

Neurasthenia Revisited: On Medically Unexplained Syndromes and the Value of Hermeneutic Medicine

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Abstract

The rise of medically unexplained conditions like fibromyalgia and chronic fatigue syndrome in the United States looks remarkably similar to the explosion of neurasthenia diagnoses in the late nineteenth century. In this paper, I argue the historical connection between neurasthenia and today's medically unexplained conditions hinges largely on the uncritical acceptance of naturalism in medicine. I show how this cultural acceptance shapes the way in which we interpret and make sense of nervous distress while, at the same time, neglecting the unique social and historical forces that continue to produce it. I draw on the methods of hermeneutic philosophy to expose the limits of naturalism and forward an account of health and illness that acknowledges the extent to which we are always embedded in contexts of meaning that determine how we experience and understand our suffering.

Keywords

neurasthenia, fibromyalgia, chronic fatigue syndrome, somatization, naturalism, hermeneutics

In 1881, New York neurologist George M. Beard published *American Nervousness, Its Causes and Consequences: A Supplement to Nervous Exhaustion (Neurasthenia)*. In this expansive work, Beard examined the explosive growth of affective and somatic symptoms emerging from “neurasthenia,” the deficiency or exhaustion of, what he called, “nerve force.” He identified a vast number of possible symptoms for neurasthenia including: neuralgia, dyspepsia, hay-fever, diabetes, sensitivity to narcotics and various drugs, depression, premature baldness, sensitivity to

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cold and heat, tooth decay, chronic catarrh, infertility, hysteria, inebriety, fatigue, and impotence (Beard, 1881, vi-xi).¹ Beard attributed the rise of neurasthenia both to a hereditary predisposition as well as the wrenching social upheavals of modernization in the United States at the end of the nineteenth century, as large swaths of the post-Civil War population migrated from slow-paced rural communities to chaotic and bustling cities in the Northeast. With this movement, men abandoned their traditional vocations as manual tradesmen and farmers for new roles as workers in office buildings, and women left their stable domestic roles as wives and mothers to compete with men in universities and professional careers. Beard also cited the new technologies of industrialization such as the periodical press, the telegraph, telephone, and steam engine, as well as the ubiquity of mechanical clocks and watches that “compel us to be on time, and excite the habit of looking to see the exact moment” (p. 103).²

These factors, taken together, contributed to the excessive strain on mental and physical life, and helped explain Beard’s claim that the “chief and primary cause” of neurasthenia is not the result of some new organic pathology but of “*modern civilization* [itself]” (p. vi). By the turn of the century, neurasthenia had spread to the other side of the Atlantic to Europe’s teeming urban centers.³ Influential cultural figures such as sociologist Max Weber and novelist Marcel Proust received the diagnosis, and neurasthenic characters became increasingly fashionable in the fiction of writers such as Edith Wharton, Theodore Dreiser, Henry James, and Thomas Mann. Indeed, the diagnosis became so common in the United States that philosopher William James referred to it as “Americanitis,” and the massive drugstore chain Rexall produced an “Americanitis Elixir” for the “man of business, weakened by the strain of [his] duties” (Osnos, 2011).

By the end of the Great War, due to its diagnostic vagueness, its unproven theory of “nervous energy,” and the ambiguous breadth of its symptoms, neurasthenia began to fall out of favor in the United States.⁴ But today we are seeing the symptoms of neurasthenia emerge once again in a proliferation of “functional somatic conditions” such as chronic fatigue syndrome and fibromyalgia. In this paper, I offer an account of the medicalization of neurasthenia and show how this process has undermined the original value of Beard’s work by failing to engage the socio-cultural forces through which neurasthenic symptoms emerged. Rather than viewing the neurasthenic from a narrow naturalistic perspective, as a discrete causally determined physical organism, Beard’s analysis views the neurasthenic in terms of, what hermeneutic philosophers such as Martin Heidegger would later call, “being-in-the-world,” a situated activity or *way of*

¹ The ideas in *American Nervousness* emerged out of an earlier article of Beard’s (1869) entitled “Neurasthenia or nervous exhaustion.”

