
DISSERTAÇÃO DE MESTRADO

# HUMANIDADES MÉDICAS E PSIQUIATRIA: UM ESTUDO DE CASO DAS OBRAS DE VIRGINIA WOOLF

MANUELA VIANNA BOEIRA

ORIENTADOR: FLÁVIO PEREIRA KAPCZINSKI

CO-ORIENTADOR INTERNACIONAL: KAY REDFIELD JAMISON

PORTO ALEGRE, MAIO DE 2019.


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Dissertação de mestrado apresentada ao Programa de Pós Graduação em Psiquiatria e Ciências do Comportamento como requisito para obtenção de título de Mestre.

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Dissertação apresentada como requisito parcial para obtenção de título de Mestre em Psiquiatria à Universidade Federal do Rio Grande do Sul, Programa de Pós-Graduação em Psiquiatria e Ciências do Comportamento.

**Porto Alegre, ..... de ..... de 2019.**

A comissão Examinadora, abaixo assinada, aprova a Dissertação "Medical Humanities and Psychiatry: a case study of the works of Virginia Woolf", elaborada por Manuela Vianna Boeira como requisito parcial para a obtenção do grau de Mestre em Psiquiatria e Ciências do Comportamento.

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Prof. Dr. Flávio Pereira Kapczinski - Orientador

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Prof. Dr. Ives Cavalcante Passos - Coorientador

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Dr. Marcelo Pio de Almeida Fleck – Membro da banca

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Dr. Cláudio Eizirik – Membro da banca

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Dr. Glen O. Gabbard – Membro da banca

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Dra. Simone Hauck – Membro suplente da banca

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Dr. Julio Cesar Walz – Membro suplente da banca

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FOR THE YEAR OF THE INSANE

A PRAYER

(Anne Sexton)

Closer and closer
Comes the hour of my death
as I rearrange my face, grow back,
grow undeveloped and straight-haired.
All this is death.
In the mind there is a thin alley called death
And I move through it as
through water.
My body is useless.
It lies, curled like a dog on the carpet.
It has given up.

(excerpt from the poem *For The Year Of The Insane, A Prayer*)

To my parents, Beatriz and Nelson.

## RESUMO

Essa dissertação é uma tentativa de integrar os resultados conceituais e empíricos de pesquisas contempoâneas acerca do transtorno bipolar e dos resultados do estudo da biografia da escritora Virginia Woolf e de seus materiais escritos (romances, ensaios, poemas, cartas) que ela produziu durante a sua vida. Essa dissertação examina as relações entre os fatores do transtorno bipolar de Virginia Woolf e a progressão da sua condição mental, a qual culminou com o seu suicídio. A incidência do transtorno bipolar, bem como de experiências traumáticas e do suicídio entre indíviduos criativos e reflexivos, especialmente escritores e poetas é discutida, utilizando Virginia Woolf como um exemplo e um parâmetro.



**Palaras chave: T**ranstorno bipolar. Saúde mental. Trauma. Suicídio. Virginia Woolf.

## ABSTRACT

This dissertation is an attempt to integrate conceptual and empirical contemporary research results on bipolar disease and the results of a study on the biography of Virginia Woolf and the written materials (novels, essays, poems, letters, etc.) she produced during her life. It examines the links between the environmental factors of Virginia Woolf's bipolar disease and the progression of her mental condition which ended with her suicide. The incidence of bipolar disease, trauma experiences and suicide among creative and self-reflective individuals, specially writers and poets, is discussed, using Virginia Woolf as an example and a parameter.



**Key words:** Bipolar disorder. Mental health. Trauma. Suicide. Virginia Woolf.

## SUMMARY

## INTRODUCTION

In this dissertation we explore the links between the environmental factors of Virginia Woolf's bipolar disease and the progression of her mental condition which ended with her suicide. For the sake of clarity we distinguished between two kinds of environmental factors. First, her social interactions and experiences (family life, childhood abuse, education, marriage, close and intimate frienships, professional contacts, historical events, etc.) which impacted her life in various ways. Second, her cultural texts (literary writings, essays, letters, etc.) which directly or indirectly (imaginatively, metaphorically, etc.) express her personal testimonies on her and other people's experiences, emotions, moods, values, reactions and other states of mind – most specially, on her illness and related sufferings.

We may say, rather improperly, that those writings – which, in addition to her creative talents, manifest the amplitude and intensity of her self-scrutiny and self-reflection – can be read as "personal clinical reports" of her origins, stages and progression of her disease. Obviously, those "personal clinical reports", in order to be validated, should have been confronted with the medical reports of the various physicians/psychiatries and health personel who examined her. Unfortunately, we were unable to gain access to those materials, something we shall try to do in the next steps of our research.

The hypothesis that support this research movement is the idea that the creative writings and similar products of creative writers affected by mental disorders can provide confirmation of recent relevant results of contemporary medical research, draw attention to aspects of the their clinical pictures not investigated as yet, and hopefully, offer new clues for

the theoretical hypotheses and empirical studies on bipolar disease and eventually to other mental disorders.

In trying to explore and integrate many distinct elements usually studied by the human sciences and the research results produced by medicine (in this case, neuroscience) we were confronted complex problems when organizing the various strings and levels of our argument in this dissertation.

In trying to produce a satisfactory written version of this type of argument we wanted to present in this text we became aware of the methodological divide between the human sciences/literature and the medical sciences. that the human sciences/literature and the medical sciences and its relevance. Each of those intelectual endeavors have their own distinct assumptions, methodologies and models of thought, characteristics that must be respected when we try to integrate their diferent perspectives. For instance, the medical sciences usually resort **to explanations in terms of the causes of actions and events**; whereas the human sciences/literature basically explore **explanations in terms of the meaning of actions and events** – that is to say, they examine and consider things from the 'actor's' point of view. The proper analysis of literary texts as narratives in medical humanities requires attention to this distinction.

Unfortunetely, we lack appropriate literary devices or text models to orient us on how to write scientific documents which artfully combine those two intelectual perspectives. I am fully aware that this shortcoming led me to to develop an written argument with multiple layers, not always clearly connected.

In addition to that, on a more theoretical level, I realized that each one of the diverse dimensions of the environmental and the biological factors which conform the bipolar disease have their own specific causal or meaningful effect in the resulting clinical disorder. In the future, efforts to construct models capable of describing and analyzing the relative force of each one of those "levels of causal/meaning effect" and their reciprocal influence in the genesis and progression of bipolar disease may eventually help us to better understand the interplay of the biological and existential aspects of that mental disorder.

The argument of this dissertation is organized in ten chapters (or nine, if we consider that one of the chapters is the article we have already published). Each chapter presents the information and the analysis needed to complement the discussions which are presented in subsequent chapters. Chapter 1 offers a general view of Medical Humanities and its major lines of inquiry and its pertinence to medical education and research. Chapter 2 briefly presents the definition of narrative and suggests how narrative analysis maybe useful for the interpretation of texts of creative writers with a history of mental disorder. Chapter 3 presents the concept of bipolar disease (BD) and describes the identifying traits of BD-I and BD-II. Chapter 4 introduces Virginia Woolf's family and its psychiatric history, as well as her own. Chapter 5 verses about Virginia Woolf and Bipolar Disorder. Chapter 6 discusses the different types of traumatic events that may antecipate the age onset of the disease and may be used as predictors of poor prognosis of bipolar disorder. Chapter 7 explores the correlation between bipolar disorder and suicide. Chapter 8 presents data which show the relationship between the incidence of bipolar disorder in individuals in the creative arts, specially writers and poets. The article that we have already published at the *Revista Brasileira de Psiquiatria* corresponds to Chapter 9, and Chapter 10, which is the final one, corresponds to Virginia Woolf's very last days.

## MATERIALS AND METHODS

Throughout this study, we have used, as our main source of research *The Letters of Virginia Woolf, volumes 1 to 6*; *The Diaries of Virginia Woolf, volumes 1 to 5* as well as the five volumes of *The Autobiography of Leonard Woolf*. We have also used some of the letters available at the Henry W. and Walter A. Berg Collection of English and American Literature within the New York Public Library. In addition to that we consulted part of the letters at the Francis Hooper Collection of Virginia Woolf available at the Mortimer Rare Book Collection at Smith College. We also have gained access to some material pertaining to the Hogarth Press, obtainable at the E. J Pratt Library of the University of Toronto.

In order to gain further understanding into Virginia Woolf's mind and creative genius, we have read some of her books such as *Orlando*, *To the Lighthouse, The Waves, a Room of Ones' Own*, *Between the Acts and on Being Ill*. We have also consulted some of the lectures she has given throughout her life.

Regarding methodology, we have tried to adjust and integrate materials from diverse sources, such as Virginia Woolf's writings of various sorts, academic books on creativity and the arts, papers on narrative analysis and, most importantly, papers on bipolar disorder and neuroprogression, as well as papers linking bipolar disorder in individuals in creative professions.

I have tried to generate some exploratory literary and autobiographical texts of Virginia Woolf and the progression of her bipolar disease in order to identify clues that can be

used as “markers” of her mental health decline, which led to her suicide. Results of this study support meaning-making hypothesis. These hypotheses will have to be validated by neuroscientific methods at a later date.

# CHAPTER 1. WHAT IS "MEDICAL HUMANITIES"?

Medical Humanities is now a well – established multidisciplinary field, which studies and incorporates theories, concepts, methodologies and lines of investigation drawn from disciplines as diverse as the social sciences, philosophy, bioethics, literature, linguistics and discourse analysis, cultural studies, health public policies, as well as medicine itself and other health related courses.

Over the past thirty years or so, numerous academic programs – mainly in the northern hemisphere, Australia and New Zealand – specialized scientific journals, research network groups and conferences have either been formed or have gained additional strength and interest. The number of conferences on the field has also been growing exponentially over the past decade. University programs on Medical Humanities are currently quite well – established in the United Kingdom, the United States, Canada, Sweden, Germany and Australia and the number of programs on the field, whether on a BSc or an MA/MSc or PhD level has been growing in many other countries in Europe, Asia and the Middle East.

The focal aim of the Medical Humanities is to provide a broader view on human health and explore its many dimensions and its impact upon the entire landscape of human experience. It does not attempt (or should not attempt) to substitute for the well-established and successful empirical methods (experiments, measurements, classifications, descriptions, established medical or medicine related questionnaires used to assess a number of diseases, etc.) of contemporary medical science , but to complement them, supplying additional clues ,

concepts and different viewpoints that may be useful to better understand illness and suffering.

In the specific case of mental disorders, in which a patients' self-understanding (or lack thereof) of their disease is of great significance and importance, the stories they might tell themselves and others about their predicament, their conflicts, their sufferings and pains and their emotions may be considered as an essential part of a patient's "clinical picture" – and in that sense offer important material for the identification of important details on symptoms and mental processes, suggest additional clues for further investigation and, hopefully, new therapeutic pathways/strategies and processes.

The attention to the subjective perception and self-understanding of the patient – no matter how distorted they might be – requires empathy, sensitivity and a *finesse* for capturing distinctive details on the different types of narratives they employ to express their "ups and downs" (and eventually, on their evolution) of their mental disturbances. Very often, a new stage of the emotional disorder is associated with a "new story" (or narrative) about his/her self-attributed identity and the causes of the evolution (or involution) of his emotional life. In other words, the patient adopts new meanings to interpret the elements of life experiences – the previous stages of his disorder, for instance.

Literature, has traditionally described and explored in detail and, in many cases, with great subtlety, the actions the moods, the emotions, the motivations, the morals, the sensitivities and the sense of intimacy, as well as the thoughts and dreams of human beings. Those descriptions and explorations have usually taken the form of narratives that integrate an individual's subjective dimensions to a wider picture, that of its social life. Throughout this

process, literature should also draw our attention to the impact of interpersonal relationships on an individual's or group of individual's life/lives.

Of particular interest are those cases of literary men and women who suffer from mental disorders. They exhibit both the objective personal experience of the disease, as well as the talent and skill to construct narratives. In addition, writers tend to be, in most cases, reflexive people, to whom the process of imagining and constructing narratives is a central dimension of their self-image and self-respect. Therefore, they may provide unusual and useful insights and clues on their mental disorders, to be further explored by other contemporary psychiatric lines.

Similar examples can be provided for other areas and disciplines which encompass the Medical Humanities, however, we shall focus on literature given the aim of this dissertation.

## CHAPTER 2. A NOTE ON NARRATIVE AND ITS RELEVANCE FOR THE STUDY OF MENTAL DISORDERS

Narratives are commonly understood as accounts by which a story is told, be it fictional or not. In general, stories present selected subjective or objective events arranged in a more or less articulated temporal sequence or process. Ideally, the explanatory power of narratives should articulate their parts to exhibit continuity, coherence and comprehensiveness. Historical writings, novels, poems, biographies, letters, dramas, films, diaries, newspapers articles, oral reports, etc. are among the many diverse forms narratives acquire. Narratives requires a narrator (or author/authors) who presents the story (in whatever format) to an audience. More precisely, narratives suppose an author and agents/actors responsible for/involved in the actions and events reported. They also presuppose a specific social scenario/context and a corresponding language which count as conditions for their intelligibility for its public. Narratives provide meanings, contexts and perspectives which are personally significant/relevant to the characters described/involved in the stories and often to the narrator/writer himself.

In this sense, physical, mathematical, chemical, economic and similar reports are not narratives, since they abstract from the subjective point of view of the individuals whose behavior, emotions and thoughts can be described or explained by the processes and causal connections they identify. In short, they ignore the meanings that are relevant to the human agents involved. It goes without saying that this “segregation” in no way affects the scientific value of their methodologies and research results.

In its broadest sense, narratives of patients have always been present in medicine in the form of clinical reports of one sort or another. Yet, until the advent of bioethics and its emphasis on the perspective of the patients, their narratives were rarely explored in their own terms. Instead, they were mostly interpreted as signs of symptoms to be explained in terms of their biological, chemical, neurological, etc. causes and their significance. Obviously, we must distinguish the attention to and empathy with the patient which was frequent in the good clinical practice and the use of patients' narratives to explain the origin of their complaints/diseases.

Psychiatry and psychoanalysis were an exception to this mode of thinking and to this methodology. In mental disorders, the self-understanding of the patient – his perceptions and eventually his ideations about his pains, sufferings, emotions, conflicts, dilemmas, etc. – is arguably part of his/her disease. The patient describes his symptoms as a temporary of more or less permanent part of his existence, as significant dimension of his ordinary experiences and as a central component of his subjectively conceived identity, or self.

Those self-descriptions are expressed in the form of narratives, which may be more or less articulated and self-conscious. They often have a motivation bearing on the patient's choices and decisions and may even become stable dispositions. Thus, close attention to those narratives of lived experiences may contain important clues for the identification of important biological and neurological processes with causal relevance.

Thus, a case may be made in favor of attentive scrutiny of narratives of patients who overly self-absorbed and conscious of the different aspects of their mental disorder and try to articulate/integrate (or fail to) them in the entire landscape of their lives. Of particular interest

are writers who in their writings meticulously describe experiences of mental disorders and the social contexts in which they occur.

Finally, of overwhelmingly importance are writers – whose activity and talent consists in constructing narratives – and who are themselves affected by serious mental disorders and testify in one form or another (novels, diaries, letters, oral exchanges, etc.) about the details and trajectory of their predicament. The medical information they provide deserve our most careful examination and analysis.

## CHAPTER 3. BIPOLAR DISORDER: BRIEF HISTORY, GENERAL OVERVIEW AND ILLNESS TRAJECTORY

Bipolar disorder is the second most prevalent psychiatric disease worldwide, being responsible for a great number of psychiatric hospitalizations worldwide and claiming the lives of many others. It is estimated that a patient with Bipolar Disorder (BD) may face, on average, four hospitalizations during a lifetime, a fact that is not only severe because it greatly affects a patient's prognosis and chances of a leading a "normal "life, but also heavily burdens countries' economies. The USA is estimated to have spent directly and indirectly, in the year 2009 alone, 30.7 and 120.3 billion dollars, respectively, while in the UK, the annual cost for the NHS (National Health Service) for the years 2009-2010 with Bipolar Disorder was estimated to be around the £342 million. It has also been proved that individuals with BD are far more likely to miss work, missing an average of 18.9 working days a year if compared employees without BD, which, on average, miss only 7.4 days of work a year.

Early descriptions of the disease date back to ancient and medieval writers as mentioned in *The Bipolar Book: History, Neurobiology, and Treatment.* Accounts from 19$^{th}$ century doctor Jules Baillanger from (1809–1890) from the prestigious Parisian Hôpital Pitié-Sâlpetrière first described Bipolar Disorder as **I*nsanity of Double Form*** at a lecture at the Académie de Medicine in 1854. His colleague from the same hospital, Jean - Pierre Falret (1794–1870) also claimed to have found a similar disorder several years earlier, which he coined ***Circular Insanity,*** which he described as a disease with manic and depressive periods, followed by some euthymic intervals.

At the end of the 19th century, Austrian psychiatrist professor at the Universities of Heidelberg and Munich in Germany, further explained the condition his fellow French colleagues had attempted to describe. He coined the term *Manic – Depressive Insanity*, which included what we currently know as Bipolar Disorder and Major Depressive Disorder. Nowadays, physicians in general, and psychiatrists and psychologists in particular, follow the major two diagnostic classification systems available worldwide when it comes to making a diagnosis of either Bipolar Disorder type I or Bipolar Disorder type II, that is to say, they either refer to the International Classification of Diseases, 11th edition (ICD-11) or to the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM -5).

Bipolar Disorder type I, or BP-I, as we shall mention it from here on, is considered to be the most severe type of Bipolar Disorder given that individuals who suffer from it not only experience episodes of severe depression, but also maniac episodes that may last from 7 (seven) days to many months, if untreated. According to Merikangas, patients diagnosed with BP -I may also present either elevated mood and three other mania-related symptoms, irritable – mood plus four other mania-related symptoms. These mania – related symptoms may range from an individual's increased activity or agitation, an exaggerated sense of well-being and self-confidence (in some cases bordering psychosis or becoming an actual psychotic episode), a decreased need of sleep, unusual talkativeness and pressured speech to distractibility and poor-decision making.

Patients who experience BP – I with mixed states or mixed features, are known to present a higher rate of suicide attempts (38% vs 9%) and report higher levels of anxiety, irritability and agitation (average composite severity score of 4.1 vs 3.4). They also present a higher level of dissatisfaction with treatment response (22% vs 14%), if compared to patients

with no depressive symptoms or depressive symptoms ranging from 0-2 (all $P<0.05$). Bipolar disorder with mixed episodes patients' are also more likely to suffer from substance abuse disorders and anxiety disorders. Patients with BP-I with mixed episodes generally have a poorer prognosis, according to Swann et al and Goldberg and McElroy.

Bipolar Disorder type II (BP – II), on the other hand, is characterized by periods of depression and hypomanic episodes or periods. Patients are defined as having BP- II if they have had at least one major depressive episode (MDE) and at least one hypomanic episode with four or more days in length and unmistakable change in functioning.

Unfortunately, it is known that an accurate diagnosis of BD - I or BD - II can take up to ten years to be reached. That is especially true in patients with BD - II, who tend to seek help only when depressed and tend to overlook or even "like" their hypomanic episodes, which patients often find useful for working purposes as they may feel more "alert" and require less sleep during these times. Many find it very positive because they feel they can "get more done" in less time. Others may appreciate these bouts of hypomania due to the additional sex drive it may give them. Exacerbated or increased self-confidence may also prevent patients from realizing that something is amiss.

That is unfortunate, however, as an increasingly large body of research has proven that the later one is properly diagnosed, the worst is one's prognosis. The later the prognosis, the worse is the range of adverse effects such as increased severity of depression, decreased quality of life and greater likelihood to attempt suicide.

The McLean-Harvard International First Episode Project also highlights the need to be constantly alert as patients who were hospitalized in a first psychotic episode were assessed at baseline and at 24 months. As Taylor et al have stated,

> […] of 500 participants completing the study, the authors found that initial diagnosis of bipolar I disorder remained stable in 96.5% of cases. However, over one quarter of changes in diagnosis were from another psychotic illness at baseline to bipolar I disorder after two years. It is therefore important to be alert for the development of BD in people with early psychosis.

The onset of BD is often in young adulthood. In a study published in 2010 in the Journal of Affective Disorders, Baldessarini RJ et al found that the median onset for BD – I was 24.3 years and 30.1 for B.D-II. A recent study carried out in the UK found some very interesting data relating mean age of BD – I onset with a patient's family history of mood disorders and also some markers of clinical severity such as higher rates of suicidality, more rapid-cycling, more mania and depression episodes' as well as greater scores of lifetime measures of depressive symptoms. This study found that individuals whose history checked some or all of the points above mentioned had a mean onset age of 18.9, another group had a mean onset age of 28.3, whereas the third group was found to have a mean age onset of 43.3 years of age.

As for the course of the Bipolar Disorders, it is known that the number of episodes, especially manic ones, have a detrimental effect in the course of the disease. The greater the number of episodes a patient has throughout his/her life, the poorer its chances of leading a normal life become. Neuroprogression, a term coined by both professors and researchers Michael Berk M.D and Flávio Kapczinsky M.D are unequivocal about the fact that the greater the number of episodes, the worse is a patient's likely outcome.

The term “neuroprogression” has been used to define the pathological reorganization of the central nervous system along the course of severe mental disorders. In bipolar disorder (BD), neural substrate reactivity is changed by repeated mood episodes, promoting a brain rewiring that leads to an increased vulnerability to life stress. The term “neuroprogression” has been increasingly used to define the pathological reorganization of the central nervous system (CNS) along the course of severe mental disorders. This reorganization could arise as the result of several insults, such as inflammation and oxidative stress. In bipolar disorder (BD), neural substrate reactivity is changed by repeated mood episodes, ultimately promoting a brain rewiring that leads to an increased vulnerability to life stress.

It has been proven that recurrent episodes, especially manic ones, increase a patient’s vulnerability to other episodes and to treatment response. Episode-dependent deterioration patterns have been found in serum biomarkers such as brain-derived neurotrophic factor (BDNF), in neuroimaging and functioning and in an increase in oxidative stress and pro-inflammatory biomarkers. A deficit in neuroprotection has also been noted, as was a decrease in cognitive and functioning performance.

## CHAPTER 4. VIRGINIA WOOLF – A BRIEF OVERVIEW OF HER FAMILY AND HER GENES

Writing an overview on a deceased person's life is a difficult chore in itself, writing about Adeline Virginia Woolf, who is not only deceased, but also one of the most acclaimed British writers of all times is a twice as hard as Virginia Woolf, as she was and is known by most, was and still is a source of great interest and debate, not only due to her highly significant contributions to literature, but also because of her complex personal life.

Adeline Virginia Woolf, née Stephen, was born on January 25th, 1882 in a house in High Park Gate, South Kensington, London. She was, no doubt, born into a privileged household, at least in terms of social standing and intellect. Her parents, Sir Leslie Stephen KCB*, born on November 28th, 1832, was a well-known literary critic, author, and an enthusiastic mountaineering. He was educated at Eton College, King's College London and Trinity Hall, Cambridge, where he was a *wrangler*, that is to say, a student who obtained first-class honors. He obtained a B.A in 1854 and an M.A in 1857, both from the University of Cambridge.

Virginia's mother, Julia Prinsep Stephen (née Jackson) was born on February 7th, 1846 in Calcutta, where her father was a physician. She was known for her exquisite beauty and was a celebrated Pre-Raphaelite model. Her mother came from a very well-off family and she spent her childhood and adolescence at Little Holland House, in what is now Melbury Road, Kensington, London. Her family was very close to names such as painters William Holman-

Hunt and Edward Burne-Jones, and to poet and sculptor Thomas Woolner and writer John Ruskin.

Virginia Woolf was born from both her parents second marriages. Her father had been previously married to Harriet Marian Thackeray, widely known as Minnie, daughter of British novelist William Makepeace Thackeray. Minnie and Leslie had a daughter, Laura Makepeace Stephen, about whom we shall write more later. Minnie passed away in 1875, living a desperate grieving husband behind and a daughter who had started to show symptoms that was something "odd" about her development.

Virginia's mother had become a widow in 1870, after only 3 years of marriage to Herbert Duckworth, with whom she had three children – George Duckworth, born in 1868, Stella Duckworth, born in 1869 and Gerald Duckworth, born in 1870.

Leslie Stephen and Julia Duckworth got married on March 28th, 1878. Leslie was then 46 and Julia 32. Soon after the marriage was consumed the family began to expand. They had four children, of their own. Vanessa Stephen was born in 1879, Thoby Stephen was born in 1880, Virginia was born in 1882 and Adrian Stephen was born in 1883. The children of the couple and the children of their previous marriages lived under the same roof at 22, Hyde Park Gate, London until Laura Makepeace Stephen was sent to the Earlswood Asylum for Idiots and Imbeciles in 1983, at the age of 23. She was discharged in 1897 and, although she initially spent some holidays with the family in St. Ives, she would spend the vast majority of her life under the care of professionals at a farm in Sandrige, near St Albans, where she lived with Dr. Corner and his family. Dr Corner was Laura's Stephen doctor at Brook House, the last institution in which she was a boarder, so, when Dr. Corner moved to a farm with his

family, he took Laura with him. Laura Stephen passed away on February 9th 1945, at The Priory, Roehampton. She was seventy-four.

Despite this dissertation being about Virginia Woolf, we find it is of extreme relevance mentioning her parents and her siblings, given that most of her close (and not so close) family suffered from one, or a combination of mental disorders and, in Laura's case, what is now known as autism and psychosis. There are a number of scholars who also believe she, just like Virginia, was subjected to sexual molestation from her half-brothers George and Gerald Duckworth. We have chosen to start by highlighting Laura Makepeace Stephen's case not only because she was the first child, but also because data on her is most scarce and, having been institutionalized most of her life, a brief explanation of what she may have suffered from and gone through may, we believe, shed light, on Virginia's mental disorder.

There are a number of theories on which mental disorders Laura might have had, but we are from the opinion she had autism and either comorbid psychosis or perhaps an extremely severe comorbid BD -I.

Virginia's father, Leslie Stephen was known for his unpredictable mood swings and is known to have had a troubled childhood and difficult parents. He was most likely cyclothymic, a heterogenous condition and, as such, it is distinguished from major mood disorders by its chronicity and subsyndromal quality (i.e. symptoms are less severe and fewer in number, or insufficient duration). Although they may resemble the bipolar disorders due to the presence of mood swings, cycles are short and patients do not experience frank psychotic episodes. According to Kottler, even though Leslie's unpredictable bouts of anger and depression did terrify his children, they do not fit the description of patients who suffer from

either BD-I or BD-II. Leslie's father was known to have a "*double nature"* and Leslie's brother, Fitzjames was also afflicted by a decaying mental health, developing dementia and ended up by dying a poor man. Both Leslie Stephen and his father are known to have been, despite their rigid exterior and of both being vigilant over their children's behavior, very sensitive men, with tendencies to sink into depression, feelings of worthlessness and hopeless dejection.

Julia Prinsep Stephen, Virginia's mother, is also known to have experienced a number of depressive episodes, which are made clear in Gillespie and Steele's book on *Julia Duckworth Stephen: Stories for Children, Essays for Adults*. This book is essential for those who may want to have a better understanding of Julia Stephen's psyche and intellect, which is often portrayed as having been intellectually shallow.

Virginia Woolf's sister Vanessa and their brother Adrian were considered cyclothymic, whereas Thoby, Virginia's first brother, is known to have had hypomanic episodes, which probably allow us to classify him as having suffered from BD-II. Given Thoby Stephen's premature death from typhoid fever we can only speculate that would be diagnosis, as we do not have enough material to substantiate our hypothesis.

Finally, Virginia Woolf (nèe Stephen), whom is at the center stage of our study, is known to have endured several severe depressions and some very manic episodes. Accounts of Virginia's mental illness can be traced back to 1895, when she was only 13 years old. In her book, *A Sketch of the Past*, Virginia Woolf describes how she first felt when she saw her mother's dead body:

> I remember very clearly how even as I was taken to the bedside, I noticed that one nurse was sobbing, and a desire to laugh came over me, and I said to myself as I

> have often done at moments of crisis since, "I feel nothing whatever". Then I stooped and kissed my mother's face. It was still warm.

In his biography of Virginia Woolf, Quentin Bell describes her first episode, which displays both maniac and depressive symptoms:

> Virginia became painfully excitable and nervous and then intolerably depressed…She went through a period of morbid self-criticism, blamed herself for being vain and egotistical, compared herself unfavorably to Vanessa and was at the same time intensely irritable.

## CHAPTER 5. VIRGINIA WOOLF AND BIPOLAR DISORDER

*"All extremes of feelings are allied with madness".*

Virginia Woolf, *Orlando*

Virginia Woolf is possibly one of the most well-known writers who suffered from bipolar disorder since an early age. As thoroughly explained in previous chapters, Virginia Woolf 's family genetics, added to fact that she suffered early childhood trauma, from the death of her mother when she was only 13 years old, to the death of her half-sister Stella, followed by the deaths of her father, for whom she nurtured very mixed-feelings but whom she missed immensely when he passed away, to the untimely death of her brother Thoby, who died of typhoid fever, to the various years in which she was sexually assaulted/molested by her half-brothers George and Gerald Duckworth made her the "perfect candidate" to a severe form of BD.

Unfortunately, that proved to be the case as the numerous accounts on Virginia's breakdowns, written by herself and by others attest. Her suicide attempts are also notorious and have been studied and scrutinized in great detail. Here, we shall try to give an account of her mental distress and suicide attempts following a chronological order. We shall list her four suicide attempts first, and then describe her depressive and manic episodes.

Virginia Woolf's first suicide attempt occurred in 1904 following her father's death. Prior to her suicide attempt she was manic. She would listen to birds singing in Greek and would imagine King Edward lurking naked in the azaleas shouting obscenities. Virginia tried to leap from a first-floor window and was then institutionalized and had to lay in bed for months. It was the first time she was subjected to the then famous "Rest Cure Therapy", which was prescribed by Dr. George Savage, who was a huge fan of his American colleague Silas Weir Mitchell treatment, which he had come up with in 1873. The therapy consisted of having the patient lay in bed all day long, eat, drink plenty of milk and not have any disturbing contacts with the outside world such as reading books, writing letters, or anything that could agitate the patient or bring unpleasant memories. Plenty of sleep was also prescribed. '***I have never spent such a wretched 8 months in my life*,**' she wrote to a friend when the crisis had passed.

Poirier quotes a description of the cure as extracted from Mitchell's Doctor and Patient:

> In carrying out my general plan of treatment it is my habit to ask the patient to remain in bed from six weeks to two months. At first, and in some cases for four or five weeks, I do not permit the patient to sit up or sew or write or read. The only action allowed is that needed to clean the teeth. In some instances, I have not permitted the patient to turn over without aid. In such cases I arrange to have the bowels and water passed while lying down, and the patient is lifted on to a lounge at bedtime and sponged, and then lifted back again into the newly-made bed. In all cases of weakness treated by rest, I insist on the patient being fed by the nurse, and, when well enough to sit up in bed, I insist that meats shall be cut up, so as to make it easier for the patient to feed herself.

Virginia Woolf's second suicide attempt occurred in 1913, one year after she had married Leonard Woolf. Her second suicide attempt was much more severe and she almost did not make it. Virginia took 100g of Veronal (*Barbital*) and, if it weren't for Leonard Woolf

and Geoffrey Keynes (who was house, surgeon at Saint Bartholomew's Hospital at that time) she would most probably have died. She required urgent medical attention so a gastric lavage was performed and, although she was between life and death for some hours, she woke up the next morning. Virginia was then sent to a private nursing home for females in Twickenham, where, once again, seclusion and the *Rest Cure* were enforced. She was placed on a regime of weight gain; four or five pints of milk daily, as well as cutlets, liquid malt extract and beef tea.

George Savage, her psychiatrist, recommended that a patient "*who went in weighing seven stone six comes out weighing 12*". This advice clearly made an impact on Virginia: she repeats it almost verbatim in Mrs. Dalloway when the celebrated psychiatrist Sir William Bradshaw orders "*rest in bed; rest in solitude; silence and rest; rest without books . . . so that a patient who went in weighing seven stone six comes out weighing 12*".

Virginia later wrote: "Leonard made me into a comatose invalid".

Even though there is a degree of truth in Virginia's complaint, she certainly wouldn't have survived much longer if it were not for Leonard Woolf's unwavering devotion and patience to keep her as safe and as far from a severe mood swing as he could. He would make her spend the mornings in bed when he foresaw an imminent crisis, he would monitor her eating and weight, her moods and her menstrual cycles. And Virginia was certainly aware of that, as we can verify in a letter, she wrote to Jacques Raverat in 1922: "**unless I weigh** 9 and half stones, **I hear voices and see visions and can neither write nor sleep"**.

She also wrote to her friend and lover, Vita Sackville-West, admitting Leonard's efforts to keep her sane, as shown below: "**I should have shot myself long ago in one of these illnesses if it hadn't been for him"**.

Virginia did not fully recover until the end of 1915. At the end of February 1915, she "entered a state of garrulous mania, speaking ever more wildly, incoherently and incessantly, until she lapsed into gibberish and sank into a coma,", according to both Leonard Woolf and Quentin Bell. By March she was being cared for by professional nurses, and **was unable to see or speak to Leonard** – he writes that she was "**violently hostile".** At times her psychotic episodes were so severe that she required four nurses to hold her down, and there was genuine doubt over whether she would ever fully recover. **She remained under professional care until November**, when she finally returned to Hogarth House: "I spend my spare time in bed, but I'm allowed out in the afternoons, and thank God the last Nurse is gone."

It is not known for certain the number of suicide attempts Virginia made during 1913-1915, but both her husband accounts and many of her biographers also state that she made a couple.

What I consider to be her third suicide attempt was in fact a suicide gone wrong, as one week prior to her death she attempted to drown on the River Ouse, next to the Woolf's house in Roadmell. At that point Leonard was already quite aware that she was not doing well and had shared his concerns with their friend and physician, Octavia Wilberforce, who would come to "visit" the couple once a week and check on Virginia. According to Leonard, she went for a walk and returned soaked wet, shivering and exhausted. When enquired on what had happened, she said she had stumbled on a rock and slipped into the sea.

However, we know that was not the case as she had written to her friend Ethel Smyth on March 1st, 1941, saying: "We have no future; I'm fished out of my element and lie grasping on the ground".

On March 28th 1941, Virginia Woolf made, once again, her way to the River Ouse, this time however, she would not return. She was wearing a heavy overcoat and had made sure the stones on both pockets were heavy enough for her to drown. Virginia's cane was found on the banks of the River Ouse on that very afternoon. Three weeks later, on April 19th 1941, children found her body near the bridge in Southease.

As Shirley Panken brilliantly puts it, "the sea, a major symbol in Woolf's life and fiction, represents the rhythmic nature of existence, the inexorable cycle of building up and destroying, the nonhuman life of which she so much felt a part."

## CHAPTER 6. TRAUMA AND BIPOLAR DISORDER IN VIRGINIA WOOLF

The correlation between traumatic events and bipolar disorder has been widely researched; we find it of the utmost importance to discuss it here given, not only its scientific significance, but also for understanding Virginia Woolf's biography. We shall revisit some of traumatic episodes of her life in light of various researches that establish the link between traumatic events and predisposition of an individual to suffer from either BD-I or BD-II. Traumas may act as a trigger to either the onset of bipolar disorders or to its additional episodes.

According to Nierenberg, early trauma can permanently change one's response to stress, leading to hyperarousal and hypervigilance and sustained stress. An imbalance in these patients' response to pro and anti-inflammatory cytokines may lead to sustained inflammation effects in multiple organs and can lead to premature death. That might be the cause why individuals with bipolar disorder may lose up to 25 years more of their lives when compared to individuals who do not suffer from BD. In patients who suffer from BD, Leverich S and Post found that early childhood trauma can be directly associated with a greater number of subsequent manic or depressive episodes, faster cycling patterns, a greater number of suicide attempts, and an increased number of additional psychiatric and medical disorders, including higher incidence of alcohol or substance abuse.

Serious outcomes were found in those who suffered sexual abuse – which was Virginia's Woolf case – especially if other non-sexually related traumatic events are endured, which in her case, were not insignificant. Losing her mother and her sister Stella at a very

early age, having a father who displayed constant mood swings someone whom she cared for deeply and died when she was twenty-two years old, followed by the death of her brother Thoby, whom she was very close to, can only have made things harder for her to cope with.

Hammersley *et al* also found that people who had suffered early-life trauma were more prone to have hallucinations. In their study, 45% of their subjects had suffered from hallucinations at some point in their lives or continuously suffered from them, a very relevant number considering that their cohort was of 96 subjects.

When compared with subjects that had not suffered physical or sexual abuse in either childhood or during adolescence, subjects who had undergone these types of trauma also showed a higher predisposition to schizoid, schizotypal and paranoid behavior, as well as to narcissistic, borderline, histrionic or antisocial behavior. The last three being more commonly found in patients who had a history of sexual abuse.

Leverich et al also support the thesis that early traumatic experiences further decrease the age of onset of BD and is also a strong predictor of a more severe unfolding of bipolar disorder.

According to Palmier- Claus *et al*, Etain B *et al* and Upththegrove R *et al* childhood adversity has been linked to the presence of psychosys.

The broad scope of the analysis presented in *Virginia Woolf and Trauma* offers a thorough and compelling analysis of the haunting, if sometimes repressed trauma narrative that can be found embodied throughout Woolf's texts. The truthfulness of Woolf's description

of the sexual abuse she suffered is present in the autobiographical memoir *A Sketch of the Past,* whilst simultaneously seeking to avoid a direct approach to the topic at hand. Consequently, "trauma" is understood as both personal – as in the deaths of Woolf's mother, half-sister Stella, and brother Thoby, and as collective, as we shall explain below.

Woolf's manifold bouts of illness, both physical and psychological, as well as the sexual abuse she suffered by being molested by her two half-brothers, Gerald and George Duckworth, were only, or mostly, private affairs, as opposed to the nationwide trauma of the two World Wars, which affected the whole of Britain and many other nations and their citizens.

Only Toni H. McNaron, retired professor from the University of Michigan, specifically deals with Woolf's non-fictional writing by investigating the way in which Woolf tackles her early sexual abuse within her essays in the book *Virginia Woolf and Trauma,* mentioned above.

Below, we shall briefly quote some of Virginia Woolf's pieces of writing that illustrate the points above mentioned.

# CHAPTER 7. SUICIDE, BIPOLAR DISORDER AND THE CREATIVE PROFESSIONS

Suicide is a major health problem. Current global suicide mortality rates amount to 1.4% of all deaths worldwide. This number might seem small, but when confronted with data from the World Health Organization (WHO), which has put it in sheer numbers – 800.000 people commit suicide every year, one realizes that it has become a serious international issue. In the last data made available by the WHO in 2016, suicide was rated as the 18$^{th}$ most prevalent cause of death worldwide. To put it even more plainly, one person commits suicide every forty-second. To make matters even worse, the WHO has proven that suicide is the leading cause of death amongst the 14-29 years old population worldwide.

Although suicide and suicide attempts certainly are not, by any rate limited to individuals with bipolar disorders, it has been widely researched that those who suffer from either BD-I or BD-II are more at risk of committing or attempting suicide than individuals who suffer from other mental disorders such as schizophrenia, obsessive compulsive disorder (OCD), generalized anxiety disorder (GAD), amongst others.

According to Novick *et al*., the number of suicides and suicide attempts (SA) do not differ significantly between patients with BD-I or BD-II. However, their literature review and meta-analysis show that patients with BD-II are more prone to use violent and lethal methods than those diagnosed with BD-I. Researchers estimate that between 25% and 60% of individuals with bipolar disorder will attempt suicide at least once in their lives and between

4% and 19% will complete suicide. Yet, Novick et al point out to the need of further research focusing on BD-II patients, as, to these date, most research on suicide and SA attempts on bipolars focused on patients with BD-I, which was believed by many researchers, until recently, to be the most severe form of the disease and thus, patients are more prone to commit suicide and SA.

Much of what we know about suicide risk in bipolar disorder is from research in which the sample is comprised largely of individuals with bipolar I disorder (BPI). In the studies that do include individuals with bipolar II disorder (BP-II), researchers rarely consider BPII outcomes separately. The prevalence of suicide attempts (SA) in BP-II, particularly in comparison to the prevalence in BP-I, is an understudied and controversial issue with mixed results. Tondo, on the one hand, found significantly higher rates of suicide attempt amongst patients with BD-II when compared with those with BD-I (21.9% versus 15.9%, respectively), whereas Coryell *et al*. found significantly higher rates among individuals with BPI than among individuals with BPII (41.2% versus 17.6%, respectively). Study design and methodology seem to be the main causes for such discrepancies so we believe further studies with similar or same study design and methodology are needed before any definite claim can be made on this matter.

Now we shall move into the topic of suicide amongst artists, writers and creative individuals in general, as this was the very case of Virginia Woolf. Even though demographics, race, gender, amongst other things, may play a role in determining which individuals are more at risk of taking their lives or attempting to do so, a study of 32 occupations with a large number of suicides carried out by Stack concluded, even after a host of demographic confounders, that artists remained at a significantly higher risk of committing

suicide if compared to other professions. Preti & Motto and Preti, *et al*. have found similar results in previous studies. According to Stack, in the best designed study, artists are found to have a risk of dying from suicide versus natural causes that is 2.12 times greater than the rest of the working population. It is worth highlighting that nine studies showed that artists constituted one of the very few occupation groups where suicide risk is independent of demographic cofounders.

Research results are even gloomier for poets and writers, which exceeded the average risk of suicide among artists or those who had chosen creative careers, such as architects, for example, who, alongside with painters, are at a lower risk than the mean.

The fact that suicide and SA are higher in poets and writers may have a number of explanations, which range from economic strain due to volatile income, pressure from printing houses, fear of critics' reaction, and a tendency for severe self-criticism are considered the most important ones.

Poets and writers are especially prone to BD-I and BD-II. Kay Jamison, a professor of psychiatry at Johns Hopkins University and the author of *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament*, said writers are 10 to 20 times as likely as other people to suffer manic-depressive or depressive illnesses, which lead to suicide more often than any other mental disorders do. According to Jamison, it is not surprising that these mood disorders seem most at home in the artistic mind. "The cognitive style of manic-depression overlaps with the creative temperament". Researchers have found that in a mildly manic state, subjects think more quickly, fluidly and originally. In a depressed state, subjects are self-critical and obsessive, an ideal frame of mind for revision and editing. "When we

think of creative writers, "Dr. Jamison said, 'we think of boldness, sensitivity, restlessness, discontent; this is the manic-depressive temperament'".

Apart from Virginia Woolf, several well-known writers and poets such as Jack London, Cesare Pavese, Anne Sexton, Sylvia Plath, Ernest Hemingway, Vladimir Maiakowski and Primo Levi ended their lives by committing suicide.

Virginia Woolf has left us some interesting letters and diary notes on that matter, and also on how she felt about literary critics, publishing houses and the panic and dread the launching of a book caused on her. Leonard Woolf, her lifetime husband, has also written some interesting accounts on how Virginia would react on such occasions, which can be found below:

> **The horror is that tomorrow**, after this one windy day of respite – oh the cold north wind that has blown ravaging daily since we came, but I've had no ears, or nose: only making my quick transits from house to room, often in despair – after this one's day respite, I say, **I must begin at the beginning and go through 600 pages of cold proof. Why, oh why? Never again, never again** (Virginia Woolf in *A Writer's Diary*).

In his diary, Leonard wrote about Virginia:

> **The torture began** as soon as she had written the last word of the first draft of her book; it continued off and on until the last reviewer, critic, friend, or acquaintance had said his say. […] **Her major works, by increasing the strain, only increased the 'dejected rambling misery' and the grey welter**'. The moment she sent back the proofs of **The Waves** to the printer she had to go to bed with a dangerous headache. When the book was published and before she had any criticism of it, whether from Hugh Walpole, John Lehmann, or anyone else, she wrote in her diary: I have come up here, trembling under the sense of complete failure – I mean The Waves, I mean Hugh Walpole does not like it – I mean John L. is about to say he thinks it bad. **And months later she said she said she still felt her brain numb from the strain** of writing **The Waves**. […] **We had a terrifying time** with The

Years in 1936; she was **much nearer a complete breakdown than she had ever since 1913**.

## CHAPTER 8. CREATIVITY AND BIPOLAR DISORDER

Even though the link between psychiatric diseases, mainly the bipolar disorders, but also schizophrenia (to a smaller degree) and creativity has gained momentum after the 1980's, it is fair to say that it is quite an ancient concept, so much so that Greek philosophers such as Socrates (469–399 BC) and his student Plato (428–348 BC) praised the benefits of *divine madness*, which they believed was literally a gift from the gods. According to Koutsantoni, the concept of madness, as deployed by Plato and Socrates, encompassed a wide range of states of thought and emotion, not just psychosis, but the emphasis was upon a profoundly altered state of consciousness and feeling. Aristotle's thoughts on these matters soon ensued. He focused, however, on the link between melancholia, madness and inspiration, asking the question: "*Why is that all men who are outstanding in philosophy, poetry or the arts are melancholic*?"

By the end of the 20$^{th}$ century, a number of scholars turned to this very question Aristotle once asked. The link between psychiatry and the humanities gained momentum and researchers sought to understand the symptoms and signs of mental health conditions in conjunction with the humans experiencing them, rather than separating the person from the condition. Systematic studies have demonstrated a causal nexus between creative genius and madness, specially writers and poets.

Amongst a body of research made to this day, Andreasen and Jamison are what one would call pioneers. In 1987 Nancy Andreasen studied rates of mental illness in 30 creative

writers (27 men and 3 women), 30 matched control subjects and the first-degree relatives of both groups. Andreasen's study showed very high rates of affective disorder, that is to say, 80% of the writers she interviewed had had an episode of affective illness at some time in their lives, compared to 30% found in the control group subjects'. Out of these 80% who presented some affective illness, 43% of them were bipolar disorders versus a "mere" 10% of subjects in the control group who had experienced bipolar illness.

In 1993, Kay Redfield Jamison published *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* where *she* discusses the clear link between creativity and bipolar disorder. Some years prior to the publication of this book, Jamison had interviewed 47 eminent British writers and artists and had found that, although most of the writers and artists she interviewed had been treated for depression and only 38% for bipolar disorder, many offered accounts of bursts of energy and swinging moods, which are consistent with hypomania, a trait of BD-II. Jamison concluded that there is a much higher than expected rate of bipolar disorder, depression and suicide in exceptionally creative artists and writers, as opposed to non-creative individuals. There is an important, albeit alarming statistical difference between the percentage of individuals in the general population diagnosed with manic-depressive illness – 1%, versus an astonishing 38% amongst artists and writers.

A more recent Swedish study lead by MacCabe, carried out over the course of 10 years, found a correlation between the risk of developing bipolar disorder and individuals who excelled academically, achieving A grades, specially in humanities. Another Swedish study lead by Kyaga and published in 2012 at the Journal of Psychiatric Research is worth mentioning, given the scope of its database. They performed a nested case-control study using longitudinal Swedish total population registers and, although this larger study did not find

significant evidence between individuals in the creative professions and mental disorders in general, it did find that authors suffered from schizophrenia and bipolar disorder more than twice as often as controls. Authors were also more likely to be diagnosed with unipolar depression, anxiety disorders, alcohol abuse, drug abuse, and to commit suicide. The finding of increased risk for suicide in authors might be secondary to other psychopathology, according to researchers. To investigate this further, they omitted all authors with any psychiatric diagnosis in the PNR – Personal Identity Number or "*Personnummer*" in Swedish (ICD-8: 290e315, ICD-9: 290e319, ICD-10: F00eF99). There was still a trend for authors without diagnosed psychopathology to commit suicide more frequent than controls (OR 1.45, 95% CI 0.97e2.16; p ¼ 0.07). Thus, regardless of psychopathology, being an author seemed to increase suicide risk.

Besides the above data, Kyaga et al also admitted that they had found no positive association between psychopathology and overall creative professions **except for bipolar disorder**.

In Virginia Woolf's case, creativity played a substantial role and it was, paradoxically, both what kept her sane and "going" and also what led her to depths of despair. To Virginia, creativity was mainly, though not only, was associated to her ability to write and read. Writing produced an exhilarating but sometimes painful effect, while writing had the ability to catapult her from gloomy moods and depressions. Her mere existence depended greatly on her being able to write and read, as we shall note in the passage below, in a letter she exchanged with Hugh Walpole on August 23rd, *1933:*

> **And then, being in a gloom the other night, I took down your Apple Trees (1932) and enjoyed it so much**, more the second reading than the first, that I invented a theory to the effect that you being a born romantic, and I not being one,

> **what I like is when you turn your rich lantern upon facts, because they become rimmed and haloed with light but still remain facts in the centre.** So, I want you to go on writing your memories. It struck me today on my walk that, that I like [Sir Walter] Scott's diaries better than all but three of four of his novels for this reason. And Vanessa – to end the argument – will have more fact in it than the others; what fun, if I'm there in flesh! – or my name's there.

Such a taste for a life devoted to writing may be connected with and account for her liking for history. Apart from Walpole's historic novels of herries series, Woolf liked Jules Michelet's *L'Histoire de France (1883-843):* for example, in a letter written on 31st January 1928 to Clive Bell:

> I am reading Michelet. Does it strike you that history is one of the most fantastic concoctions of the human brain? That it bears the remote likeness to the truth seems to me unthinkable." Consider the character of Louis 14th. Incredible! And those wars – unthinkable! Ought it not all be re-written instantly? Yet, he fascinates me.

In another letter from February 26th, 1928, addressed to Julian Bell, Virginia wrote: "I am reading Michelet's History of France – God knows why. I find it fascinating, but wholly fictitious. Do you think any history is even faintly true?"

What autobiographical and historical writing may have in common is facts, whether truthful or fictional. Woolf's taste for the two genres most probably helped her deal with the facts of her own life and redefine the art of the self-portrait in her letters. In a passage on the *Essays of Virginia Woolf,* she wrote: "the 'leaning-tower writers', with help from Dr. Freud, wrote more about themselves in their autobiographies 'honestly', therefore creatively".

In another entry from her fourth volume of letters Virginia wrote:

> They told the unpleasant truths, not only flattering truths". That is why autobiography is so much better than their fiction or poetry. **Consider how difficult**

> **it is to tell the truth about oneself – the unpleasant truth; to admit that one is petty, vain, mean, frustrated, tortured, unfaithful and unsuccessful.**

Woolf not only emphasizes the importance of such truthful self-analysis but also insists that such an "unconscious" state of writing should be further developed by the next generations of writers. Her creativity was based on her intense and continuous self-examination and her desire to express herself through a **highly elaborated** personal and literary writings.

Such a form of self-expression was more than simply the exercise of a natural and highly educated talent. It was her major defense against the destructiveness of her past traumas and scars they had left in her adult emotional life. In her literary life she could not avoid dealing with the themes which grew out of the intimations of her traumas and their consequences. She could not avoid confronting the ghosts which were, in part, a byproduct of her bipolar condition.

# CHAPTER 9. SPECIAL ARTICLE: VIRGINIA WOOLF, NEUROPROGRESSION, AND BIPOLAR DISORDER

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## ABSTRACT

Family history and traumatic experiences are factors linked to bipolar disorder. It is known that the lifetime risk of bipolar disorder in relatives of a bipolar proband are 5-10% for first degree relatives and 40-70% for monozygotic co-twins. It is also known that patients with early childhood trauma present earlier onset of bipolar disorder, increased number of manic episodes, and more suicide attempts. We have recently reported that childhood trauma partly mediates the effect of family history on bipolar disorder diagnosis. In light of these findings from the scientific literature, we reviewed the work of British writer Virginia Woolf, who allegedly suffered from bipolar disorder. Her disorder was strongly related to her family background. Moreover, Virginia Woolf was sexually molested by her half siblings for nine years. Her bipolar disorder symptoms presented a pernicious course, associated with hospitalizations, suicidal behavioral, and functional impairment. The concept of

neuroprogression has been used to explain the clinical deterioration that takes places in a subgroup of bipolar disorder patients. The examination of Virgina Woolf's biography and art can provide clinicians with important insights about the course of bipolar disorder.

**Key words:** Mood disorders; bipolar; suicide; stress; sexual assault; cognitive neuroscience

Family history and traumatic experiences are factors linked to bipolar disorder (BD). It is known that the lifetime risk of BD in relatives of a bipolar proband are 5-10% for first degree relatives and 40-70% for monozygotic co-twins.[1] It is also known that patients with early childhood trauma present earlier onset of BD, increased number of manic episodes, faster cycling pattern, and more suicide attempts.[2]

Additionally, we have recently reported that childhood trauma partly mediates the effect of family history on BD diagnosis.[3] It is noteworthy that sexual abuse was associated with BD in our study, but not with major depressive disorder.[3] Moreover, other authors have reported that illness trajectories are largely variable in bipolar disorder.[4]It seems that a subset of patients may develop a neuroprogressive course associated with poor outcomes, such as suicide attempts, hospitalization, and functional and neurocognitive impairment.[4] In light of these findings, we reviewed the biography and work of Virginia Woolf, one of the most renowned female writers of the 20th century and amongst the finest British novelists ever, and who, according to biographers, suffered from bipolar disorder.[5],[6]

Mental illness in Virginia Woolf's family can be traced back to James Stephen, her grandfather on her father's side. James was allegedly cyclothymic and, according to Bell, also given to self-mortification and depression.[7] He was eventually institutionalized, after running naked through Cambridge. He died in an asylum. Virginia Woolf's parents also suffered from

mental disorders - her father was what at the time was called cyclothymic, whereas her mother suffered from depression.[6] Sir George Savage, a prominent psychiatrist in the late 19th and early 20th centuries, diagnosed Virginia's father Leslie with "neurasthenia," a common medical term used in the late 19th to early 20th centuries.[8]-[10] Her half-sister Laura, who spent most of her life at the Priory Hospital Southgate in London, is believed to have had some type of psychosis. Her specific mental illness (or illnesses), however, is yet unknown.[6] Amongst Virginia's other siblings, both Vanessa and Adrian appear to have been cyclothymic, and Thoby was known to have hypomanic episodes.[6] Hence, Virginia's BD symptoms appear to be strongly linked to her family background.

Virginia's biological inheritance translated into great risk of developing mental illness. Nevertheless, it could be argued that her disease would have been milder had she not been exposed to childhood traumatic experiences.[11]Virginia Woolf was sexually abused by her half siblings, George and Gerald Duckworth, for nine years.[6] According to De Salvo, "these experiences had spoiled her life before it had fairly begun."[10] When she was only six, Gerald molested her while the Stephen family was vacationing in St. Ives, Cornwall. George's advances would not come until seven years later, after their mother Julia had passed away. The age difference between Virginia and her brothers should be noted - Gerald was 16 years her senior, and George was 15 older. Below is Virginia's account of Gerald's first sexual move towards her.[12]

There was a slab outside the dining room door for standing dishes upon. Once, when I was very small, Gerald Duckworth lifted me onto this, and as I sat there he began to explore my body. I can remember the feel of his hand going under my clothes; going firmly and steadily lower and lower. I remember how I hoped that he would stop; how I stiffened and

wriggled as his hand approached my private parts. But it did not stop. His hand explored my private parts too. I remember resenting, disliking it - what is the word for so dumb and mixed a feeling? It must have been strong, since I still recall it. This seems to show that a feeling about certain parts of the body; how they must not be touched; how it is wrong to allow them to be touched; must be instinctive. (Poole,[13] p. 25)

Virginia Woolf also left written accounts about how, after the death of her mother Julia, her half-brother George would enter her room and enthusiastically lie next to her and take her into his arms. She later wrote about his "violent guts of passion," and that his behavior was "a little better than a brute's."[13] In "22 Hyde Park Gate," Virginia describes George sexual advances towards her. Virginia noticed that someone had entered her room as she was lying in bed trying to sleep. Her account is as follows:

Who? I cried.

Don't be frightened, George whispered. And don't turn on the light, oh beloved! Beloved - and flung himself on my bed, and took me in his arms. (Poole,[13] p. 111)

De Salvo suggested that[14] Virginia Woolf later attempted to "heal her childhood wounds" through writing.[14]

Such issues may have emerged in her writing of the novel *The Wise Virgins*, which was started during her honeymoon. The novel's main character, Camilla, bears enormous resemblance to Virginia Woolf in her attitudes towards sex, such as fear and sometimes aversion to it.[15] Even so, Virginia hoped to have children. Shortly after her wedding, Virginia was heartbroken when her doctors advised her to refrain from motherhood on account of her ongoing mental health issues.[16]

As mentioned at the beginning of this article, early trauma is associated with increased number of suicide attempts in patients with BD.[2] Virginia Woolf's first suicide attempt happened when she was 22 years old, after her father's death.[16] Having withstood her mother's and Stella's death, her father's departure triggered an even greater depression that seemed too much to bear for someone who was already in the doldrums. She tried to jump out of a window in the family's home in London. Fortunately, the window she jumped from was not high enough to cause her any major injuries. She was hospitalized for a short period but soon returned home.[17] Her second suicide attempt was very serious and happened in 1913, when Virginia was 31 years old.[18] This time she attempted suicide by taking 100 g of barbital. She would have died if it weren't for Leonard and two physicians, Henry Head and Geoffrey Keynes, who came to the home and pumped Virginia's stomach with a pump borrowed from St. Bartholomew's hospital. Henry Head was an English neurologist whom Virginia was supposed to see in London, and Geoffrey was the brother of an acquaintance from the Bloomsbury Group who lived in Brunswick Square. Throughout her recovery, her writing and reading were rationed, and she was only considered fully recovered in August 1914.

From 1910 to 1913 Virginia was hospitalized several times for suicide attempts, and was submitted to "rest cure therapy" at a "private nursing home for women" in Twickenham.[19],[20] The therapy consisted mainly in gaining weight, sleeping, and "rest of the intellect." Virginia loathed her institutionalizations but somehow agreed that they were her only way towards recovering her sanity. Virginia went through several severe depressive and manic episodes until she committed suicide. Many of the episodes preceded the release of her books, always a cause of anxiety and self-doubt. Leonard often had her "institutionalized at home," cared by one or several nurses, depending on the severity of the episode.[21] It seems that Virginia had decided to end her life, and some scholars believe she tried to drown herself

one week before finally "succeeding at it." One evening, she arrived home soaking wet after a failed suicide attempt. According to Leonard, she looked ill and shaken but she told him that she had slipped into a dyke.[16]

One week later, Virginia Woolf filled her overcoat pockets with heavy stones and headed to the River Ouse to never return. She died at the age of 59. At that time the couple was living at Hogarth House in Roadmell, East Sussex. She had been severely depressed. Despite Leonard's attempts to keep her sane (he himself was also depressed), and despite the involvement of Dr. Octavia Wilberforce's, his efforts were, sadly, of no use.

Towards the end of her life, Virginia's mental health deteriorated even further. According to her biographer's account, she became suspicious, even paranoid.[16],[17] She started to doubt her publisher's praise of her soon to be published *Between the Acts*. She wanted to revise it further, but mentions in her diaries that she felt that she could no longer write, that she was "losing her art."[22] Apparently there was some truth in her editor's lack of certainty towards her work.[23] It is known that some of her publishers started to become ambivalent towards her work, which was a major blow to her ego. Her inability to read and concentrate, and also to perform "the simplest of tasks" such as holding a pen for long periods time was clearly unbearable to her.[23] Throughout the last  years of her life, symptoms of mood episodes typical of BD occurred increasingly more frequently, despite the fact that they were not new to Virginia. The episodes would start with sleeplessness, progressing to hearing voices.

The course of BD is highly variable, but it seems that Virginia Woolf presented a pernicious course, associated with hospitalizations, suicidal behavior, and cognitive impairment. Recently, the term neuroprogression was proposed in order to explain why a

subset of BD patients might experience a worsening of their mental health over time.[24] Neuroprogression has been hypothesized as the pathological rewiring of the brain that takes place in parallel with cognitive, functional, and clinical deterioration in the course of BD.[4] In this sense, reductions in the volume of the fronto-limbic system and cognitive impairment have been reported as a function of previous manic episodes and hospitalizations.[25-28] In addition, it has been proposed that trauma and number of mood episodes may show sensitization to themselves and cross-sensitization to one another, leading to residual vulnerability to further occurrences of mood episodes and faster illness progression.[29] The progression of Woolf's BD seems to fit the model proposed by the hypothesis of neuroprogression - this is supported by some of her final diary entries and the suicide note she left to Leonard:

> I feel certain that I am going mad again. I feel we can't go through another of these terrible times. And I shan't recover this time. I begin to hear voices and I can't concentrate. So I am doing what seems the best thing to do. (Glendinning,[30] p. 323)

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## CHAPTER 10. VIRGINIA WOOLF'S FINAL DAYS AND SUICIDE

*"Against you I fling myself, unvanquished and unyielding, O Death!*

*The waves broke on the shore"*

Virginia Woolf in *The Waves*

As Virginia's suicide and death approached, Leonard, always very perceptive to her mood swings and any other signs that something might have been amiss, decided to contact Dr. Octavia Wilberforce, who is known to have been Virginia Wool's last physician. Octavia practiced medicine in Montpelier Crescent, Brighton, where she lived with Elizabeth Robins. The Woolf's had met Octavia Wilberforce some years prior, when they had invited her partner to dine with them in London.

When the Woolf's were in Roadmell, usually from August to September, Octavia and Elizabeth would visit them and they would sometimes pay them a visit in Brighton. By then, Octavia Wilberforce had, according to Leonard, became Virginia's doctor to all intents and purposes.

Leonard expresses his concern in his diary:

> I told Octavia and consulted her professionally. The desperate difficulty which always presented itself when Virginia began to be threatened with a breakdown – a difficulty which occurs, I think again and again in mental illness – was to decide how far it was safe to go in urging her to take steps – drastic steps – to ward off the attack. Drastic steps meant going to bed, complete rest, plenty of food and milk. But part of the disease was to deny the disease and to refuse the cure. There was always

> the danger of reaching the point when, if one continued to urge her to take the necessary steps, one would increase not only the resistance but her terrible depression.

According to Leonard Woolf accounts, by February 7th, 1941 she couldn't remember why she had been depressed an wrote an entry in her diary: "Why was I depressed? I cannot remember".

On the 11th the couple travelled to Cambridge where they visited The Hogarth Press at Letchworth and saw the Principal of Newham College, Cambridge and dined at King's College, also in Cambridge, with Dadie Rylands. They were visited by Elizabeth Bowen, Vita Sackville- West and Enid Jones. Again, according to Leonard accounts, Virginia seemed to be enjoying herself a great deal.

As proof of Virginia's intense mood swings is an account written by Leonard describing a conversation that Virginia had had with Octavia Wilberforce in mid – March of 1941, when she would persuade Octavia to tell her the story of her life. Virginia was particularly fond of autobiographies and had attempted at convincing many of her friends into writing one and had written a biography on Roger Fry herself.

Leonard wrote in his diary:

> Whenever Octavia came to see us, Virginia tried to get her to tell the story of her life and she had this vague idea of perhaps making it into a book. "However, there is a note from March 18th, 1941, which is distressing.
>
> **I am not sure whether early in the week she did not attempt to commit suicide**. She went for a walk in the water-meadows in pouring rain and I went, as I often did, to meet her. She came back across the meadows soaking wet, looking ill and shaken. She said that she had slipped and had fallen into one of the dykes.

> On Friday Octavia came to tea and I told her that **I thought Virginia on the verge of danger**.

By March 26th Virginia was overcome by desperate depression, her thoughts raced beyond her control; she was terrified of madness. According to Leonard: One knew that **at any moment she might kill herself.** The only chance for her was to give in and admit she was ill, but this she would not do.

At Leonard's request, and also because she was indeed quite concerned herself and did care for Virginia not only as a patient, but also as a friend, Octavia Wilberforce kept on visiting the Woolf's once a week and always brought milk and cream, which she knew were essential to Virginia, specially at such times, when she would go hours without eating or eating barely nothing. But, as Leonard stated in his autobiography, Virginia was unaware of the reason for such visits.

> These visits were, so far as Virginia was concerned, just friendly visits, but I had told Octavia how serious I thought Virginia's condition was becoming and from our point of view, the visits were partly medical.

> On Wednesday, March 26, I became convinced that Virginia's mental condition was **more serious than it had ever been** since those terrible days in August 1913 which led to her complete breakdown and attempt to kill herself.

Virginia Woolf final diary entry dates from March 24th, 1941, after her failed suicide attempt but four days prior to her suicide. It gives us a glimpse into what her thoughts were back then. It is quite interesting to note what she omits rather than what she openly says. Her last diary entry goes as follows:

> Monday March 24
>
> She had a <face> nose like the Duke of Wellington & great horse teeth & cold prominent eyes. When we came in, she was sitting perched on a 3 cornered chair with knitting in her hands. An arrow fastened her collar. And before 5 minutes had passed, she told us that two of her sons had been killed in the war. This, one felt, was to her credit. She taught dressmaking. Everything in the room was red brown & glossy**. Sitting there I tried to coin a few compliments. But they perished in the icy sea between us. And then there was nothing**. **A curious sea side feeling in the air today.** It reminds me of lodgings on a parade at Easter. Everyone leaning against the wind, nipped & silenced. **All pulp removed**. This windy corner. And Nessa is at Brighton, **& I am imagining how it wd be if we could infuse souls. Octavia's story. Could I englobe it somehow?** English youth in 1900. Two long letters from Shena & O. **I can't tackle them**, yet enjoy having them. L. is doing the rhododendrons…

As mentioned in previous chapter Virginia had attempted to kill herself one week before but was "unsuccessful". She did not admit it though but Leonard was sure that she had tried to drown on the River Ouse as he met her halfway and found her soaked wet, trembling and shaking. Her lies made Leonard even more concerned and he was thorn between having to force her into, once again, leading a "vegetative life", as he called it, something he too found inhumane and undignifying. He knew that, this time, Virginia was not willing to cooperate and get onboard the "restorative therapies" that had saved from losing her mind as well as her life before. It is interesting, and profoundly sad that, Leonard and their physician and friend, Dr. Octavia Wilberforce had decided on the 27th of March, after much consideration, that she had to be institutionalized. However, she was more determined than both of them and walked towards the River Ouse in the morning of March 28th, 1941. This time, she made sure she was wearing a heavy overcoat and that she had plenty of rocks on her pocket so that she would certainly drown. Her cane was found on the bank of the Ouse that afternoon. Her body, however, was found only three weeks later by children playing next to a bridge. Her body had been carried by the currents.

She left two poignant suicide letters (although some scholars state there she left some more), which are known by many, but, instead of first quoting the suicide letter addressed to her husband Leonard, on which she explained her motives for killing herself but mostly thanks and reassures him of everything he has done to her, we shall first quote the letter she left to Vanessa, which we find much more revealing in terms of how desperate and hopeless she was feeling at that time.

The note reads:

> Sunday
>
> Dearest, You can't think how I loved your letter. But I feel I have gone too far this time to come back again. I am certain now that I am going mad again. It is just as it was the first time, I am always hearing voices, and I shan't get over it now. All I want to say is that Leonard has been so astonishingly good, every day, always; I can't imagine that anyone could have done more for me than he has. We have been perfectly happy until these last few weeks, when this horror began. Will you assure him of this? I feel he has so much to do that he will go on, better without me, and you will help him. I can hardly think clearly anymore. If I could I would tell you what you and the children have meant to me. I think you know. I have fought against it, but I can't any longer. Virginia.

The note she left Leonard had been drafted on the 25th of March, three days prior to her suicide, which indicates that she was absolutely resolute about her decision.

Below is the letter she left to her husband Leonard:

> Dearest,
>
> I feel certain I am going mad again. I feel we can't go through another of those terrible times. And I shan't recover this time. I begin to hear voices, and I can't concentrate. So I am doing what seems the best thing to do. You have given me the greatest possible happiness. You have been in every way all that anyone could be. I don't think two people could have been happier till this terrible disease came. I can't fight any longer. I know that I am spoiling your life, that without me you could

> work. And you will I know. You see I can't even write this properly. I can't read. What I want to say is I owe all the happiness of my life to you. You have been entirely patient with me and incredibly good. I want to say that – everybody knows it. If anybody could have saved me it would have been you. Everything has gone from me but the certainty of your goodness. I can't go on spoiling your life any longer.
> I don't think two people could have been happier than we have been. V

Her end was anticipated in Virginia Woolf's mind and words in many occasions since her adult's life. She seems to have been waiting for a sum of an unbearable combination of subjective distresses and objective disasters that finally came in the weeks before March 28th, 1941.

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