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# Diagnosis and Treatment of Sylvia Plath and Virginia Woolf

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Diagnosis and Treatment of Sylvia Plath and Virginia Woolf

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**Abstract**

Diagnosis and Treatment of Sylvia Plath and Virginia Woolf

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Previous research indicates a correlation between creativity and psychopathology, particularly among female authors and poets, possibly heightening this group's risk for suicide. This article aims to provide a psychohistory containing psychological evaluations and hypothetical treatments plans for two prominent female writers, Sylvia Plath and Virginia Woolf both of whom completed suicide. Primary source material such as Plath's journals, Woolf's diaries, and related autobiographies were used as supplemental data for the clinical assessment. Plath is argued to have hypothetically met today's DSM-5 criteria for Major Depressive Disorder, and Woolf for Bipolar I Disorder in addition to trauma-related difficulties.

*Keywords and phrases:* Sylvia Plath, Virginia Woolf, diagnosis and treatment, psychohistory, Bipolar Disorder, Major Depressive Disorder, creativity, psychopathology.

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### Diagnosis and Treatment of Sylvia Plath and Virginia Woolf

The link between creativity and psychopathology has been investigated over long periods of time and in multiple fashions (Andreasen, 1987; Chávez-Eakle, Lara, & Cruz-Fuentes, 2006; Ludwig, 1992; Prentky, 2001; Thys, Sabbe, & De Hert, 2014). It is often romanticized that one must be mad in order to be a creative prodigy. While this stereotype is found in some cases, mental illness is not a prerequisite for creativity. The onset of psychopathology is variable, for one could experience symptoms before or after creative pursuits or never have any symptoms at all. Research has also been conducted concerning which creative professions are more susceptible to mental illness and ultimately suicide (Andreasen, 1987; Kauffman, 2001; Ludwig, 1992; Serlin, 1993). The current research aims to analyze the works of two popular writers, Sylvia Plath and Virginia Woolf, in terms of formulating and proposing a diagnosis and prognosis of their condition if current diagnostic criteria, assessments, and treatments were available during their lifetime.

### **Literature Review**

Multiple theories have been proposed concerning the factor that results in the correlation between mental illness and creativity. Prentky (2001) argued that cognition patterns associated

with creativity and deviance, possess certain biological influences that produce a predisposition for mental illness. Personality is also a potential factor that links creativity to psychopathology, particularly aspects of personality like temperament and character (Chavez-Eakle, Lara, & Cruz-Fuentes, 2006). The common research method for such studies selects participants via creative accomplishments then analyzes for psychopathology.

However, another research design is to analyze for creativity from individuals with psychological disorders. For instance, one study utilized a diagnosis based approach by examining a population of affective disorders, manic-depressives and cyclothymes, for signs of creative achievement, and then comparing normal relatives and control subjects (Richards, Kinney, Lunde, Benet, & Merzel, 1988). The results indicated that the milder the predisposition or symptoms of affective disorders, the more creative an individual, insinuating that more severe mental disorders may inhibit one's creative potential (Richards et al., 1988).

Despite the lack of a general consensus on what establishes the link between creativity and psychopathology, researchers primarily agree that the link exists and that creative professions may have a higher likelihood of mental disorders (Ludwig, 1992). Ludwig (1992) conducted research on eminent figures from varying professions and found that writing professions tend to have a greater risk of mental disorders, with poets having the highest incidence compared to other professions. Writing professions, particularly poets, having higher risk for mental disorders seems counterintuitive, given the research body that suggests that expressive writing alleviates symptoms of mental disorders (Cummings, Hayes, Saint, & Park, 2014; Phillips & Rolfe, 2016). Kaufman (2005) hypothesized that poets may have higher chances of mental illness because poetic writing may not offer the same therapeutic benefits as other forms of writing.

Kaufman's argument is that poetic writing lacks a formal narrative, and a narrative is essential for writing to be therapeutic (Kaufman & Sexton, 2006). Poetic writing is usually fragmented and lacking a narrative, thus the writing, while expressive, may not be coherent enough for a writer to properly manage. Another argument is that perhaps the illness not the writing is the determining factor (Kaufman & Sexton, 2006). Those with more severe forms of mental illness may be prone to a more fragmented writing style.