² George Simmel develops this point in his pioneering 1903 essay, “The Metropolis and Mental Life” (1903/1997) by exploring the emotional costs of clock-time, where “punctuality, calculability, [and] exactness are forced upon life by... metropolitan existence.” (p. 177; see Aho, 2007)

³ It is interesting to note that neurasthenia stretched across class and gender lines in a way that was unique among functional somatic conditions. It was diagnosed first among upper middle class women; then among “stressed out” middle class business men; and finally among the lower working classes before vanishing altogether from American medicine. (Gosling, 1987; Wessely, 1990)

⁴ Although it eventually disappeared as a diagnostic category in the United States, the diagnosis continues to be applied in Europe and is still listed in the ICD-10, and it is used widely in countries such as Japan, Korea, China, Australia, and Russia.

being that is already involved and embedded in a meaningful socio-historical context. This situated activity not only shapes the way we experience, feel, and perform our bodies, more importantly, it informs how we interpret and give meaning to our nervous distress. Drawing on the insights of hermeneutic philosophy, I call into question some of the core naturalistic assumptions in medicine today. This questioning, in turn, makes it possible to interpret the toxic experiences of stress and nervous suffering from within the context of our contemporary ways of living. Which is to say, in effect, that modern medicine is often complicit in enacting and perpetuating the very pathologies it is seeking to treat.

Neurasthenia and Naturalism: A Brief History

The diagnosis of neurasthenia emerged against the backdrop of enormous successes in the natural sciences in the nineteenth century in areas such as anatomy and physiology, zoology, evolutionary theory, and in the emerging field of neurology of which George Beard was a pioneer. These successes contributed to the loss of religious authority and an increasing trust in the methods of natural science to explain and alleviate bodily suffering. This secular turn not only contributed to the emergent vocational prestige and cultural power of the medical professions, it also influenced the pervasive naturalistic paradigm that has fundamentally transformed the ways in which medicine interprets pathology.⁵

Naturalism in medicine entails both an epistemological and a metaphysical assumption. From an epistemological standpoint, naturalism generally presupposes that the view of theoretical detachment and the objective procedures of empirical science are best suited to gain knowledge of the ailing body. From a metaphysical standpoint, naturalism assumes a position of physicalism, that all manifestations of sickness must be constituted in terms of physical substances in causal interaction and that these interactions can be quantified under mathematical laws of mass and motion (Ratcliffe, 2009). This paradigm creates the mechanistic and objectifying picture that characterizes medicine today, where a disease is considered legitimate or “real” only insofar as there is a measurable lesion or a deviation from normal functioning that is identifiable by anatomical or physiological-chemical observation.

The result is a kind of biological reductionism, where pathology—including mental illness—is generally viewed as having a physical or bio-chemical origin. On this account, apropos of mental illness, the Dutch physiologist Jakob Moleschott wrote, “The brain secretes thoughts as the kidney secretes urine” (cited in Szasz, 2007, p. 47). This reductionism was evident in the way American medicine framed its understanding of nervous disorders at the end of the nineteenth century.⁶ Indeed, it could be argued one of the reasons that Beard’s account of neurasthenia became a diagnostic juggernaut is because it was viewed as “a physical, not a mental state” (Beard, 1881, p. 17). By 1900, neurasthenia had become the single most common diagnosis in the area of neuropathology and psychopathology (Shorter, 1992). By tracing its origin to a congenital weakness of the nervous system, Beard’s thesis made it “real” from the perspective of

⁵ This cultural shift was evident, for example, in the ways that various forms of social deviance earlier regarded as religious or moral failings by priests—such as alcoholism, depression, and homosexuality—came to be medicalized by doctors in the twentieth-century (see Aho & Aho, 2008, pp. 65-70).

⁶ It is important to note that medical treatment and the interpretation of disease in the United States tends to be far more reductive and mechanistic than other Westernized countries (e.g., Payer, 1989).

naturalism, and this gave it scientific legitimacy. Although many of its most pronounced symptoms were psychological—including crippling phobias, depression, panic anxiety, and compulsiveness—its status as a physical disease meant that the medical establishment could take sufferers seriously. It was not madness that triggered the “nervous breakdown,” but a physiological depletion of the body’s finite reserves of electrical “nerve force.”

By removing the stigma of shame and fear associated with insanity, neurasthenia was often viewed positively: not only as a mark of a highly evolved and refined nervous system but of a man’s commitment to the Protestant values of industriousness and productivity or, in the case of women, of sensitive intellectual and literary proclivities. Emerging in the busy urban corridors of the East Coast, it was initially viewed as the signature disorder of middle and upper class “brain workers”—as opposed to rural “muscle workers”—whose focus and ambition could not match the frantic pace of a modern capitalist society. Physician George Drinka (1984) described the phenomenon in terms of a person

with a nervous tendency [who] is driven to think, to work, to strive for success. He presses himself and his life force to the limit, straining his circuits. Like an overloaded battery, or like Prometheus exhausted from reaching too high for the fire of the gods, the sufferer’s electrical system crashes down, spewing sparks and symptoms and giving rise to neurasthenia. (p. 191)

In this way, neurasthenia provided both a scientifically legitimate (i.e., naturalistic, physical) and culturally accepted (i.e., burnout, overwork) justification for being sick (Abbey & Garfinkel, 1991). Rather than being viewed as insane, treated by a psychiatrist (or “alienist” as they were called at the time because they dealt with those who were alienated or estranged from everyday life), and banished to the custodial care of the mental asylum, a prosperous neurasthenic could be cared for privately by a “real” doctor, a neurologist trained in general pathology and internal medicine, and given the standard somatic treatment of the time, namely, bed rest, a milk diet, electrical stimulation, and massage (Freedman, 1987; Shorter, 1997, pp. 129-136). This is how neurasthenia exploded in popularity at the turn of the century, becoming a “catch-all” diagnosis for anyone suffering from inchoate feelings of exhaustion, pain, anxiety, and nervousness. But almost as quickly as neurasthenia emerged as a diagnostic behemoth, it began to fade, eventually disappearing from American medicine altogether. This decline can be attributed to a number of overlapping factors.

First, what contributed to the staggering popularity of neurasthenia also contributed to its precipitous decline, namely the sheer broadness of its definition. Beard identified over seventy-five possible symptoms of neurasthenia with the result that virtually anyone could be diagnosed with the condition. In terms of neurasthenia-related phobias alone, he listed: “fear of lightning, fear of responsibility, fear of open places, fear of closed places, fear of society, fear of being alone, fear of fears, fear of contamination, fear of everything” (Beard, 1881, p. 7). As a result, “one found [neurasthenia] everywhere,” wrote a French author of the time, “in the salons, at the theater, in the novels, at the palace. By virtue of it, one explained the most disparate reactions of an individual: suicide and decadent art, adornment and adultery; it became the giant of neuropathology” (cited in Chatel & Peele, 1970, p. 37) The ubiquity of neurasthenia’s symptoms made the disorder virtually impossible to classify with any precision. In describing what he

called ‘the caprice’ of the condition, Beard acknowledged that, “sufferers often times wonder and complain that they have so many symptoms [because] their pain and distress attack so many parts and organs” (Beard, 1880, p. 76). This diagnostic ambiguity resulted in increasing skepticism in the scientific community, becoming “the garbage can of medicine” (Wessely, 1990, p. 47).

The decline was also marked by the fact that neurasthenia’s medical advocates could not identify a specific organic or physiological cause. Beard’s belief was that it was a physical disorder of weakened nerve cells characteristic of a hereditary or congenital condition. The stronger one’s heredity, the more strain an individual could endure before succumbing to “nervous bankruptcy” and vice versa (Gossling, 1987, pp. 84-5). It was thought that the dramatic social, economic, and technological changes taking place in America at the time served as a trigger for those with a congenital weakness of “nerve force.” As Beard (1881) put it:

The force in [the] nervous system...is limited; and when new functions are interposed in the circuit, as modern civilization is constantly requiring us to do, there comes a period, sooner or later, varying in different individuals, and at different times of life, when the amount of force is insufficient to keep all the lamps actively burning; those that are weakest go out entirely, or, as more frequently happens, burn faint and feebly—they do not expire, but give an insufficient and unstable light. (p. 99)

The neurasthenic, in short, could not endure the physical and mental strain of a country that was “becoming rapidly Americanized.” The problem, of course, is that Beard’s thesis remained scientifically untestable. Yet, even though physicians could not find an organic cause for neurasthenia, they also could not deny that a condition existed that was overwhelming a large swath of America’s urban population, incapacitating individuals who were previously living successful and productive lives (Freedman, 1987).⁷ The question for physicians was whether or not it could be demonstrated that it was a single disease or if a more precise nosology could identify specific disorders that existed within this broad classification. And it was the issue of nosology that sealed neurasthenia’s fate.

Neurasthenia, Psychiatry, and the Crisis of Validity

In 1895, Sigmund Freud published a paper called “*On the Grounds for Detaching a Particular Syndrome from Neurasthenia under the Description of Anxiety Neurosis.*” This signaled one of the first attempts to provide a more rigorous system of classification, parceling out “anxiety neurosis” and “hysteria” from the general category of neurasthenia. Shortly thereafter, Freud’s contemporary Pierre Janet did the same with “compulsivity,” detaching it from neurasthenia. These diagnostic changes meant far fewer were suffering from the condition (Gossling, 1987, p. 169; Wessely, 1990, p. 47). Although *fin de siècle* figures like Freud, Janet, and Jean-Martin Charcot were trained as neurologists and were still committed to the idea of the physical nature

⁷ Beard’s theory was further undermined by the discovery of hormones in 1902, which convinced physicians they had identified a specific causal agent—a chemical or hormonal imbalance that fit nicely into the mechanistic model of naturalism. The problem with this early version of the “chemical imbalance” theory was that, although hormones certainly exist, it could never be demonstrated that they in fact caused nervous disorders (Chatel & Peele 1970).

of nervous disorders, they did not rely exclusively on the trademark somatic therapies of the day such as bed rest, electrical stimulation, massage, and water and thermal therapies. They focused instead on mental processes or disorders of the mind, with the idea that the physical symptoms of neurosis might arise as the result of unconscious, usually libidinous, conflicts that emerged in early childhood. With this turn, “psychotherapy” (or the “talking cure”) was born as a way of verbally accessing long repressed sexual desires and fantasies. Using dialogical techniques such as dream analysis, free association, and transference, the therapist would help the patient become aware of their unconscious conflicts, and this awareness might free them of the physical symptoms of neurosis, demonstrating, in the words of one of Charcot’s students, “that the body could be cured by the mind” (cited in Shorter, 1997, p. 138).

Although the “talking cure” became wildly popular with middle and upper class society in mid twentieth century America and was generally recognized by the medical establishment as offering legitimate therapeutic techniques to treat neurosis, its scientific foundations remained dubious. This is because psychoanalysis does not fit well into the empirical framework of naturalism. The assumption that an individual’s neurotic behavior could, for example, be explained in terms of repressed libidinous fantasies did not meet the objective standards of observation and testability that characterize empirical science. As opposed to somatic medicine, there is no way to physically locate, test for, or measure the source of repression or psychic conflict that manifests neurotic symptoms. Unlike physical abnormalities of blood, muscle, and bone, the abnormalities of the mind cannot be directly observed because, obviously, mental phenomena are not physical substances. The psychiatrist cannot point to an organic lesion or marker in the brain that secretes abnormal thoughts and emotions. As a result, they can only infer what a given mental disorder or abnormality is based on speculative theoretical assumptions, that is, on the metapsychology of the psychiatrist. But such inferences are unscientific precisely because they are impossible to empirically refute or falsify.

In the latter half of the twentieth century, with advances in neuroscience, pharmacology, and genetic research, psychiatry attempted to regain a footing in the natural sciences by embracing a more empirical and biologically informed approach to mental illness. This new vision of bio-psychiatry was framed by influential figures like Nancy Andreasen (1984) who wrote:

The major psychiatric illnesses are diseases... They should be considered illnesses just as diabetes, heart disease, and cancer are... caused principally by biological factors, and most of these factors reside in the brain... The brain is the organ of the body that serves to monitor and control the rest of the bodily functions, as well as providing the source and storehouse of all psychological functions, such as thoughts, memories, feelings, and personality. As a scientific discipline, psychiatry seeks to identify the biological factors that cause mental illness. The model assumes that each different type of illness has a different cause. (pp. 29-30)

