1 "I owned to great egotism"

The Neurotic Model in Woolf Criticism

And I haven't said anything very much, or given you any notion of the terrific high waves, and the infernal deep gulfs, on which I mount and toss in a few days.

(*Letters* 3: 237)

In her biography, diaries, and letters Virginia Woolf left ample evidence to convince psychiatric specialists that she suffered from a "classical case of manic-depressive illness."[1] Literary-psychoanalytic studies of her life and art, however, have shied away from the biological implications of such a diagnosis. They have focused instead on her childhood traumas, explaining her mental breakdowns as neurotic, guilt-driven responses to the untimely death of her mother, the patriarchy of her father, and the sexual abuse inflicted by her half-brothers. Virginia's nephew Quentin Bell, for instance, regards his aunt's symptoms as manifestations of a profound longing for virginity tied to morbid guilt and repressed sexuality. Others conclude that Woolf did not grow beyond her preoedipal attachment to her mother, so that her lifelong sense of loss and her desperate fear of adult sexuality alternately produced novels and madness instead of full womanhood, or that Woolf might have been driven mad by a "profound but unconscious guilt" inspired by oedipal jealousy and an unacknowledged wish that her mother would die. Some, conversely, claim that Woolf's fiction functioned as a defense mechanism against grieving, against confronting unresolved feelings of guilt, defilement, anger, and loss. Given Woolf's suicide, one critic worries that her much-touted "moments of being" may not have been epiphanies at all but dark dissolutions of the self, flirtations with death disclosing a misguided desire to escape her individuality, her very self.[2]

Most recently, three book-length psychobiographies have consolidated these arguments. In *Virginia Woolf and the "Lust of Creation": A*

Psychoanalytic Exploration, Shirley Panken portrays Woolf as "self-destructive, masochistic," "deeply guilt-ridden" because of her early closeness to her father, humiliated by her sexual inhibitions, and victimized by a "passive aggression [that] masks oral rage." For Panken, even Woolf's physical symptoms must be seen as psychosomatic, a "channeling of her guilt, grief, and anger."[3]

Alma H. Bond, in *Who Killed Virginia Woolf? A Psychobiography,* acknowledges that "manic-depression has an inherited, probably metabolic substructure," but then inexplicably dismisses the implications this admission has for psychology and hunts instead for oedipal and preoedipal origins of Woolf's symptoms: a mother's ambivalence, a child's masochistic wish to surrender to an idealized mother, a daughter's envy of the father's penis. Because psychoanalysis privileges mentation over metabolism, Bond concludes that Woolf "chose" to become manic or depressive as a way of avoiding growing up, and because psychoanalysis gives early events etiological priority over later, Bond resorts to an unsupported speculation that Woolf's lifelong sense of failure and self-hatred "probably" resulted from her mother's having "devalued" her daughter's feces. Working backward, Bond uses adult breakdowns to prove the existence of childhood trauma, which is then cited as the cause of psychosis. At a critical juncture, having found numerous psychological similarities between family members (which should have prompted her to grant due importance to genetic inheritance in mood disorder), she contorts logic by arguing: "As a result, although father and daughter in a genetic sense resembled each other uncannily, it seems unnecessary to postulate a biochemical factor as the major 'cause' of Virginia Woolf's manic-depressive illness."[4]

Finally, Louise DeSalvo, in *Virginia Woolf: The Impact of Childhood Sexual Abuse on Her Life and Work,* follows the old formula of explaining complex mental states in terms of simple trauma because of a metaphorical similarity between the two. DeSalvo argues that, since Woolf was sexually abused as a child and since victims of childhood abuse often develop symptoms of depression as adults, we may therefore conclude that her "madness" was not really insanity but only expressed a logical reaction to victimization. But DeSalvo's theory cannot account for full-blown mania, for the cyclic and often seasonal form of bipolar breakdowns, or for their severity (to DeSalvo, psychotic behavior is merely amplified anger), because she does not venture beyond a narrow theoretical context: the reactive depressions of incest victims. Certainly, victims of childhood abuse do suffer depressions, and DeSalvo forcefully presents their pain and argues