Females who engage in poetic writing may not reap benefits from expressive writing, and may have a greater tendency to suffer from mental illness. A possible explanation is that the style of poetic writing attracts those with mental illness, particularly women (Kaufman & Baer, 2002). Kaufman and Baer (2002) argued that an external locus of control can contribute to mental illness, so when poets, particularly female poets, attribute a muse or other external stimuli to their success, it impacts self-esteem. Poetry may involve more personal expression than other forms of writing, and literary analysts have proposed that Sylvia Plath's condition worsened as her poetry shifted from more traditional to expressive.

Given the extensive background of creativity, mental illness and writing studies, research also has been devoted to studying specific creative individuals, in this case writers, Sylvia Plath and Virginia Woolf. Plath exhibited psychological stressors in her life ranging from her father's death to marital discord. The death of Plath's father led to her longing for appraisal and recognition, that Plath felt her mother neglected (Gerisch, 1998; Schulman, 1998). Firestone (1998) emphasizes Plath's tendency toward isolation and inwardness. Plath was also highly invested in her work, putting in a great deal of time and energy into her writing, this led Runco (1998) to hypothesize that Plath's depression was in part due to her commitment to her writing.

Indeed, Plath's writings often harbored her inner feelings which reinvented via metaphor in her poetry and novel, *The Bell Jar* (Boyer, 2004; Smith, 2012).

Virginia Woolf lived in a period of experimentation in clinical orientation and treatment, so Woolf was at the mercy of the current popular doctrine for psychological services. Woolf was diagnosed by her family doctor, George Savage, with neurasthenia, a common diagnosis for the time period that covered a variety of affective and other symptoms. Later Woolf was introduced to psychoanalytic theory in which her manic-depressive tendencies were lumped into the diagnosis of "neurosis", which sought to explain her condition through traumatic losses and regressive behavior.

Furthermore, Woolf had an extensive family history of mental illness that could imply a biological component to the onset of her symptoms. Woolf's half-sister, Laura, was institutionalized for life-long psychosis. Her father Leslie, though never institutionalized, often exhibited unpredictable mood swings, and Leslie's father suffered from chronic depression. However, in addition to family history, Caramagno (1988) asserts that trauma can play a role in manifestation of manic-depressive disorder. Woolf experienced much trauma in her early life which could have triggered her disorder. Some particular instances include the death of her mother and the sexual abuse she endured by her half-brothers. These instances could have served as the triggers for her manic-depression, or related disorder rather than true bipolar disorder, and resulted in her mental breakdowns. These stressors and biological factors were distressing to both Woolf and Plath, and may have been part of the complex set of factors resulting in their eventual suicides.

### **Psychological Evaluations**



The following reports are two hypothetical, theoretical evaluations and treatment plans for Sylvia Plath and Virginia Woolf based on their personal journals and diaries, confessional prose and poetry, and prior research. All diagnoses are derived from today's current Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (APA, 2013).

### Hypothetical Psychological Assessment Report

Name: Sylvia Plath

Age: 30

Sex: Female

### Demographics and Historical Context

Sylvia Plath was a Caucasian female born October 27, 1932 in Boston, Massachusetts to parents Aurelia Schober and Otto Plath. Though born into the era of the Great Depression, Plath's family was lower middle class, for her father was a biology professor with publications. Plath had a younger brother, Warren Plath born April 27, 1935. Plath expressed interest in writing from a young age with her first publication at eight years old. Winning multiple scholarships, Plath attended Smith College and Newnham College at Cambridge University. Plath married Ted Hughes, a fellow poet, on June 16, 1956. The couple had two children Frieda Hughes (April 1, 1960) and Nicholas Hughes (January 17, 1962). Hughes left Plath for another woman in 1962. Plath completed suicide February 11, 1963. Plath published her first novel *The Bell Jar* under the pseudonym Victoria Lucas, due to the blatant similarities of the plot and characters to her actual life.

### Social History

Plath expressed conflict concerning her relationship with her parents. Plath's father died November 5, 1940 from untreated diabetes, when Plath was only eight years old. Plath felt she

had lost not only fatherly love but male love in general. Plath blamed her mother for his death, since she married him despite the age difference between them. Plath wrote in her journal:

I never knew the love of a father, the love of a steady blood-related man after the age of eight. My mother killed the only man who'd love me steady through life: came in one morning with tears of nobility in her eyes and told me he was gone for good. (2000, p. 431)

As for her mother, Plath claimed to love her mother yet resent her, as Plath wrote in her December 1958 – November 1959 journal, "I could pass her in the street and not say a word, she depresses me so. But she is my mother" (2000, p.433). Plath struggled with the hostility she felt for her mother, having said:

So how do I express my hate for my mother? In my deepest emotions I think of her as an enemy: somebody who "killed" my father, my first male ally in the world. She is a murderess of maleness. I lay in my bed when I thought my mind was going blank forever and thought what a luxury it would be to kill her, to strangle her skinny veined throat which could never be big enough to protect me from the world. (p. 433)

Plath also experienced turbulence in her relationship with husband Ted Hughes. Plath and Hughes relationship seemed amiable in the beginning of their marriage. Plath wrote "I have the impossible, the wonderful – I am perfectly at one with Ted, body & soul" (2000, p. 361). Other times, there was intense competition between Plath and Hughes, given that both were poets. Hughes had been known to criticize her work as juvenile. However, Plath had to balance her writing with her duties as a housewife, while Hughes could focus solely on his work. Plath described this balancing act in her journal:

I want to write stories and poems and a novel and be Ted's wife and a mother to our babies. I want Ted to write as he wants and live where he wants and be my husband and a father to our babies. (2000, p. 436)

Aside from rivalry, Plath felt distrusting of Hughes and thought him to be cheating. She perceived his dishonesty as something unforgivable, and considered her own blind faithfulness a folly, saying "what a fool one is to sincerely love. Not to cheat. To two time" (2000, p.391). Ted once called Plath by the name of another woman, Shirley (567, 390). In 1962, Hughes left Plath for another woman.

In general, Plath experienced issues with men, that she suggested stemmed from the death of her father. Plath claimed to hate all men saying, "I hated men because they didn't stay around and love me like a father" (2000, p. 431). Furthermore, Plath loathed the idea of men as a necessity, and she felt that there existed a double-standard between men and women, where men were permitted certain privileges that women were not. She wrote in her journal of this caveat saying, "I have hated men because I felt them physically necessary: hated them because they would degrade me, by their attitude: women shouldn't think, shouldn't be unfaithful (but their husbands may be), must stay home, cook, wash" (2000, p. 461-462).

Plath was also highly concerned with success and reaching her potential as a poet and writer. Plath wrote of her desire for success saying, "I want to write because I have the urge to excel in one medium of translation and expression of life. I can't be satisfied with the colossal job of merely living" (2000, p.184). This desire for success had been evident since childhood, given Plath's early writing talent and ambition. Plath felt that her need for achievement and recognition had "grown more mammoth and unsatiable" (2000, p.518) since childhood. Her yearning for success often left Plath isolated as she engrossed herself in her writing.

## Mental Health History and Symptoms

Plath expressed multiple symptoms of depression ranging from cognitive to somatic symptoms. She lacked interest in activities that once brought joy, activities such as writing and reading. In *The Bell Jar*, Esther, Plath's fictional double, expressed her difficulty with writing:

When I took up my pen, my hand made big, jerky letters like those of a child, and the lines sloped down the page from left to right diagonally, as if they were loops of string lying on paper, and someone had come along and blown them askew.

(2000, p.130)

When Plath did want to write, she had difficulties concentrating. Plath explained her lack of journaling saying "I haven't had one decent coherent thought to put down" (2000, 33).

Depression left Plath in stupor of despair where she pleaded with herself, "please, think – snap out of this" (2000, p. 187).

Plath's personal hygiene and self-care suffered due to her dejected mood. In her journals, Plath presents herself as typically a cleanly person, but in *The Bell Jar*, Plath illustrated depression via lack of hygiene, given that Esther had not washed her hair for three weeks and had not changed her clothes either (Plath, 2000, 2005). Plath also experienced chronic insomnia, stating a lack of sleep for up to twenty-one nights (Plath, 2000, 2005).

Plath journal's also emphasized her unrealistic negative evaluations of herself. Plath often compared herself to Hughes, as if he were the dominant and successful partner while she was "a mere accessory" (Plath, 2000, p. 524). Plath also believed that Hughes was the better poet and that she did not work hard enough on her writing. Most of all, Plath sought approval from her mother. She did this via her drive for success, for she believed that being successful would

finally earn her mother's approval (Plath, 2000). However, this just added to Plath's stress and negative views of herself, for she could not please herself and her mother.

Plath also expressed that there was nothing physically wrong with her. It was her mind that caused her distress. As Esther explained in *The Bell Jar*, "if only something were wrong with my body it would be fine, I would rather have anything wrong with my body than something wrong with my head" (Plath, 2005, p.182). Plath felt that her depression was literally smothering her, like she was "flooded with despair, almost hysteria" (2000, p. 395). Plath's mind circulated with depressive thoughts, some of which focused on suicide.

Plath articulated multiple accounts of suicide ideation in her fiction and her journals, as well as suicide attempts. Plath perceived death as an act of courage and an escape from her depression. In *The Bell Jar*, Esther pondered the various ways she could take her life, ranging from slitting her wrists to drowning. She even admired the Japanese who in the past disemboweled themselves, saying "It must take a lot of courage to die like that" (Plath, 2005, p. 138). In her journals, Plath struggles to identify why she wants to end her life. In November of 1952, Plath has been experiencing sleeplessness and has "come close to wanting to commit suicide" (2000, p. 149). However, Plath also had insight into her situation, for she was aware that her circumstances were more than ideal and that multiple women would have loved to have been in her place (Plath, 2000). Plath listed out multiple reasons she should have been happy:

I am not ugly, not an imbecile, not poor, not crippled – I am, in fact, living in the free, spoiled pampered country of America and going for hardly any money at all to one of the best colleges. I have earned \$1000 in the last three years by writing. Hundreds of dreaming ambitious girls would like to be in my place. (Plath, 2000, p. 150-151)

Nevertheless, Plath was unhappy and still having thoughts of suicide. She begins to compare herself to other women writers, inquiring “Why did Virginia Woolf commit suicide? Or Sara Teasdale – or other brilliant women?” (Plath, 2000, p.151). Despite Plath’s insight into her internal struggles, she did not wish to seek help due to the stigma and cost associated with getting help. Instead, she decided that the only option is to pretend, that “masks are the order of the day – and the least I can do is cultivate the illusion that I am gay, serene, not hollow and afraid” (Plath, 2000, p. 151).

Plath’s method of coping via concealment proved unsuccessful in quelling her suicidal ideation. Plath’s first suicide attempt was in 1953, three years before she met Hughes. She took a bottle of sleeping pills and hid in the crawl space under her house, until she was found three days later. Plath was hospitalized and treated with electroconvulsive therapy (p.212) and insulin injections at McLean Hospital in Belmont, Massachusetts. She also received psychotherapy from Dr. Ruth Beuscher.

### Diagnosis

Plath’s report matched the symptoms for Major Depressive Disorder, recurrent. Criteria for the diagnosis requires five out of nine symptoms that have been present for a minimum of two weeks and has resulted in impaired functioning (APA, 2013). Plath’s journals exhibited the following symptoms: persistent depressed mood, diminished interest and pleasure, diminished ability to concentrate, insomnia, feelings of guilt and worthlessness, and suicidal ideation. Plath’s condition caused impairment in social and occupational functioning.

Plath was also known for her occasional bouts of impulsive behavior, such as promiscuity and risk-taking, which has led some to propose Bipolar II. However, these instances appear to be hallmarks of her personality, not instances of hypomania. It could also be argued that Plath may

have been experiencing some post-partum depression, given that her suicide was within a year after the birth of her son.

#### Assessment

Despite clear symptom matches with the DSM-5 criteria for Major Depressive Disorder, Plath may have benefited from other assessments in order to present a complete evaluation. Empirical assessment items such as the Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF) and Beck Depression Inventory (BDI) would be implemented to chart Plath's current affect and severity of depressive symptoms and gather influential personality related information.

The MMPI-2-RF provides an overview of personality and could assist in distinguishing Major Depressive Disorder from Bipolar disorder, as well as indicating susceptibility of suicidal ideation (Gottfried, Bodell, Carbonell, & Joiner, 2014; Watson, