent almost entirely on exceptional training and skill in auscultation and stethoscopy to make a good diagnosis (one that could be confirmed only postmortem since techniques for visualizing heart action and state in living persons did not exist). Such skills were part of the repertoire of those few physicians trained in great medical centers like Vienna, Paris, London, and a very few places in the United States. For the most part, U.S. medical schools were “diploma factories,” often turning out poorly trained, marginally competent physicians—a condition that was not to change until after the publication of the Flexner Report in 1910 (see for example, Porter, 1998). We can have no sure idea of how many soldiers actually had functional, as opposed to pathological, heart disorders. The capacity to make clear differential diagnoses between the two lay in the future.

POSTWAR PHENOMENA

In terms of postwar psychological and physical symptoms, the consequences for the soldier are difficult to discern and require a study of primary sources when they are available.5 Linderman (1987) feels that, because of the overall patterns of American culture, veterans retreat into silence and do not allow themselves to contemplate their physical or psychological wounds. He attributes this in part to the soldiers’ sense of disillusionment by the “real” nature of warfare in contrast to the civilian vision of the war. As Linderman (1987, p. 268) notes:

In the war wounds had been suffered by some and not by others; the problems they created were thus the concerns of the individuals involved, not of society. The soldier had wished to rid himself of the effects of body wounds as rapidly as possible; the veteran would do everything he could to accelerate the disappearance of mind wounds. Disturbing memories were to be kept to oneself.

Linderman’s (1987, p. 269) description of the postwar behavior of Oliver Wendell Holmes is pertinent

He was a war hero whose demeanor surprised those entertaining him during a tour of England in 1866: He was “as little military as need be, and, like Coriolanus, not baring his wounds . . . for public gaze.” He would not read of the war or observe the anniversaries of its battles.

consider as being functional, psychogenic, or stress driven could not be construed as such then. The major exceptions were the symptoms denoted as hysterical, and at that point in time they were still considered unique to women.

5An attempt to assess the psychiatric consequences of the Civil War (particularly for veterans in the postwar period) came to my attention, unfortunately, too late to be drawn upon for this report (Dean, 1997).
The realities of war were effaced, first by silence and then, 20 years after the Civil War, by a renaissance of the heroic view of war as the splendid shaper of the citizenry and men’s characters. Dean (1997) has published a pertinent view of the probable range of consequences for Civil War veterans in the postwar era, including symptoms consonant with posttraumatic stress disorder. While his sample was drawn from veterans hospitalized in asylums in Indiana, he construes them as a window on a wider range of less dramatic disabilities afflicting other veterans. His small sample demonstrates higher risk for youth, combat exposure, wounding and prisoner-of-war status than his control group. The contributions of alcohol abuse and alcoholism have resonance with those who were psychologically damaged in other wars. The markedly high levels of violence and spousal abuse of this hospitalized sample, however, is not reflected in the experience of veterans of later wars.

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6This vision of the United States was epitomized in the behavior, writings, speeches, and conversations of Theodore Roosevelt.