As an experience, madness is terrific I can assure you, and not to be sniffed at; and in its laws I still find most of the things I write about. It shoots out of one everything shaped, final, not in mere driblets, as sanity does. And the six months—not three—that I lay in bed taught me a good deal about what is called oneself.

Virginia Woolf, Letters 4: 180

Although the diaries and letters of Virginia Woolf provide enough evidence to convince the psychiatrist Sherman C. Feinstein that she suffered from a "classical case of manic-depressive illness which fulfills every criterion" (339), psychological studies of her life and art by literary critics have shied away from the biological implications of such a diagnosis, focusing instead on her childhood traumas and explaining her mental breakdowns as a neurotic response to the untimely death of her mother, the tyranny of her father, or the sexual abuse inflicted by her half brothers. Quentin Bell notes his aunt's symptoms accurately but regards them as manifestations of a profound virginity tied to morbid guilt and repressed sexuality. The more sympathetic Jean Love, Betty Kushner, Susan Kenney, and Edwin Kenney, Jr., while admiring Woolf's spirit, do not think she advanced sufficiently beyond her precocious attachment to her mother; her lifelong grief, they contend, alternately produced novels and madness instead of full womanhood. Roger Poole, Mark Spilka, and Murray Sherman theorize that her fiction functioned as a defense mechanism against grieving, against confronting unresolved feelings of guilt, defilement, anger, and loss. James Naremore speaks for many other critics when he notes that, given Woolf's suicide, her "moments of being" may be not epiphanies but dark dissolutions of the self disclosing a misguided desire to die. And, most recently, Shirley Panken consolidates all these arguments by layering one neurosis over another, portraying Woolf as "self-destructive, masochistic" (4), "deeply guilt-ridden" (13), humiliated by her sexual inhibitions, and victimized by a "passive aggression [that] masks oral rage" (68–71). For Panken, even the physical symptoms of Woolf's breakdowns evidence a desperate though unconscious "need for punishment" due to early developmental traumas (16). Underlying such thinking is the faulty assumption that Woolf became an artist because she was a neurotic, that she filled her books with references to death and strange desires for a depersonalized union with the cosmos because she was afraid to live fully outside fiction. Books were her lonely refuge, plaintive elegies sung by a confined but poignant Lady of Shallot, half mad, half magical, more beautiful dead than alive. Critics need only point to her suicide as proof of a lifelong morbidity, some even arguing that Woolf chose drowning in the "boundaryless waters" of the Ouse to symbolize an unconscious wish to merge with her dead mother (Wolf and Wolf 44). Biographers value continuity in the inconvenient anarchy of an artist's life, and so Woolf's death is viewed almost as a creative act and her novels as elaborate drafts of a suicide note.

There are several reasons why this approach has been popular. Freud's ideas about art were closely tied to the Romantic tradition, which stresses the irrational, unconscious, and reputedly insane states of mind that artistic inspiration induces. But Freud the scientist was a thoroughgoing materialist who sought to reduce creativity to a question of drives and defenses. However mysterious the appeal of art, he focused his attention on instinctual demands and infantile traumas, viewing art more as a fearful evasion than as a joyous exercise of skill and perception (Spector 263). This attitude led Frederick Crews to have 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. (81)
Crews overstates the case, particularly since recent revisionists like Meredith Skura, Steven Marcus, and Roy Schafer have offered exciting new approaches to patients and texts in nonreductive ways. But little of this new light has fallen on Woolf criticism, still influenced by what Crews aptly calls the "anaesthetic security" of the "neurotic-artist" model. 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 reductionistic order that points backward, focusing on the infantile and evasive rather than the adult and adaptive. Inevitably, it is the critic who plays the role of the adult and fancies the artist to be the sick child.

The problem of Woolf's biography is compounded by her own misdiagnosis. In her letters she sometimes describes her illness to fit the prevalent model of the time—the neurotic artist:

And I haven't said anything very much, or given you any notion of the terrific high waves, and the internal deep guls, 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)

She patterned the style and even the content of her self-analyses on the self-descriptions of her hypochondriacal, egotistical father, Leslie Stephen, identifying with him not only as her parent but as the source of her disorder. His "violent rages and despairs" (Letters 4: 353) she could also see in herself. The family doctor, George Savage, reinforced this model by diagnosing her illness as "neurasthenia," the same label he had earlier given Leslie's complaints.

Ascertaining just what Woolf did think of her illness is complicated by Savage's inconsistent explanations of the various Stephen nervous disorders. Neurasthenia ("nerve weakness") was a convenient Victorian euphemism that covered a variety of vaguely recognizable symptoms, just as neurosis, a term outmoded in modern psychiatry, lumped together various disorders for much of this century. Both words also had their unflattering implications. In his published essays, Savage explained mental illness generally as a "defect" in "moral character," expressing irritation at what he perceived to be his patients' infantile self-indulgence in their illnesses (when they did not get well), even while he accepted a physiological basis for breakdowns, especially those involving hallucinations (J. Marcus, "Virginia" 35). Thus, Savage—like many other Victorian doctors—would order extended bed rest to restore the patient's nerve tissue but would simultaneously moralize on the need for order, control, and self-restraint (Bassuk 143). Woolf learned early on to acquiesce to family influences and yet blame herself for losing control of her emotions.

Later, of course, the Woolfs encountered psychoanalytic theory, which helped Leonard diagnose his wife's ailment correctly; but Freud thought of the manic-depressive disorder as a neurosis, tying it to traumatic losses in childhood and describing it as regressive behavior. Early Freudian theory would only have ratified Virginia's opinion that her breakdowns revealed a defect of character, a narcissistic weakness exacerbated by the loss of her mother, the sexual abuse inflicted by her half brothers, and so on. At this time she was already exploring her illness through her fiction, seeing provocative connections between madness and modernism. She would not be likely to seek out rehashed Victorian reproofs of her own inadequacies.

Unfortunately, not all critics have likewise freed themselves from Freud's orientation. Quentin Bell, whose slanted and sexist biography of Woolf has unhappily become the standard, downs the assertive political and feminist stances, as well as her passionate feelings for Vita Sackville-West, and prefers to portray his aunt as childlike, ethereal, and "terrified," frozen in "defensive panic" by sex (Rogat 101). This bias has seriously affected Woolf criticism. When Louise A. DeSalvo, for instance, traces the manifold revisions of The Voyage Out, she sees not evolution but dilution of a deeply fantasized self-annihilation, the novel functioning as masquerade to disguise forbidden desires (154–59). When Mark Spilka puzzles over Rachel Vinrace's "odd," "mysterious," and unexplained death, he looks to Woolf's own suicide for an answer, concluding that both author and character must die because they could not face "painfully blocked emotions" (6); for the sake of logic, he discounts Woolf's intense (and apparently unblocked) feelings for Vita Sackville-West and Violet Dickinson as "neurotic attachments to older women," poor substitutes for her dead mother (8). As the archetypal madwoman, Woolf has, indeed, become what Jane Marcus calls "a case study of female failure," a bogeywoman whose vision is disparaged as...
“deadly” and “disembodied” (“Tistinonabulations” 145) and whose veracity is continually questioned because presumably such a defective person could not, or would not, discover the truth about herself.

Besides the convenience of neurosis as an explanation for a woman’s art and behavior, the formidable difficulties of recognizing manic-depressive psychosis also affect the situation. A German psychiatrist, Emil Kraepelin, was the first to recognize a pattern in the numerous and often bewildering array of symptoms in this disorder, but as a clinical tool his diagnosis was slow to spread outside Heidelberg; an English translation was not available until 1921, and even then his theory suffered stiff opposition from the Freudians because it described manic-depressive illness not as a neurosis that could reveal a patient’s psychodynamics but as a familial disorder resistant to psychoanalysis. It was not until 1969, when the accumulated genetic evidence indicated a biological mechanism and when symptoms seldom alleviated by psychotherapy were found to respond to medication, that the American Psychiatric Association finally conceded that the manic-depressive condition was not a neurosis (Fieve 11).

The manic-depressive disorder is specifically an affective psychosis, afflicting 1% of the general population, that can profoundly modify mood, cognition, personality, sleep patterns, and metabolism. Breakdowns are associated with a neurohormonal disbalance, a complex amalgam of alterations in the levels and functions of amine neurotransmitters (chemicals involved in all brain functions), electrolyte metabolism in the blood, actions of peptidergic hormones, and neuroendocrine output and response (Potter et al. 40–41). Although its specific actions on body chemistry are not yet understood, orally administered lithium carbonate, a common mineral salt normally present in the blood, dampens severe mood swings, fostering a relatively stable position between the periodic “highs” of mania and the “lows” of depression. Today, psychiatrists regularly combine drug therapy and psychotherapy in treating manic-depressives, using the first to control the mood swings and cognitive disturbances, the second to rebuild a coherent self-structure impaired by the disease. Significantly, recent studies show that restructuring a manic-depressive’s sleep cycle can also effect at least a temporary remission of depression. The success achieved with both “phase advance” (going to bed earlier and rising earlier) and sleep deprivation has led researchers at the National Institute of Mental Health to speculate that manipulating the sleep-wake cycle may someday provide either an alternative to drug therapy or a technique for hastening the onset of therapeutic response to drug therapy (Wehr et al. 66–68). At least one Freudian critic has charged Woolf with neurotic cowardice for not abandoning the old Savage rest cure (Goldstein 447–50), but rest may indeed have provided some relief.

The evidence for genetic transmission is quite strong. If one identical twin has manic-depressive illness, the other runs a 70% chance of having it too, whereas a fraternal twin risks only a 20% chance. Studies of adopted manic-depressive children show that more than 30% of their biological parents displayed clear signs of the disorder, but only 2% of the adoptive parents did (Whybrow et al. 180). Thus, it is not primarily an environmentally induced or learned disorder—although the symptomatic form that it can take is certainly modified by the individual’s personality and personal history (Keller 22–23). It does not affect every family member; only 35% to 55% of those who inherit the suspect genes will develop the disease. Recent studies have identified two genes primarily implicated in the etiology of manic-depressive illness, and more are expected to be found. Since it is likely that other genes (as well as other modifying bodily factors) are involved, the illness probably results from a number of different genetic combinations, a hypothesis that may account for its several phenotypes and myriad symptoms (Hodgkinson et al.; Egeland et al.). Just when an inherited predisposition actually produces the illness is not yet predictable. Sometimes a breakdown results from a particular stressful event (such as the death of a loved one, especially a parent), but many shifts of mood or even complete breakdowns cannot be traced to an exterior or “psychological” cause. Studies suggest that this genetic inheritance makes the patient’s affective system more vulnerable to stress, a finding that may explain why the disease can resemble a neurosis, but in fact the central ingredient of the Freudian model for neurosis—repression leading to symptom substitution—is missing. Biology, not psychology, is the primary mechanism of predisposition. Life events can trigger, but not cause, madness (Wolpert 584–86; Paykel).

Genetically, Virginia Woolf’s family history tallies with current theory and with studies showing
that relatives of bipolar (manic-depressive) patients are more likely than the general population to exhibit affective disorders—for example, cyclothymia and schizoaffective ailments (Keller 24). We know that Leslie Stephen’s first daughter, Laura (Virginia’s half sister), was institutionalized for a lifelong psychosis, which Jean Love diagnoses as probable childhood schizophrenia (162); Virginia’s cousin, James Kenneth Stephen, went mad after a seemingly insignificant head injury in 1886 and was institutionalized for intense mania until his death by self-starvation in 1892 (Q. Bell I: 35–36); Leslie’s unpredictable mood swings, though never severe enough to qualify as a manic-depressive psychosis, were most likely cyclothymic; his father, the gloomy, self-mortifying Sir James, did suffer from chronic depression (Q. Bell I: 5); and Leslie’s brother, Fitzjames, became mad and died in 1894 (J. Marcus, “Virginia” 30, 48). Because at least one of the primary genes seems to be transmitted by the X chromosome (the female sex chromosome), the illness is passed from father to daughter or from mother to sons and daughters but rarely from father to son (Baron et al.). Since none of Julia’s three children by her first husband, Herbert Duckworth, fell ill, Virginia most likely inherited her manic-depressive disorder from Leslie, for neither of his own sons, Adrian and Thoby, exhibited the illness. Vanessa was Leslie’s only normal daughter out of three, a rather low ratio to be merely coincidence (Morizot 77).

When manic-depressives do fall ill, they may exhibit various symptoms that can mystify and frustrate not only their families but their doctors as well. Unipolar patients show signs of either mania or depression; bipolar, or “cyclic,” individuals (such as Virginia) alternate between mania and depression, although the speed, duration, and intensity of the mood swings vary greatly from individual to individual and from episode to episode. A bipolar patient may make a complete circuit in a matter of seconds or years. Breakdowns can begin as early as adolescence, but 85% of these patients recover on their own and resume their normal lives—until the next breakdown, which may not be for days, weeks, or years. Rarely does a breakdown result in an important personality defect (Winokur et al. 15–21). The “madness” is only temporary and seemingly unrelated to the individual’s normal personality, as Leonard’s observation attests:

When Virginia was quite well, she would discuss her illness; she would recognize that she had been mad, that she had had delusions, heard voices which did not exist, lived for weeks or months in a nightmare world of frenzy, despair, violence. When she was like that, she was obviously well and sane.

For Woolf, this problem of relatedness—the connection between the “sane” Virginia and the “insane” Virginia—was a crucial one. Like many other manic-depressives, she needed to know that somewhere beneath the bewildering panoply of symptoms there was a real Virginia, that central, wedge-shaped core. Lily Briscoe feels intuitively is the hidden essence of Mrs. Ramsay, that subterranean self Mrs. Dalloway sinks into when surface personality has become mere chatter, mere invention. Virginia Woolf searched for it too, a pure sense of being lying below her ever-changing (and, for her, “egotistical!”) consciousness. The issue of how identity is tied to mood and perception was especially crucial for a woman who struggled to throw off Victorian dogma that limited and what a woman could be. Because Savage identified sanity with social conformity, he denigrated the value of establishing a distinctive sense of self and brushed aside his patient’s “experience” of her illness (Basuk 141). The seeming incoherence of her symptoms meant nothing to him.

Although Woolf cooperated with Savage, in private she ridiculed him and rightly questioned his chauvinistic assumptions of what “coherence” was (Letters I: 147, 159). But, left on her own, she faced considerable difficulties in establishing an identifiable self-structure, for the changes in her mood and perceptions could be drastic or mild, brief or drawn-out, with various symptoms, each presenting a serious problem in interpretation.

In the manic phase, the elevated mood ranges from infectious cheerfulness to ecstasy and exaltation or, also without cause, vitriolic hatred marked by verbal abuse, what Kay Redfield Jamison, a researcher with the National Institute of Mental Health, has recently nicknamed “‘Virginia Woolf’ scenes” (116)—a reference to Virginia’s sudden outbursts of hostility, particularly toward Leonard, during her breakdowns. Socially, manics can be witty and inventive, producing a torrent of ideas and words connected by complex webs of associations (Woolf describes this state as feeling “scattered & various & gregarious” [Diary 2: 193]). But uninhibited and accident-prone (characteristics that earned Virginia the family title of “The Goat” [Q.
Manic-Depressive Psychosis and Critical Approaches to Virginia Woolf

Bell 1: 24), they may also embarrass their companions by ignoring social protocol or behaving rashly.

Accompanying the heightened mood are accelerated psychomotor activity and intensified sensory perceptions that provide further ammunition for the manic's belief that life is profoundly meaningful: objects simply look vivid and exciting. When Vanessa's husband, Clive Bell, visited Virginia in the Twickenham asylum in the summer of 1910, he was surprised to find his formerly suicidal sister-in-law transformed... suddenly life, which she had found drab and dreary, had become thrilling and precious... everything seemed exciting or amusing... and all the trivial things that made up that existence had significance too. The magician had cast her spell. (Q. Bell 1: 164)

As if their imaginations have gone into overdrive, manic feel unable to restrain their racing thoughts, espying great significance in ordinary events; experiencing seemingly profound (but inexpressible) insights, delusions, or (in severe cases) hallucinations; interpreting or imagining actions by nurses or friends as proof either of God's greater glory or of a sinister conspiracy against them—evidence that may result in even more desperate attempts to "read" the environment by imposing meaning and order on a world that spins faster and faster out of control (Wolpert 65–68).

The strong emotions of mania skew perception, creating an obscure solipsistic symbolism, a pathetic fallacy the perceiver is completely blind to. Thus, a sudden vision of life's true meaning or the hearing of voices seems miraculously to "explain" what the manic is feeling at that moment. These explanations are both true (because they bring "coherence" to discontinuous experience) and false (because they are merely mental constructs assumed to be literally true). They are pieces of fiction that, like all fiction, are meaningful only if we understand their objective and subjective components. But manics live in mirrored rooms and fail to see the discrepancies between what they project and what they perceive. They re-create the world and replace it with inflated visions of themselves.

Woolf's manic episodes ran the gamut from frenetic sociability to wild and incoherent gibberish. When mildly manic, she felt energized and creative, and invention came easily to her: "my body was flooded with rapture and my brain with ideas. I wrote rapidly till 12" (Q. Bell 2: 131); "& these curious intervals in life—I've had many—are the most fruitful artistically—one becomes fertilised—think of my madness at Hogarth—and all the little illnesses" (Diary 3: 254). When severely manic, she could talk with the ghost of her dead mother, imagine that the birds in her garden were singing in Greek, or believe with fierce conviction that Leonard and her nurses were conspiring against her. During her breakdowns she was unable to distinguish between meaning and meaninglessness, as Leonard remembers:

... she talked almost without stopping for two or three days, paying no attention to anyone in the room or anything said to her. For about a day what she said was coherent; the sentences meant something, though it was nearly all wildly insane. Then gradually it became completely incoherent, a mere jumble of dissociated words. (172–73)

Woolf herself understood that the hallucinations, heightened perception, and ecstasy of her manic mood were connected:

I've had some very curious visions in this room too, lying in bed, mad, & seeing the sunlight quivering like gold water, on the wall. I've heard the voices of the dead here. And felt, through it all, exquisitely happy. (Diary 2: 283)

Complete manic breakdowns were, fortunately, relatively rare. For the most part, her mania only bordered on the insane, especially in what Quentin Bell labels her "conversational extravagances":

This was one of the difficulties of living with Virginia; her imagination was furnished with an accelerator and no brakes; it flew rapidly ahead, parting company with reality, and, when reality happened to be a human being, the result could be appalling for the person who found himself expected to live up to the character that Virginia had invented.

... she must have reduced many poor shop assistants to the verge of blasphemy or of tears, and not only they but her companions suffered intensely when she found herself brought to a standstill by the difference between that which she had imagined and that which in fact was offered for sale. (1: 148–49)

What could Woolf have learned from episodes that seem merely extravagant and meaningless? The manic stage stimulated her already rich imagination to create and project ideas that had little basis in reality. She mistook her subjective world for the objective and learned through disappointment that...
perception was neither reliable nor simple, as she
defesses in two penitent letters to Leonard after
one of her abusive scenes:

Dearest, I have been disgraceful—to you, I mean. . . .
You've been absolutely perfect to me. Its all my fault.
I do want you and I believe in spite of my vile
imagination the other day that I love you and that you
love me.

(Letters 2: 34)

The reconnection between mind and world threat-
ened her with a sudden, dispiriting deflation of self.
The shock of falling out of solipsistic mania taught
her the integrity of objects, their objective solidity,
independent of the illusions her "unreal" self could
foster about the real world. Often the characters in
her fiction experience similar disillusionment and
deflation of wishful thinking: James Ramsay, for
instance, who finally sees the lighthouse building
as it really is, loses simultaneously his idealized
childhood vision and his self-serving hatred of his
father.

Even if experience teaches limited lessons about
the hazards of interpretation, the manic projections
of bipolar patients are inevitably undermined by
mood swings in the other direction. Depressive
symptoms are mirror opposites of manic feelings,
ranging from sadness to intense despair, from help-
lessness to uncontrollable tearfulness. In contrast
to manic exuberance and inflated self-esteem, this
mood is chronically miserable, worried, dis-
couraged, irritable, or fearful. Many depressives ex-
perience great fatigue, insomnia or repeated early
morning waking, slowness in thinking and motor
skills, and decreased sex drive (impotence in men,
frigidity in women). Some lie in bed, immovable,
despondent, completely helpless in the face of de-
spair and guilt, while others become agitated by
their black thoughts, wringing their hands in panic
or striking out at others. Quentin Bell records such
a combination of depressive symptoms in his aunt's
1896 breakdown:

[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 unfavourably to
Vanessa and was at the same time intensely irritable.

(i: 45)

And Woolf herself notes her wavelike symptoms in
a 1928 entry to her diary: "... such an exaggerated
tiredness; such anguish & despair; &
heavenly relief & rest; & then misery again. Never
was anyone so tossed up & down by the body as I
am, I think" (3: 174).

- Physiological and psychological symptoms often
combine. Loss of energy and appetite is typical of
a general slowdown in bodily processes, but the pa-

tient may try to explain the loss of desire by as-
sociating it with some other depressive symptom,
such as lowered self-esteem: thus, the patient may
reason that, since self and world are degraded, evil,
and repulsive, to perpetuate such a dismal life by in-
corporating even more of the world into oneself is
unendurable. Bell himself noted this pattern in
Virginia:

. . . she thought people were laughing at her; she was
the cause of everyone's troubles; she felt overwhelmed
with a sense of guilt for which she should be punished.
She became convinced that her body was in some way
monstrous, the sordid mouth and sordid belly demand-
_ing food—repulsive matter which must then be excreted
in a disgusting fashion; the only course was to refuse to
eat. Material things assumed sinister and unpredictable
aspects, beastly and terrifying or—sometimes—of fear-
ful beauty.

(2: 15)

Often, as if to make sense of their hellish despair,
depressives accuse themselves of terrible sins or
claim responsibility for family tragedies, real or
imagined. Sometimes they hear voices making these
charges for them and thus become further con-
vinced that they are losing their minds. If, in the
manic phase, the subjective world dominates the
objective, the depressive stage reverses these posi-
tions, rendering self powerless, hopeless, worthless,
and uncreative, without even the desire to question
its interpretation of a world emptied of meaning.
Depressives see their work as trivial and valueless
and themselves as failures (as when Woolf chastizes
herself as an "elderly dowdy fussy ugly incompe-
tent woman vain, chattering & futile" [Diary 3:
111]). If there is evidence to the contrary, they dis-
mise or misinterpret it to fit their despondent mood.
Since depression interferes with memory and the
brain's ability to concentrate and evaluate, the pa-
tient's work usually does suffer, making matters
worse. Suicide seems attractive because the mind is
already experiencing a kind of death, a death of the
soul (Wolpert 86–88).

To understand why they feel so bad, depressed
patients tend to think back over the years and cen-
ter obsessively on some past event, an unpardonable
sin (to explain their hopelessness and guilt) or a
traumatic experience (to explain their helplessness and life's emptiness) or the loss of a significant person (to explain their sense of abandonment and loneliness). For Woolf, the central tragedy that seemed to "explain" her emptiness, despair, and loss of a stable self-structure was the death of her mother in 1895. Julia's sudden death apparently triggered her daughter's first breakdown, but, more important, it became the metaphorical stream in which Virginia pictured herself as a fish, fixed, "held in place" by "invisible presences" ("Sketch" 80); it offered a coherent story line for experiences that would otherwise seem only senseless and impersonal. If history provides no such emblematic event, some depressives will castigate themselves for sins that are entirely imaginary or that they cannot remember. In fact, it is not the sin itself that matters. The patient merely seizes on some event to explain an otherwise inexplicable mood.

Woolf exhibited many depressed symptoms and seemed to have grasped their significance. In her diary, she described two mild episodes:

Here is a whole nervous breakdown in miniature. We came on Tuesday. Sink into a chair, could scarcely rise; everything insipid; tasteless, colourless. Enormous desire for rest... avoided speech; could not read. Thought of my own power of writing with veneration, as of something incredible, belonging to someone else; never again to be enjoyed by me. Mind a blank. Slept in my chair. Thursday. No pleasure in life whatsoever; but felt perhaps more attuned to existence. Character & idiosyncrasy as Virginia Woolf completely sunk out. Humble & modest. Difficulty in thinking what to say. (3: 103)

[It's] a physical feeling as if I were drumming slightly in the veins: very cold; impotent & terrified. As if we were exposed on a high ledge in full light... And I am powerless to ward it off: I have no protection. And this anxiety & nothingness surround me with a vacuum. (5: 63)

Like Rhoda in The Waves, the depressed Woolf feels naked and vulnerable, stripped of all illusions, as empty on the inside as the world appears to be on the outside. Depressed patients typically identify the self with the external world, and in this confusion between inner and outer, perception itself destroys the perceiver's sense of self, because in depression the mind is incapable of synthesizing a beneficial meaning from experience. Helpless and hopeless, Woolf feels as if the "veils of illusion" have been drawn, leaving her "to face a world from which all heart, charity, kindness and worth had vanished" (Letters 3: 50). All her worst fears seem validated by what she perceives. Self is a blank, powerless, with no value and no capacity to generate fiction, which at least would provide evidence that a self existed. Fiction, in this sense, could validate and nurture like a mother, like the mother she had lost.

If we find our sense of self, of identity, expressed in our words and actions, then Woolf's problem was to find the self underlying her disparate experiences. Rocked back and forth between subjective omnipotence and depersonalized impotence, she wondered whether self was merely an illusion too—a speculation Randy S. Milden finds crucial to his patients' therapy:

I contend that because of the nature of this illness affective patients emerge with particular problems in organizing a sense of self that are specific to this illness... When a patient has a major affective episode, his or her normal self disappears. The patient becomes someone foreign, another self. By definition, this self has a different affective organization from the normal self. There are different thoughts, behaviors, and personality traits. . . . Who, then, is the real self for someone who has been up and down and in between? Is the real self who one is when one is euthymic (normal)? Is it possible or even necessary to construct a whole self out of an amalgam of the "self-in-episode" and "self-out-of-episode"? Can this integration ever achieve the same coherence of self-structure that the patient previously took for granted? (346-47)

Woolf sought to achieve this integration in her fiction by fusing two modes of perception, manic and depressive, wedding her ability to "imagine" to a lucid recognition of reality in epiphonal moments when her inner being and the outer world cooperated with each other, each ratifying the existence, integrity, and worth of the other. These "moments of being" helped her establish a comprehensive self-structure—sane and insane, both together, as expressed in Mrs. Dalloway in the uncanny combination of a psychotic Septimus Warren Smith and a normal Clarissa Dalloway or in The Waves in the multiple selves speaking at random of their various moods but somehow coming together in the person of Bernard. "After being ill and suffering every form and variety of nightmare and extravagant intensity of perception" (Letters 4: 231), Woolf questioned her "terrible irregularities," her "spasms of one emotion after another" (Letters 5: 29). But in-
stead of discounting the "mad" feelings as incoherent and irrelevant, as Savage had done, or imposing a patriarchal and pathological Freudian explanation, she turned the issue around and used her experiences to question all mental states—normal or abnormal—and the unexamined assumptions about their integrity: "I mean, what is the reality of any feeling?" (Letters 2: 400). This is an important question. If all feelings are fictional, then self is not a given but a creation, and the power to give birth to herself lay in her hands alone: "I thought, driving through Richmond last night, something very profound about the synthesis of my being; how only writing composes it: how nothing makes a whole unless I am writing" (Diary 4: 161).

Fiction was good therapy for Woolf because it too deals with subject-object transactions that make a whole, a meaning that ratifies the integrity of both self and text. It involves all of us, authors and readers alike, in the difficult task of creating and yet discovering a meaningful reading, of reconciling our experience of the text with the objective text itself, avoiding the twin errors of underreading (passively receiving information without projecting meaning, failing to realize that the text cannot create our subjective experience of it) and overreading (mistaking our own projections and perspectives for the text's). In reading and writing, we must alternate repeatedly between reception and projection, between impression and explanation, using each to reinforce and correct the other. Fiction is intrinsically good ground for exploring manic-depressive illness: in both, making interpretations is the crux of the problem.

Woolf's metacritical explorations of the difficulties of interpretation challenge our traditional approaches to her life and her novels. In general, we do not question the "reality of any feeling" unless we already have some other meaning, presumed to be "more" real, ready to fill the void. We may doubt Woolf's ability to know her true feelings, but we take it for granted that they exist, submerged and repressed though they may be, and so we try to infer them from suspicious behavior, unguarded words, or seemingly autobiographical novels. As biographers, we hope to detect a pattern in the evidence of our subject's life and work, but what pattern we recognize may depend on our preconceptions of what an artist is, what mentality is, and what a woman's mentality is. True objectivity is impossible because the "story" of our subject's life is, to some extent, the result of our having imposed a premature order on the evidence we have gathered, an order that we may fail to remember is fictitious itself. As Shoshana Felman argues:

Does psychoanalysis, then, aspire to meaning—or to truth? . . . This now unavoidable question of the meaning of psychoanalysis . . . is in fact a contradiction in terms, since "meaning" is forever but a fiction and since it is psychoanalysis itself which has taught us that. But contradiction, as we know, is the mode of functioning par excellence of the unconscious, and consequently, also of the logic of psychoanalysis. To reckon with psychoanalysis is to reckon with contradiction, including its disequilibrium, without reducing it to the specular illusion of symmetry or of a dialectical synthesis. (120)

Thus, our orderly version of the meaning of an artist's life may indeed reveal a biographical truth. Or it may be a kind of countertransference, an unconscious response that, if left unacknowledged and unanalyzed, will create a defensive misunderstanding, an analytical fiction that protects us against meaning and interferes with our ability to interpret correctly. Countertransference can be useful in psychoanalysis, providing additional material because the therapist's responses may illuminate the hidden nature of a patient's behavior—but only if the analyst can tolerate awareness of this spontaneous and largely unconscious interpretation. The psychoanalyst Christopher Bollas describes this process as tolerating a "generative split in [the] analytic ego" that remains open to the threat of incoherence by delaying the security of analysis:

I am receptive to varying degrees of "madness" in myself occasioned by life in the patient's environment. In another area of myself, however, I am constantly there as an analyst, observing, assessing, and holding that part of me that is necessarily ill. (6)

By living out this form of "self-relating" in the presence of a patient, paradoxically tolerating disorder while detecting patterns, Bollas finds new material for analysis in his own subjectivity. When self-relating fails, however, the analyst reverts to making "official psychoanalytic decodings" that reductively impose coherence (7). Such transactions occur in reading as well. As Arthur F. Marotti contends, a literary interpreter can develop a "'pseudo-methodology' since his rational strategies will then be as much an unconscious defense against inner disruption as a cognitively suitable reaction to the external world" (473). Reasoning along similar
lines, Steven Marcus concludes that Freud's analysis of Dora essentially failed because Freud remained unaware of his own identification with Herr K. Freud could not accept her rejection of K's advances and defended himself by accusing her of resisting psychoanalysis. The order Freud imposed on the fragments of her life story was more appropriate to his own life; but instead of accepting his reading of her narrative as problematical, he revised for the sake of logic.

Too much has been read into Woolf by psychoanalytically inclined literary critics wishing to find neurotic coherence in genius and to establish Woolf's complicity in her own madness. Her breakdowns are notable for their almost bewildering array of symptoms, seemingly a fertile field for interpretation, but for that reason a dangerous one, since manic-depressive symptoms do not reliably reveal a deep-seated conflict. The "biographical" relevance of this illness is limited. This point is particularly crucial in any analysis of her self-recriminations, which usually centered on her parents: when depressed, she believed she had killed them simply by wishing them dead. Mark Spilka offers two likely Freudian interpretations:

Did she want her mother to die, as some Freudians might conjecture, and was she therefore secretly pleased (and later overcome by guilt) when life granted her wish? Or was she angry with her mother for dying, for depriving her of love, and . . . was she then unable to grieve (and later overcome by guilt), as still other Freudians . . . might argue?

Spilka candidly admits to having held both views, theorizing that Woolf wrote novels about her mother as obsessive restitutions for the unconscious crime of repressing her grief. DeSalvo and Panken take this theory a step further: when fiction failed and Woolf realized the illusion of restitution, she became depressed and attempted suicide as an act of atonement and self-sacrifice (158–59; 267). All three biographers assume that guilt causes mental disorder. Thus for them meaning and order are restored once it is made clear that Woolf brought on her own tragedy. The uneasy fear that madness can strike anyone, randomly, unjustly, has been explained away. And like Milton's God, Spilka, the Kenneys, and the Wolfs pronounce that Woolf had been given all she needed to live correctly but had perversely chosen not to—not to grieve, not to resolve her conflicting emotions, not to seek therapy before the composed face of the psychoanalytic truth giver. To Edward Albee's question, "Who's afraid of Virginia Woolf?" we may answer, "Everybody, but there are different ways to handle this fear." We need not blame Woolf for making us afraid.

Now disorder (and this disorder) usurps authority: in manic-depressive psychosis the easy assumption of the psychodynamic relation between cause and effect (event and illness, repression and symptom) is no longer valid. Indeed, it has been reversed. Depression is a vicious cycle because it can fabricate evidence justifying itself, fulfill its own prophecy, and "read" in the environment what it has produced. Depression is not reliable evidence of a repressed suicidal wish, and guilt, if primarily due to a temporary neurohormonal imbalance, may only be the result of a disturbance, not the cause (Wolpert 584). What evidence, then, can the biographer use to make life square up? What a manic-depressive thinks about or experiences during a breakdown may reveal inner conflicts—or it may not. If what a patient thinks about is a construction designed to explain otherwise inexplicable feelings and thoughts, can we too automatically assume that the explanation is valid? or reliable enough to be treated as a disguise for a deeper conflict? Did Woolf perceive her body as repulsive, the "sordid mouth and sordid belly demanding food," and refuse to eat because of lifelong frigidity and self-hatred created by sexual trauma or the loss of her mother (Q. Bell 2: 15; Panken 68)? Or is this perception about the body a mood-induced projection, a fiction to give some form, any form, to the uncontrollable and inexplicable feelings of emptiness and evil that manic-depressives have when their biochemistry falters? If biographical and autobiographical writing explains as it chronicles, we must be very careful about confusing cause and effect, about selecting evidence for our own explanations based on the subject's preselection. Woolf's subjective reports of her symptoms (and even the symptoms themselves) may be hypothetical constructions designed to impose a biographical order and meaning where none exists. The "deep-seated conflict" we find may be as much a fabrication of hers as of ours.

If we confine ourselves to what is known about manic-depressive psychosis, we need no longer regard fiction as a neurotic and illusory attempt to restore lost parents or deny repressed guilt; we would view it not as a symptom or a disguise at all but as
a transformation. Since none of Woolf’s doctors could explain how the manic and the depressive personalities were related to each other or to the same Virginia, I argue that she explored components of her own symptoms in the characters she created, as if, like Emil Kraepelin, she too found it helpful to examine without reduction what appeared to be hopelessly disorganized. In this, she duplicated both the scientist’s and the biographer’s work of marshaling evidence, but with one advantage: fiction enabled her to avoid reducing the complexity of life experiences in the service of a psychological model. It may be for this reason that her work is often puzzling and difficult; it is meant to mystify because it is designed to represent a perplexing and biographically meaningless disorder in perception and mood. “Form in fiction,” Woolf wrote, in a letter to Roger Fry, “is emotion put into the right relations” (Letters 3: 133); if this is so, then disturbances in emotion require of fiction an asymmetrical form, and reading such a work must test its ability, as Shoshana Felman puts it, to “read the unreadable,” the fiction that purports to express madness as it is, without reducing or systematizing or translating it into coherent, nonmad discourse.

How can we read the unreadable? The question . . . subverts its own terms: to actually read the unreadable, to impose a meaning on it, is precisely not to read the unreadable as unreadable, but to reduce it to the readable, to interpret it as if it were of the same order as the readable. . . . [H]ow does the unreadable mean? (187)

Woolf’s incoherence is not an evasion, not a loss of control, but a translation, an expressive discourse similar to the apparent visual disjunctions of the surrealists (Hunter). Psychoanalytic critics like Shirley Panken, who desire “to demystify the aura surrounding Woolf’s emotional oscillations” (2), must learn to tolerate and even value disorder if they are to understand the manic-depressive’s world. For Woolf, both art and madness explore what cannot survive dissection, what exists in a state of incoherence, unread and unrecognized, but with a power to help readers explore and revise self-structure, to live and live till we have lived out those embryo lives which attend us in early youth until “I” suppressed them. . . . Incomprehensibility has an enormous power over us in illness, more legitimately perhaps than the upright will allow. In health meaning has enroached upon sound. Our intelligence dominates over our senses. But in illness, with the police off duty . . . if at last we grasp the meaning, it is all the richer for having come to us sexually first . . . (Woolf, “On Being Ill” 18-19)

Our reading, then, becomes our illness, but only, as Felman insists, if it is “an intoxicating reading,” if we become crazed, “drawn into the dizzying whirl of [our] own reading,” where deciphering the text involves deciphering our own dreams of the text, recognizing that incoherence speaks as loudly of ourselves and the author as does the ordered, the symmetrical, and the intelligible (64). In a private manifesto, written during the composition of The Voyage Out, Woolf declared:

I attain a different kind of beauty, achieve a symmetry by means of infinite discords, showing all the traces of the mind’s passage through the world; achieve in the end, some kind of whole made of shivering fragments; to me this seems the natural process; the flight of the mind.

(Q. Bell I: 138)

To describe the elusive contact between self and world, she used symbols and images (which in a neurotic writer might serve as reliable “symptoms” of the author’s psychology) to create more ambiguity and incoherence than they resolved: “I am sure that this is the right way of using them—not in set pieces, as I had tried at first, coherently, but simply as images; never making them work out; only suggest” (Diary 4: 10-11). Woolf never worked them out because she was not interested in giving us ready answers about the meaning of reality. She questioned the very process of reading, of how we make interpretations in general.

Such an approach, of course, can result in shapelessness, a “harlequinade” of patches alternating between meaning and meaninglessness—a problem Woolf felt had dogged The Voyage Out (Diary 2: 17). But it also avoids the imposition of a coherence that obscures, and it deliberately frustrates those readers who expect to stick, as she put it, “little horns manfully into facts . . . the steepl intelectuals who treat literature as though it were an ingenuous picture puzzle, to be fitted accurately together” (Diary 2: 214). To “shape” her fiction to express what her manic-depressive experience had taught her, she invited countertransferences.

An example may help dramatize this problem. Critics have long been worried about the peculiar morbidity of the ending of The Voyage Out. Why does the heroine unexpectedly and pointlessly die
three chapters before the conclusion of what could have been a romantic and uplifting bildungsroman? The meaning of her death has been interpreted in various ways, perhaps because the reticent narrator withholds judgment about the action she describes—Rachel's disturbing delirium and slow wasting—leaving the reader to deal with a naturalistic close to an otherwise impressionistic, almost poetic novel. Often critics admit to being confused or nonplussed. Millicent Bell, for instance, considers Rachel's death "seemingly gratuitous" (671), an imposition on a story meant for a happier climax. Jean Guiguet agrees that Rachel's end is "pointless and unnecessary" but accepts it with equanimity as "natural" and appropriate to what he sees as the fundamental incongruity of life (198–200). Problems arise when critics try to explain away their initial feelings. Avrom Fleishman admits that Rachel's death defies analysis, striking the reader as a "blank fact"—but he then proceeds to analyze it, filling in the "blank" as if it were not meant to be there (21). Mitchell Leaska responds to the "tragic pointlessness" of Rachel's death, recognizes that it is "intentionally made ambiguous," but concludes somewhat mysteriously that Rachel unconsciously seeks out her own death ("it is a self-willed death" [38]), even while complaining that Woolf has withheld corroborating evidence: "The author, however, names no proliferating organism, specifies no unwashed vegetables; and we are at liberty to speculate on why we are not able 'to give a reasonable explanation for Rachel's dying'" (34). Instead of enjoying this "liberty" to speculate on the meaninglessness of such a disturbing event, Leaska presumes that, since "everything is there not by chance, but by choice" (35), this narrative gap stands for something that is missing or hidden because it is latent, intolerable, repressed, some crucial element that will give the "real" reason for the novel's central event. Claiming that we can dip into Rachel's (and Virginia's) unconscious mind, Leaska finds discarded references to sexuality, violence, and bestiality in earlier versions of the novel and reestablishes them as motives for Rachel's panicky withdrawal into fever, delirium, and death (38).

Leaska ignores his initial impression, that Rachel's death seems gratuitous and confusing, to establish a rationale that will explain away the sense of tragic pointlessness, making unsupported interpretations along the way (for instance, that Woolf's earlier revisions or deletions of "bestial" passages give us a privileged view into her mind "at work in the unguarded act of creation" [37]). Leaska follows the old Freudian formula that attributes neurotic symptoms or gaps in dreamwork to a suppressed wish. According to Freud's principle of psychic determinism, no mental event occurs by chance, and so Leaska assumes that Rachel's death must make sense, must be caused by deeper conflicts than Woolf is willing to grant (indeed, by definition neurotics are not willing to examine what they have repressed). Thus, he gives himself license to supply what is not in the text, to make clear what has been left deliberately unclear, and ignores the significance of obscurity, of absence, of meaningless.

Beyond Rachel's death, a fundamental uncertainty pervades The Voyage Out and elicits such defensive measures by readers: Should we embrace life or not, untrustworthy as it is? The cruelty of accidental death lies, as Woolf herself said, not in the death itself but in its blank meaningless. When death strikes us as "merely aimless" (Letters I: 150), so unrelated to the individual's life that it seems arbitrarily imposed, it destroys our customary assumption that character and event each make the other intelligible. The life that has ended is trivialized because "chance"—a tropical germ picked up somewhere—predominates, shaping closure, and so Woolf was tempted to ask, Is all life, then, chance? Have we been, all along, deluded, like the overconfident manic, about our power over our live, about our ownership of ourselves? Does self too prove to be a mere construct when a rise in temperature or a change in blood chemistry can distort it almost beyond recognition, until we are quite mad?

The Voyage Out invites us to experience a problematic reading by presenting us with an intricable fact: that even a fictitious event may be meaningless. The narrative focuses our attention on the biological basis of Rachel's delirium and death: her illness is due to a severe typhoidlike fever whose high temperatures are quite capable of distorting perceptual and cognitive processes for purely physical reasons. Because Rachel's symptoms contain powerful and disturbing images, Leaska and DeSalvo read them as biographically significant, but Rachel's hallucinations and emotional withdrawal are not necessarily neurotic or self-imposed; no causal relation has been established between Rachel's feelings and her fever. Leaska and DeSalvo assume that feelings have either caused or informed the fever, but the reverse is more likely. In effect, Rachel's character is judged by physical criteria out
of her control, just as Woolf’s has been: Woolf’s body imposed madness on her, without a readily apparent rationale, and she was acutely conscious that with this irreducible biological fact came arbitrary interpretations of what madness “meant,” meanings that threatened to reduce and trivialize her as well. If body, not mind or event, is the origin of manic-depressive illness and if germ, not repressed desire or emotion, is the origin of Rachel’s fever, can we still read this narrative as the disjointed confessions of a fearful neurotic who creates lapses of meaning merely to deny unconscious conflict? Or are we reading a text that expresses the undeniable, sometimes senseless multiplicity of life and mind as the manic-depressive knows it?

To drive this point home and perhaps undermine critical attempts to reduce her text, Woolf seems to have deliberately laid interpretative traps throughout the novel for wary readers who look for reliable signposts to guide their way. Such is the case of the defensive William Pepper, gloomy, cross, severe, who has disciplined himself against the treacheries of life until his heart has become “a piece of old shoe leather” (19) and who abjures the freedoms of living in a spacious villa for the constraints of a crowded hotel because he fears infection from improperly cooked vegetables. Pepper clearly expresses before an assembled company what seems to be a convenient piece of narrative foreboding:

“If you all die of typhoid I won’t be responsible!” he snapped.
“If you die of dullness, neither will I,” Helen echoed in her heart. (93)

Pepper’s paranoia would seem to be justified by Rachel’s subsequent death by fever; indeed, A. D. Moody concludes that Rachel’s death is “the inevitable end of romantic dreaming” (12), as if authors were bound by convention to act as divine providence, blessing wise characters with sanity and life, damning foolish ones to insanity and death. But this assumption makes the problem of interpretation here all the more difficult. Is Woolf suggesting that Pepper’s caustic contraction of spirit constitutes prudence because infectious diseases exist in this world? Did Rachel die because she naively traveled abroad and fell in love? Perhaps, but Helen’s silent retort rings true: though Pepper’s body lives, his emotional life is a death of the soul, hardly an attractive alternative. Does the novel undermine his authority by romanticizing risky adventures up tropical rivers (is true love worth the danger?), or does it advocate that we too become dull, leathern, and irascible to reduce the risk of tragedy? Throughout, Woolf is noncommittal, giving hints that are always indirectly undercut.

The Voyage Out approaches this most lifelike condition of uncertainty whenever it deals with how characters find meaning in their lives. Thus Clarissa Dalloway extols life’s abundance (“when you’re my age you’ll see that the world is crammed with delightful things”) [58], briefly infecting Rachel with exuberance (“it seemed indeed as if life which had been unnamed before was infinitely wonderful, and too good to be true” [61]), but in fact, for these women, life is too good to be true: Rachel dies, and Clarissa’s ecstatic visions of a noble husband and an ennobling England are frustrated by the tawdry realities of his philandering and the spiritual emptiness of national politics. Still, we cannot use these tragedies as evidence for the opposite conclusion, that life is inherently bad, for Rachel benefits as much by Clarissa’s idealized image of life’s goodness as she does by Richard’s demonstration of its badness, and the text does not specifically reduce the paradox. Both views, presented as irreducibly contradictory, help her realize what the world is like and what she needs from it.

The Voyage Out is a hodgepodge of emotions and views that do not sort themselves out into any convenient order. No one in this novel possesses an “authoritative” reading of events. Although Helen’s depressive fears about the tragic randomness of fate are realized by Rachel’s death, it would be a mistake to view them simply as narrative forebodings. Woolf knew by experience that depression could occur independent of events, even though life does occasionally prove the depressive’s view to be correct. The manic-depressive must always struggle to keep mood and event causally separate, remembering that even the blackest despair may or may not be an insight into reality. There can be no reliable litmus test for how realistic our feelings are when feeling itself distorts the results. Our task as readers is not to fall ill ourselves and overread the text. Thus, the text tests our ability to interpret, not by giving us a heavy-handed Freudian disguise to decode, but by underscoring the fundamental dilemma of perception—the need to avoid solipsism on the one hand and meaninglessness on the other, even though both are necessary to gain meaning.

Woolf’s fiction draws attention to our attempts to clarify and systematize complex texts. The author
liberated herself from reductionism by creating characters out of her symptoms and allowing them room to assert their own "truths" within ambiguous contexts. Voluntarily giving voice to her illness, Woolf found that the power to authorize self was no longer limited to her mother's body or a long-lost, unredeemable past. Dramatizing symptoms was not regressive but adaptive; it gave her the opportunity to explain her illness, to represent it, without simplification. This helped her to accept not only her illness but her wellness too: the sane and the insane, differentiated yet one, the one Virginia Woolf. Critics must likewise learn to suspect the psychological preconceptions that reduce complexity to simplicity by eliminating the meaning of complexity. When a psychological profile makes too much sense, something has been ignored.

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