Central to this shift toward bio-psychiatry was a major revision by the American Psychiatric Association (APA) to the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980. This involved a thorough rejection of the ideology and jargon of psychoanalysis with the aim of implementing a system of disease classification based on empirically observable symptoms. According to Robert Spitzer, the primary architect of the

DSM-III, this revision represented psychiatry's return to medical legitimacy, "an advancement toward the fulfillment of the scientific aspirations of the profession" (cited in Lewis, 2006, p. 4). Key to this transformation was the elimination of the broad and ideologically loaded category of "neurosis" that was replaced with the more neutral medical term "disorder." Henceforth, what was once neurosis was carved into seven more precise and reliable disease classifications, each with its own symptoms and diagnostic criteria: agoraphobia, panic disorder, post-traumatic stress disorder, obsessive compulsive disorder, generalized anxiety disorder, simple phobia, and social phobia (Horwitz, 2002).

Having addressed many of the affective dimensions of neurasthenia by eliminating neurosis, the DSM-III also addressed somatic dysfunctions. It did this by eradicating the archaic category or "hysteria" and replacing it with a new diagnostic label, "somatoform disorder." This was intended to identify those patients who presented with symptoms like chronic pain, dizziness, weakness, gastrointestinal issues, and fatigue, but had no demonstrable physical cause. For diagnostic precision, this category was also broken up into seven discrete disorders: body dysmorphic disorder, conversion, somatization, somatoform pain disorder, undifferentiated somatoform disorder, somatoform disorder not otherwise specified, and hypochondriasis (Lipowski, 1988).

But discarding antiquated disease categories and the metapsychology of psychoanalysis for the sake of diagnostic precision did little to address the core issue of scientific validity; instead, it simply created more disorders. While the DSM-I (1952) was only 130 pages long and listed 106 different disorders, the DSM-III was almost 500 pages long and contained 265 disorders, and DSM-V (2013) is 800 pages and describes nearly 300 disorders. Not only is there tremendous overlap or co-morbidity among these disorders (for instance, someone diagnosed with somatoform pain disorder could also present symptoms of generalized anxiety disorder, agoraphobia, and major depression, resulting in a patient having not just one but four distinct disorders), none of the disorders can be explained using the "gold standard" of pathology, namely, a physical marker in the brain. In other words, the hope that an empirically rigorous system of classification might help legitimize psychiatry as a medical science by providing "greater objectivity, diagnostic precision, and reliability" (USDHHS, 1999, p. 44) has proven to be an illusion.

To this day, psychiatry has generally failed to demonstrate that behavioral, cognitive, and emotional abnormalities are the effects of biological diseases of the brain, this, in spite of the recent discovery of neurotransmitters and receptors, advances in genetics, and magnetic resonance technologies. Indeed, only in the most severe cases, such as schizophrenia and bipolar disorder, is there any evidence at all of a biological (i.e., genetic) marker (Horwitz, 2002). For the vast number of nonpsychotic disorders listed in the DSM, the psychiatrist is left to make inferences, not on the basis of biology but on the basis of the observable behavior of the patient, their speech patterns, posture, facial expressions, and comportment. But what counts as abnormal in these respects are not medical (i.e., scientific); they are social, cultural, and religious (Szasz, 2007). Psychiatrist, Nassir Ghaemi (2013), summarized the situation this way: "the leaders of the DSM [do not] believe there are scientific truths in psychiatric diagnosis—only mutually agreed upon falsehoods. They call it reliability" (n.p.). As a result, psychiatry continues to be regarded with suspicion and skepticism, even by its own practitioners, as "the dustbin of modern medicine"

(Wessely, 1990, p. 42). Sufferers of nervous disorders remain, as ever, haunted by the specter that what they experience is “imaginary,” “unreal,” or “in their heads.”

In what follows, I suggest this enduring skepticism about psychiatry may shed light on the renewed interest in medically unexplained somatic conditions such as fibromyalgia and chronic fatigue syndrome that bear striking resemblances to neurasthenia. By emphasizing a somatic or non-psychiatric explanation of symptoms, the diagnosis creates the impression of medical legitimacy, of being “real.” I argue that, from a hermeneutic perspective, this is crucial for the narrative integrity and self-constitution of the sufferer.

Hermeneutics, Somatization, and Medically Unexplained Syndromes

One of the advantages of approaching questions of health and illness from a hermeneutic perspective is the way in which it reconfigures the traditional conception of the human being. Rather than viewing the human being in naturalistic terms, as a causally determined physical substance, hermeneutic philosophy sees it as an interpretive activity, where we exist in the narrative identities and self-interpretations that we create for ourselves. On this view, it is not an account of “*what* we are” as biophysical entities that is important, but “*how* we are,” that is, how we ceaselessly fashion and refashion our own being (or identity) as our lives unfold. This is why, when referring to the hermeneutic self, Heidegger wrote, “we are expressing not its ‘what’ (as if it were a table, house, or tree) but its being” (1927/1962, p. 180) This means that there is no pre-given physiological essence that fundamentally determines who we are. On the contrary, what distinguishes us from non-human animals is the fact that we are “self-interpreting” (Taylor, 1985), that is, we “create” or “understand” who we are by interpreting and giving meaning to our physiological givenness. As self-interpreting beings, when we suffer from nervous exhaustion, diffuse pain, and anxiety it is up to each of us to understand it, that is, to imbue those symptoms with the intelligibility and significance that they have.

Moreover, the meanings we give to our suffering are always embedded in a particular socio-cultural context. As a result, the hermeneutic self cannot be viewed as an encapsulated subject separate and distinct from an external world of objects (including other people). Rather, “self and world belong together. [They] are not two beings like subject and object ... Self and world are the basic determination of [human existence] itself in the unity of the structure of being-in-the-world” (Heidegger, 1982, p. 297). As an inter-subjective “being-in-the-world,” our interpretations are limited or constrained by the meanings made available by our situation. The world, on this view, opens up an array of possible ways for us to understand and make sense of our suffering. And because our interpretative context today is shaped so decisively by the paradigm of natural science, it is easy to see how the symptoms of neurasthenia are reborn in “functional somatic” conditions like fibromyalgia and chronic fatigue syndrome.⁸ Because we are so invested emotionally and cognitively in physical or somatic explanations for our nervous

⁸ In listing the symptoms of neurasthenia, Beard referred to “profound exhaustion,” “pains in the back,” and “heaviness in the loins and limbs” (1881, p. 7) which today could indicate a diagnosis of *chronic fatigue syndrome*. He cited “localized peripheral numbness and hyperesthesia,” “ticklishness,” “local spasms of muscles,” and “vague pains and flying neuralgias” which fit the diagnostic profile of *fibromyalgia* (pp. 7-8) And he cited special idiosyncrasies with regard to “food,” “cramps,” “nervous dyspepsia,” and “indigestion” (pp. 7, 41) which resemble the symptoms of *irritable bowel syndrome*.

distress, it follows that under the auspices of naturalism, such explanations indicate the existence of something legitimate and “real.” This is why, as Robert Aronowitz cautioned, “[there is] a market for somatic labels... in the large pool of ‘stressed-out’ or somaticizing patients who seek to disguise an emotional complaint or to ‘upgrade’ their diagnosis from a nebulous (i.e. psychiatric) one to a legitimate disease.” (1991, p. 97)

This process can be described as “somatization.” Not to be confused with the somatoform disorder in the DSM, somatization refers to a type of narrative construction or self-interpretation, where mental exhaustion, diffuse pain, anxiety, and stress arising largely out of the situated upheavals and emergencies of living are experienced and explained as a physical disorder, even when there is no evidence to support it (Lipowski, 1988).

Consider the case of Linda.

Linda had spurned previous recommendations for psychiatric counseling. She would not accept that she might have a psychiatric illness, and was angry, rather than relieved, when doctors implied that ‘Nothing is wrong with you’ and that ‘It is all in your head’. She was convinced that something was physically wrong, and she wanted [the doctor] to identify and treat that problem. (Young, 2003, p. 165)

Although physicians would usually treat Linda’s condition as “psychosomatic,” as a somatic presentation of mental illness, for sufferers there is something deeply consoling when it is explained in physicalist terms. This is because it allows the patient to fashion a narrative that fits into the culturally accepted paradigm of naturalism. Even though “functional somatic” conditions are scientifically dubious (i.e., they cannot be traced back to an organic cause), the fact that they are regarded as physical explanations of their symptoms is often sufficient for the patient to construct an account of their suffering in a way that is not only intelligible but culturally legitimate. Fibromyalgia and chronic fatigue syndrome, then, are not just useful diagnostic labels. For patients, they are symbols that reflect a specific cultural reality and help to create a meaningful identity. As Jerome Groopman (2000) claimed, “Of all the words a doctor uses, the name he gives the illness has the greatest weight.... With a name, the patient can construct an explanation of his illness not only for others but for himself” (n.d.).

On the hermeneutic view, language and the words used in diagnostic medicine are expressive of a wider culture and are as rhetorically valuable as the physician’s stethoscope, syringe, or scalpel because it allows the patient to fashion an intelligible self-interpretation. This helps to sharpen the distinction between the biochemical aspects of “disease” and the subjective experience of ‘illness’ (Conrad, 1987). If the physician’s instruments treat and measure disease, language allows the patient to give meaning to the lived-experience of their unease. Where the language of spirits, sin, and guilt was expressive of the context of meaning that allowed people to make sense of their suffering in the middle ages, the language of naturalism and somatization is expressive of our context today. This helps explain why, instead of going to a psychiatrist for complaints of inchoate feelings of pain and fatigue, insomnia, racing heart, digestive problems, or difficulty concentrating, we instead go to a medical specialist to validate our experience. We seek an immunologist to receive a diagnosis of chronic fatigue syndrome, a rheumatologist for a fibromyalgia diagnosis, a neurologist for tension headache, a cardiologist for atypical chest pain

and palpitations, or a gastroenterologist for irritable bowel syndrome. By medicalizing these symptoms, the patient feels validated, that there is a “real” cause to his or her suffering even if the physician does not see it this way (Barker, 2002; Hearn, 2009; Jimenez & Mayer, 2015).

Thus, even though the majority of those labeled with fibromyalgia and chronic fatigue have an accompanying psychiatric disorder, and the treatment is often the same as the treatment for anxiety or major depression (e.g., a combination of antidepressant medication, exercise, and/or some form of cognitive-behavioral therapy), patients generally favor a “functional somatic” diagnosis because it avoids the stigma of unreality associated with mental illness (Wessely, 1990). The uncritical assumption underlying somatization, then, is that it is only a matter of time before an authentic biochemical “fact” can be found that directly causes the syndrome. And excitement builds in the medical community with the scientific discovery of each new cause, whether it is measurable deficiencies in neurotransmitters like serotonin and dopamine, low levels of somatotropin or growth hormone, or the poor sensory functioning of “substance P” (Groopman, 2000). But it is this assumption that is precisely what a hermeneutic approach to medicine calls into question. Even if such a discovery is made, it is still up to the sufferer to understand and give meaning to their own subjective experience on the basis of the interpretative resources made available by their world.

Hermeneutic philosophy dissolves the traditional scientific distinction between objective “facts” and subjective “values.” From the standpoint of hermeneutics, there are no brute, value-less facts when it comes to human experience. As Charles Taylor wrote, such “a reductive explanation of human experience in physiological and ultimately in physical and chemical terms” is a denial of the qualitative meaning and value we attribute to our experience (1985, p. 47). In fact, on closer view, the allegedly neutral and objective explanations of biochemistry are *themselves* value-laden insofar as they emerge against the background of a common language and are viewed by culture in qualitative terms as “valid” and “real.” We can make sense of our experiences only through the language that we grow into. Biomedical reductivism betrays this aspect of enculturation and the complexity and ambiguity of “being-in-the-world,” and this brings us back to the value of Beard’s initial characterization of neurasthenia.

Neurasthenia Today

Although Beard’s theory of “nerve force” was scientifically unfounded, what makes it so relevant today is how it critically engaged the way of being unique to modernity. Instead of regarding the sufferer as a discrete object separate and distinct from his or her context and offering a biochemical account of physical and emotional exhaustion, Beard focused on the broad social and cultural upheavals taking place at the end of the nineteenth century, and he examined the possibility that simply *existing* amidst these upheavals might be unhealthy. By attending to the destabilizing social forces associated with turn of the century American life—urbanization, industrialization, the insecurities of a market economy, new transportation and communication technologies, and the emerging dominance of clock-time—Beard recognized that neurasthenia was “an inevitable reaction from the excessive strain of mental and physical life” (1881, p. 83). As a physician, approaching questions of health and illness in a historically and sociologically informed way, he saw the obvious, that the human being is not an encapsulated material body but an interpretative *way of being* that is already bound up in a particular life-

world, one that invariably shapes our emotional and physical health. Today, with corporate downsizing and outsourcing, increased productivity and efficiency measures, and overall economic insecurity combined with wearable technologies that keep us perpetually on alert, electronically tethered to work and to each other, Beard's conclusion seems self-evident, that "nervous sensitiveness and nervous diseases ought to increase with the progress of modern civilization; and neurasthenia would naturally be more abundant in the present than in the last century" (p. 137).

Beard's account of the toxic effects of an over-stimulated, insecure, and mechanized existence not only reflects contemporary descriptions of American life as perpetually "overwhelmed," "stressed," and "burned out." It also opens the possibility for a deeper analysis of the particularities of nervous distress. This is especially interesting as it pertains to issues of gender. Whereas for men, neurasthenia was once widely regarded as a mark of ambition and drive, "[an] acceptable and even an impressive illness... ideally suited to a capitalistic society and to the identification of masculinity with money and property" (Showalter, 1985, p. 135). For women, the situation is far more complex. Among those suffering from neurasthenia at the turn of the century, women were disproportionately represented. And today, the vast majority of those complaining of medically unexplained somatic conditions are also women, including ninety percent of all fibromyalgia sufferers (Groopman, 2000). Rather than attributing this overrepresentation to the idiosyncrasies of a woman's reproductive organs and hormones, Beard took a broad hermeneutic view, focusing on the changing social roles and meanings for women in a new industrialized economy, her entry and acceptance into colleges and the professions, and her emergent vocational ambition and drive (Abbey & Garfinkel, 1991, p. 1643).

Although criticized as a misogynist by regarding motherhood and domesticity as a woman's natural state,⁹ Beard's view resonates to the concerns of contemporary feminist critics by exposing the limits of medicalization and drawing our attention to the concrete social and historical forces that produce and reproduce our nervous distress. This not only helps frame what Betty Freidan in the 1960s called, "the problem that has no name" (referring to the social conformism of the post-World War II American economy that pushed women into lives of empty domesticity resulting in "housewife neurosis" and its accompanying symptoms of fatigue, emotional irritability, and despair) (Shuster, 2011, p. 164). It also situates the gendered incarnation of fibromyalgia and chronic fatigue syndrome today as women struggle with rapidly changing social roles, busily trying to balance careers, family obligations, and personal ambitions all while confronting social obstacles like discrimination, lower pay, and sexual harassment. In this way, Beard's account anticipates the relational complexity and ambiguity of our "being-in-the-world" later acknowledged in hermeneutic philosophy and creates an opening for health care professionals to adopt a more nuanced and contextualized perspective when it comes to the experience and interpretation of nervous suffering. While it is true that medicalizing nervousness creates a consoling sense of legitimacy by making it "real" under the paradigm of

⁹ Beard and his contemporary, neurologist S. Weir Mitchell warned against the educational, creative, and intellectual pursuits of women as they contribute to her nervous exhaustion. After prescribing his notorious "rest cure" for writer Charlotte Perkins Gilman, for instance, Mitchell implored her going forward to "live as domestic a life as possible. Have your child with you all the time... Lie down an hour after each meal. Have but two hours' intellectual life a day. *And never touch pen, brush or pencil as long as you live*" (Gilman, 1975, p. 96, my emphasis.)

naturalism, it fails to critically engage the historical context that made the paradigm possible in the first place. Hermeneutic medicine acknowledges our “being-in-the-world”; that we exist only in the social meanings we create for ourselves, and that it is only through these shared self-interpretations that we can experience and make sense of our suffering.

Compliance with Ethical Standards: This article does not contain any studies with human participants or animals performed by the author.

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