eloquently for our understanding. But she oversimplifies etiology, for she fails to discriminate between different types of depression: (1) those depressions which result from psychological conflicts (e.g., those created by the trauma of sexual abuse), (2) those which are inherited genetically and/or physiological in origin (such as manic-depressive illness), and (3) those in which both psychological and physiological causes interact. DeSalvo dismisses "inherent madness" as an "archaic" notion and so frees herself from the task of reading recent biological research. Unwilling to consider an imposed mood disorder, she looks instead for explanations of why Woolf would want to die, and incest serves as a reasonable cause. We lack specifics about Woolf's victimization: Was it rape or unwelcome caresses? Was it frequent or rare? Was it long-term or short? The evidence is scarce and ambiguous. So DeSalvo uses the severity of Woolf's adult depressions as proof that her childhood abuse must have been rape, quite frequent, and chronic. The problem here is that inherited biochemical depression can be very severe without any preceding childhood trauma. Suicidal impulses cannot, by themselves, serve as a reliable indicator of the significance of early or late trauma, because despondency results from various conditions, some merely biochemical. And when severe depression alternates with mania in a family with a history of inherited mood disorders, unconscious conflict resulting from trauma is the least likely origin. DeSalvo's rubric for judging mental states fails to differentiate between the despair of a molested daughter and the despair of a manic-depressive. It ignores the inconvenient complexity of mind-brain interaction.[5]

Psychobiographers ignore psychobiology, in part because they are afraid of having to undertake a whole new program of self-education—reading dense biological texts, digesting unfamiliar jargon, and, perhaps worst of all, poring over psychiatric journals for late-breaking developments (nearly 1,200 reports on manic-depressive illness appear each year worldwide in medical journals). Psychoanalytic literature evolves more slowly, is frequently taught in graduate school, and has often been adapted to literary study. It also fortifies common cultural stereotypes about artists. Underlying Freudian thinking is the unspoken (and even unconscious) assumption that Virginia Woolf became a great artist *because* she was a neurotic, that her books are filled with references to death and strange desires for a depersonalized union with the cosmos because, like all neurotics, she was afraid to live fully. Books were her lonely refuge, plaintive elegies sung by a confined, poignant Lady of Shalott, half mad, half magical, more beautiful dead than alive, especially for critics. Once neuroticized, Woolf

becomes the target for all sorts of accusations. Picturing her as "a damaged thing, a spoilt, wingless bird," one writer has made the sexist accusation that Virginia "would take refuge in nervous stress" to escape her marital problems.[6] Critics point to her suicide as proof of a lifelong morbidity, some even arguing that Woolf unconsciously chose drowning in the "boundaryless waters" of the Ouse to symbolize her repressed wish to merge with her dead mother.[7] Biographers value continuity in the inconvenient anarchy of an artist's life, and so they tend to view Woolf's death almost as if it were a work of art itself and her novels elaborate drafts of a suicide note.

Why should psychoanalytic criticism be so morbid? Freud's ideas about art were closely tied to the Romantic tradition, which stressed the irrational, unconscious, and reputedly insane states of mind that artistic inspiration can induce. But Freud the scientist was a thoroughgoing materialist who sought to reduce mental operations to drives and defenses. However mysterious he found the appeal of art, Freud focused his analytic attention on instinctual demands and infantile traumas, viewing art more as a fearful evasion than as a joyous exercise of skill and perception[8]—an attitude that led one ardent devotee, Frederick Crews, to express serious misgivings about the psychoanalytic method itself:

> Indeed, because the regressiveness of art is necessarily more apparent to the analytic eye than its integrative and adaptive aspects are, psychoanalytic interpretation risks drawing excessively pathological conclusions. When this risk is put together with the uncertainties plaguing metapsychology itself, one can see why Freudian criticism is always problematic and often inept.[9]

Since Crews made his denunciation, a few revisionists have begun to offer intriguing approaches to patients and/or texts in nonreductive ways. But, with the exception of feminist psychoanalytic criticism, little new light has fallen on Woolf studies, which still cherish what Crews aptly calls "the anaesthetic security" of the old Freudian bias toward the model of the neurotic artist.[10] In inexpert hands this paradigm invites misdiagnosis, because it reinforces the biographer's wish to explain mentality through events, which are, of course, the staple of life histories. Neurosis readily provides coherence for biographical data, but in past Woolf criticism it has often been a reductionist order that points backward, emphasizing the infantile and evasive in art rather than the adult and adaptive. Inevitably, the critic plays the role of the adult and casts the artist as the sick child.

This was certainly not the way Woolf's friends felt about her, as Rosamond Lehmann remembers:

> She had her share of griefs and bore them with courage and unselfishness. It is important to say this in view of the distasteful myths which have risen around her death: the conception of her as a morbid invalid, one who "couldn't face life", and put an end to it out of hysterical self-pity. No. She lived under the shadow of the fear of madness; but her sanity was exquisite.[11]

And Clive Bell objected to the tendency of biographical postmortems to depict Woolf as "the gloomy malcontent": "Let me say once and for all that she was about the gayest human being I have known and one of the most lovable."[12] But psychobiographers find well-adjusted subjects dull material and find irresistible the great Freudian temptation of explaining even Woolf's happy periods as the result of a defensive repression of those shameful horrors that were unleashed suddenly during her breakdowns.

The problem of pathology is compounded by Woolf's own misdiagnosis, which was affected by both her experience of the disorder and the alternative explanations available to her. In her letters she sometimes fell into a description of her illness in terms of the prevalent model of her time—the neurotic artist. When Walter Lamb confronted Woolf with "dreadful stories" of bad behavior, she quickly confessed guilt as well as madness: Lamb "was puzzled by parts of my character. He said I made things into webs, & might turn fiercely upon him for his faults. I owned to great egoism & absorption & vanity & all my vices," the same self-accusation she made to Leonard during their courtship.[13] In a letter to Vita Sackville-West, she again blamed herself for suffering mood swings:

> And I haven't said anything very much, or given you any notion of the terrific high waves, and the infernal deep gulfs, on which I mount and toss in a few days. . . . And I'm half ashamed, now I try to write it, to see what pigmy egotisms are at the root of it, with me anyhow—(*Letters* 3: 237)

Manic-depressives typically confuse mood swings with egotism, because the initial (and usually mild) symptoms often mimic egotistic behavior; patients may become overly concerned with themselves (e.g., exhibit hypochondria), draw attention to themselves through boisterous behavior, or misinterpret events solely in relation to themselves (e.g., experience

feelings of persecution). Such an impression was evidently shared by some of the specialists of the time: in 1931 a psychologist, Helge Lundholm of Duke University, argued that egotism was an *integral* component of manic-depressive illness and that it was a *precursor,* marking the loss of psychic inhibition and an increased vulnerability to a major breakdown—just as Woolf herself thought.

And Woolf had a much nearer "nervous" model on which to base her diagnosis: the style and even the content of her self-analyses resemble the self-descriptions of her "hypochondriacal" and "egotistical" father, Leslie Stephen, with whom she identified not only as a writer but as the source of her disorder:

> But—oh damn these medical details!—this influenza has a special poison for what is called the nervous system; and mine being a second hand one, used by my father and his father to dictate dispatches and write books with—how I wish they had hunted and fished instead!—I have to treat it like a pampered pug dog, and lie still directly my head aches. (*Letters* 4: 144–45)

In Leslie's "violent rages and despairs" (*Letters* 4: 353), his feelings of failure and his self-abasements alternating with excitement and satisfaction, Virginia saw milder forms of her own symptoms and could have reasoned that the cause of both was "an egoism proper to all Stephens" (*Diary* 1: 221). Manic-depressive children do tend to over-identify with any close family member, and particularly a parent, who they think also has the disorder.[14] The old family doctor, George Savage (1842–1921), reinforced the neurotic-genius model in Virginia's mind by diagnosing her illness as "neurasthenia," the same label he had earlier put on Leslie's complaints. Although Virginia experienced much more severe manias and depressions than her father had, Leslie's nervous breakdowns from 1888 to 1891 were accompanied by "fits of the horrors" and "hideous morbid fancies" of despair and death—feelings his daughter certainly could have recognized.[15]

Ascertaining just what Woolf did think of her illness is complicated by her doctor's inconsistent explanations of nervous disorders. Neurasthenia ("nerve weakness") was a Victorian euphemism that covered a variety of vaguely recognizable symptoms, just as the term *neurosis* lumped together various disorders for much of this century (today, in psychiatry, neurosis is considered an outmoded category, no longer listed in the statistical manual of the American Psychiatric Association as the basis for establishing

a diagnosis).[16] Certainly the theory of neurasthenia was thoroughly materialistic. The essential elements of the Silas Weir Mitchell (1829–1914) rest cure that Savage prescribed for Woolf's breakdowns were extended sleep and "deliberate overfeeding to stabilize the irregular brain cells supposedly responsible for the illness."[17] Later nineteenth-century neurologists such as Savage were "deeply antagonistic, not merely to psychological *explanations* of insanity, but to any sustained or systematic attention to mental therapeutics."[18] Savage himself believed that patients who came from "neurotic stock," especially those families that produced geniuses or ambitious intellectuals (an apt description of the Stephen family), were more likely to go out of their minds periodically for purely biological reasons. He was particularly convinced that patients who experienced auditory hallucinations (Virginia heard birds speaking Greek and King Edward shouting obscenities in the garden bushes) had inherited their madness. Because he believed in the somatic basis of insanity, Savage saw a connection between mental breakdowns and physical stress, especially that caused by influenza, fatigue, fever, alcoholism, and irregular temperature,[19] an association both Leonard and Virginia discussed:

> If Virginia lived a quiet, vegetative life, eating well, going to bed early, and not tiring herself mentally or physically, she remained perfectly well. But if she tired herself in any way, if she was subjected to any severe physical, mental, or emotional strain, symptoms at once appeared which in the ordinary person are negligible and transient, but with her were serious danger signals. The first symptoms were a peculiar "headache" low down at the back of the head, insomnia, and a tendency for the thoughts to race. If she went to bed and lay doing nothing in a darkened room, drinking large quantities of milk and eating well, the symptoms would slowly disappear and in a week or ten days she would be well again. (L. Woolf, *Beginning Again* 76)

> I pass from hot to cold in an instant, without any reason; except that I believe sheer physical effort and exhaustion influence me. (*Letters* 1: 496)

> I had the flu again—but a slight attack, and I feel none the worse and in my view the whole thing is merely a mix up of influenza with my own remarkable nervous system, which, as everybody tells me, can't be beaten for extreme eccentricity, but works all right in the long run. (*Letters* 2: 560)

> My soul diminished, alas, as the evening wore on; & the contraction is almost physically depression. I reflect though that I'm the sink of

> 50 million pneumonia germs with a temperature well below normal. And so these contractions are largely physical, I've no doubt. (*Diary* 2: 236)

Significantly, recent medical research suggests that influenza, fevers, and a variety of other infections and physically stressful disorders may indeed be associated with the timing of manic-depressive episodes, and even in 1921 Emil Kraepelin reported that headaches were "extraordinarily frequent" among his patients.[20] Manic-depressive illness, perhaps more than any other psychiatric disorder, exemplifies the close connection between brain and mind. It is

> a kind of biological rhythm. Episodes of mania and depression remit and relapse spontaneously, and recur in a quasi-periodic manner. Also, the occurrence and severity of affective symptoms [a person's emotional coloring and responsivity toward the world] sometimes seem to be strongly influenced by normal biological rhythms. For example, the classical feature of diurnal variation in mood in endogenous [biochemical] depression suggests that some daily physiological rhythm aggravates or mitigates the depressive process. The association of exacerbations of affective symptoms with phases of the menstrual cycle and seasons of the year has been repeatedly observed by physicians treating individual patients and by epidemiologists surveying populations of patients. In recent years experimental evidence has accumulated that shows that rhythms in the body, especially the daily sleep-wake cycle, may be centrally involved in the processes responsible for depression and mania.[21]

Moreover, depressive symptoms can manifest themselves *as* physical disorders: that is, the depression can express itself in bodily disturbances, hypochondria, and other psychosomatic illnesses before its distinctive psychological effects become noticeable:[22]

> The initial complaint of depressed patients is quite often likely to be some common physical complaint rather than one of sadness, hopelessness, or a feeling of failure. Some of the manifestations, such as fatigue, headache, insomnia, and gastrointestinal disturbances are similar to those produced by anxiety; others are more distinctive, such as anorexia and weight loss, bad taste in the mouth, chronic pain, loss of interest, inactivity, reduced sexual desire, and a general feeling of despondency. It can be appreciated readily that anxiety-depression can mimic many diseases or disorders.[23]

Such symptoms would indeed seem like precursors to a breakdown, to many other doctors and patients as well as to Savage and Woolf. Woolf's

mood swings often did coincide with headaches, toothaches, influenza, and fatigue.

We cannot dismiss the further possibility (as yet inconclusively researched) that depression itself affects immune-system function, rendering its victims more susceptible to infection, which might then exacerbate the mood disorder.[24] Panken's statement that Woolf's physical symptoms were "unconsciously resorted to in hope of restoring or appeasing her mother" or were an "attention-getting" device to regain her father's love is therefore most likely wrong. Panken assumes that Woolf's incomplete mourning for her dead mother and a neurotic "channeling of her grief, guilt, and anger" produced the somatic disturbances of her manic-depressive breakdowns, but a disease with such potent metabolic changes may very well affect bodily health and mental functioning without involving self-destructive wishes.[25] So, too, biology should dissuade us of Louise DeSalvo's speculation that Woolf feared becoming sick because she had once been molested by Gerald Duckworth while recovering from whooping cough.[26] Much more than simple association is at work here.

Despite his arguments for biology and heredity, however, Savage also had "psychological" opinions of mental illness, though they are hardly more than the products of personal bias and culturally prescribed Victorian stereotype. He believed, for instance, that spoiled children were likely to develop unsound minds and that too much education was mentally harmful for the lower classes and for intelligent young women rebelling against their natural roles as wives and mothers.[27] But, what was perhaps worse, in his published essays Savage explained some kinds of mental disorders as a "defect" in "moral character," and he expressed irritation at what he perceived to be his patients' self-indulgence in their illnesses (especially when they did not get well under his care)—a reaction he may have picked up from Silas Weir Mitchell himself, who believed that "yielding too easily to the expression of all and any emotion" was a predisposing cause of nervous disorders. Both physicians advocated "order, control, and self-restraint" as a cure for mental illness, an attitude not uncommon among Victorian doctors.[28] Savage should have had little difficulty in convincing Woolf that her excessive emotionalism fit the moral-weakness bill, especially since her own father, Leslie, adopted Savage's line when he referred to the mental difficulties of his first daughter, Laura, as a moral deficiency caused by "willful perversity," an obstinate waywardness he thought he could cure by imposing "a stronger will and greater self-discipline."[29] Consequently, in the first year of their marriage, Leonard

found he had to reassure Virginia that an episode of depression was merely "illness & nothing moral" (L. Woolf, *Letters* 191). Virginia had learned early on to attribute her symptoms to family genes and yet to blame herself for losing control of her emotions, as she does in the following diary entry and three apologetic letters, two to Violet Dickinson and the third to her sister Vanessa:

> —a little more self control on my part, & we might have had a boy of 12, a girl of 10: This always [m]akes me wretched in the early hours. So I said, I am spoiling what I have. . . . No doubt, this is a rationalisation of a state which is not really of that nature. Probably I am very lucky. (*Diary* 3: 107)

> I know I have behaved very lazily and selfishly, and not cheerfully as Ozzy [Dickinson] would have me. I feel numb and dumb, and unable to lay hands on any words. (*Letters* 1: 279)

> When I hear of your worries and wishes—I dont know if a pen is as fatal to you as it is to me—I feel positively fraudulent—like one who gets sympathy on false pretenses. (*Letters* 1: 280)

> Oh my beloved creature, how little use I am in the world! Selfish, vain, egoistical, and incompetent. Will you think out a training to make me less selfish? It is pathetic to see Adrian developing virtues, as my faults grow. (*Letters* 1: 411)

Psychoanalytic critics have only detected the obvious without questioning its context when they see her as both perversely resistant to self-insight and riddled with unconscious guilt—convenient signposts of neurosis.[30]

Savage's dualistic attitude was typical of many Victorian doctors. The nineteenth century developed these two parallel lines of psychiatric thought, each having its vogue for several decades: either insanity was so biologically based that it was not intelligible at all (and so patients were warned not to think about their "ill" experiences), or madness resulted from a weak character and immoral decisions voluntarily made.[31] Symptoms of madness, therefore, were either meaningless epiphenomena of underlying morbid states or representations of one's sinful nature. Patients could feel either disconnected from their own illness or ashamed for failing to control themselves. Woolf, at times, felt both.

As a woman, Woolf faced an additional challenge. Her illness and her femaleness both threatened her with a profound sense of powerlessness and depersonalization. In her own family her mother Julia and her half-sister Stella had shown her what it was like to be sacrificed to the

Victorian god of feminine decorum. She instinctively rebelled against what she called "non-being," that selfless emptiness enforced by a sexist society—and by her depressions. But open rebellion was risky. Under the Lunacy Act of 1890, 70 percent of Britain's mentally ill were certified and committed by 1900, most often for suicide attempts, leading one scholar to conclude:

> If Virginia Woolf had been certified and admitted to an asylum in the hopeless condition in which we find her in 1912, it is possible she could have been lost on the back wards and even her private physicians would not have been able to legally obtain her release.[32]

Only as long as Woolf cooperated with what was essentially an unacknowledged parody of Victorian stereotypes about femininity could she remain safe from institutionalization.[33]

It was a ticklish situation. Both her feminism and her manic-depressive experiences urged Woolf to further exploration of the mind, but overt self-assertion or preoccupation with symptoms was viewed either as self-indulgence or as evidence of madness. Savage, like Mitchell, evaluated his patients' progress in terms of their submission to his conservative view of reality: the patient was told to relinquish control to the doctor, to follow directions without question. Because Savage identified sanity with social conformity, he denigrated the value of self and brushed aside the patient's experience of her illness.[34] After Woolf's "summer madness" in 1904, which included an unsuccessful suicide attempt (she threw herself out of a second-story window), Savage pronounced her "cured" by January and had no better advice for Virginia than that she should disregard what had happened:

> I am discharged cured! Aint it a joke! Savage was quite satisfied, and said he wanted me to go back to my ordinary life in everything and to go out and see people, and work, and to forget my illness. (*Letters* 1: 175)

Indeed, Victorian physicians generally discounted the content of female complaints and judged them by the patriarchal mythology of the nature of femininity:

> Expressions of unhappiness, low self-esteem, helplessness, anxiety, and fear were not connected to the realities of women's lives, while expressions of sexual desire, anger, and aggression were taken as morbid deviations from the normal female personality. The female life cycle, linked to reproduction, was seen as fraught with biological crises during which these morbid emotions were more likely to appear.

> . . . The menstrual discharge in itself predisposed women to insanity, since it was widely believed that madness was a disease of the blood.[35]

Thus, the theory of female insanity reduced the value of women to their usefulness to society, not as persons seeking self-discovery, but as submissive wives and selfless mothers. An independent will in a woman "could be regarded as a form of female deviance that was dangerously close to mental illness," a rebellion which invited censure and control by the physician:

> The traditional beliefs that women were more emotionally volatile, more nervous, and more ruled by their reproductive and sexual economy than men inspired Victorian psychiatric theories of femininity as a kind of mental illness in itself. As the neurologist S. Weir Mitchell remarked, "The man who does not know sick women does not know women."[36]

Ridiculous as these opinions appear today, at the time the threat was quite real. As the nineteenth century progressed, more and more women were institutionalized: by 1875 females made up a majority of asylum inmates, and some physicians put the blame on the growing feminist movement, which advocated intellectual achievement for young women.[37] Although in private Woolf ridiculed Savage as "tyrannical" and "short-sighted" and rightly questioned his chauvinistic definition of "coherence" (*Letters* 1: 147, 159), she submitted to rest cures when ordered.

Later the Woolfs encountered psychoanalytic theory. Leonard read the first English translation of *The Interpretation of Dreams* in 1913, and the Woolfs' Hogarth Press published Freud's "Mourning and Melancholia" in the *Collected Papers* in 1925. These studies helped him to recognize the significance of the bipolarity of Virginia's symptoms and to diagnose her disorder correctly as manic-depressive illness:

> When I cross-examined Virginia's doctors, they said that she was suffering from neurasthenia, not from manic-depressive insanity, which was entirely different. But as far as symptoms were concerned, Virginia *was* suffering from manic-depressive insanity. In the first stage of the illness from 1914 practically every symptom was the exact opposite of those in the second stage in 1915. In the first stage she was in the depths of depression, would hardly eat or talk, was suicidal. In the second she was in a state of violent excitement and wild euphoria, talking incessantly for long periods of time. In the first stage she was violently opposed to the nurses and they had the greatest difficulty in getting her to do anything; she wanted me to be with her continually and for a week or two I was the only person able to get her to eat anything. In the

> second stage of violent excitement, she was violently hostile to me, would not talk to me or allow me to come into her room. She was occasionally violent with the nurses, but she tolerated them in a way which was the opposite of her behavior to them in the first stage. (*Beginning Again* 161)

Leonard must also have learned a good deal of symptomatology from Karl Abraham, who published essays on manic-depressive illness in 1912, 1916, and 1924, incorporating all three in a 1927 edition of his papers put out by the Hogarth Press. And there were other sources: between 1919 and 1925 the British press published 400 articles, editorials, news items, and reviews on Freud and his followers. Psychoanalysis had become a fad, a subject for dinner conversation: "every moderately well-informed person," one reviewer in 1920 claimed, "now knows something about Jung and Freud,"[38] and Leonard himself said that Virginia made one of that number (L. Woolf, *Letters* 522).

With all this discussion of mental illness, then, why did Woolf not seek psychotherapy? Was it a kind of neurotic cowardice, as at least five Freudian critics have already suggested?[39] Was she afraid of discovering the truth about her illness because that truth was connected to deeply repressed conflicts? Did she prefer to be ill because it brought her attention and love? Does the fact that she avoided psychoanalysis prove that she was hiding something neurotic or forbidden? Or was her rejection of Freud merely childish, vindictive, and small-minded, resulting from her childhood hostility to her brother Adrian, who grew up to become a practicing psychoanalyst?[40]

I do not believe Woolf could have held much hope of finding a cure in Freud. Like Savage, he saw abnormality in social nonconformity. And, as feminist psychoanalytic critics have cogently argued, Freud's own case history of Dora, which was published by the Hogarth Press, displays his rigid, patriarchal attitude toward the organization of a patient's symptoms, at least when that patient happened to be a woman. He completely failed to understand why the adolescent Dora had not been sexually excited by the clumsy attentions of an older married man (whose wife was having an adulterous affair with Dora's father) when he had grabbed her suddenly and kissed her, pressing his body to hers. Freud reasoned that she must have felt K.'s erection through their clothing, and that she was denying she had responded in kind. This conclusion Dora flatly rejected; she found Herr K.'s actions repulsive. Freud was unaware of his own unconscious identification with K., or that he felt Dora's rejection of K. was linked

to a repudiation of himself. He defensively concluded that her feelings of repulsion were evidence of neurosis. How could a normal girl resist an older man? And beneath that lay another question: how could Dora resist Freud's masterful diagnosis? The answer was, she couldn't; therefore, she must be sick. He refused to accept at face value her version of what had happened and how she had felt, turned her reproach against her father's duplicity into self-reproach, and acted as if Dora's mother were of no consequence (indeed, Freud generally minimized the role of women, particularly in his equation for the Oedipus complex).[41] In the 1920s Karen Horney clearly discerned Freud's "phallo-centric" view of women and objected to his having relegated them to a passive-masochistic sexual role.[42] Even in Woolf's lifetime it was becoming evident to feminists that Freud imposed his own unexamined views upon women, invalidating the coherence he thought he had discovered as underlying the seeming incoherence of women's symptoms.

Moreover, we cannot regard Savage's rest cure as so completely ineffective that only a neurotic would continue treatment. Recent studies at the National Institute of Mental Health (NIMH) showed that restructuring a manic-depressive's sleep cycle can effect at least a temporary remission of symptoms: in 60 percent of patients, sleep deprivation causes switches from depression to normal or manic states,[43] and recovery sleep after sleep deprivation can trigger switches out of mania. The success achieved with both "phase-advance" sleep (going to bed four to six hours earlier and rising earlier) and sleep deprivation has led NIMH researchers to speculate that manipulating the twenty-four-hour sleep-wake cycle may, in some patients, either replace or enhance drug therapy.[44] Such a hypothesis implies that a genetic defect in the brain's internal circadian (twenty-four-hour) clock is involved in the etiology of manic-depressive illness. Studies show that nights of total insomnia often precede mania, acting either to trigger an episode or to exacerbate one already begun.[45] Consequently, clinicians warn that patients need to be alert to environmental changes leading to insomnia (e.g., anxiety, excitement, grief, travel, hormonal changes). Even a single night's sleeplessness "should be taken as an early warning of possible impending mania." Patients should be counseled to avoid stressful or stimulating situations "likely to disrupt sleep" routines, and physicians should consider prescribing sedatives (such as clonazepam) to prevent significant sleep loss.[46] Overall, "the regularization of circadian rhythms through the regularization of meals, exercise, and other activities should also be stressed to patients."[47] Leonard acknowledges his belief in this

premise in his autobiography, and he offers details in a 1929 letter to Vita Sackville-West:

> It was a perpetual struggle to find the precarious balance of health for her among the strains and stresses of writing and society. The routine of everyday life had to be regular and rather rigid. Everything had to be rationed, from work and walking to people and parties. (*Downhill All the Way* 49)

> Virginia has been a good deal better the last two days though she is still not right & is more or less in bed. The slightest thing is apt to bring symptoms back. But this has always been the case when she has been so near breaking point, & I think, if she keeps quite quiet, for another week, it will pass away. She has not really had such a severe attack as this for the last 3 or 4 years. It was not, of course, due to anything like influenza or sea-sickness cures, but simply to her overdoing it & particularly not going to bed at 11 for all those nights running. It has been proved over & over again in the last 10 years that even 2 late nights running are definitely dangerous for her & this time it was 7 or 8. (L. Woolf, *Letters* 236)

Since Victorian medicine believed that stress triggered "neurasthenic" episodes, Savage ordered Leonard to keep visitors, activities, and household stress at a minimum when Virginia was ill and to make sure she ate well and rested regularly. From 1913 (the beginning of a two-year period of affective episodes) to the end of 1919, Leonard kept an almost daily journal of Virginia's moods (time of onset, duration, and intensity), her sleeping and eating patterns, temperature, weight, dose of drug taken, and date of onset of menstruation. Correlations between bodily rhythms and mental states helped him anticipate what level of care she would need. In later years, whenever Virginia felt ill, Leonard returned to his monitoring, using his measurements as a predictor of impending breakdown. When she suffered from intractable insomnia, he gave cautious doses of hypnotic sedatives (listed as "chloral [hydrate]," "veronal," "medinal," "potassium bromide," and "sodium bromide" in his personal diary in his Monks House Papers, now housed at the University of Sussex). Chloral hydrate was widely prescribed for inducing sleep and calming the insane, especially manics, whose metabolism could be so hyperenergized that neither sleep nor self-control was possible.

For any sedative, it is important to recognize just how much is too much, as both Leonard and Dr. Savage understood. In 1879 Savage wrote a paper entitled "Uses and Abuses of Chloral Hydrate," in which he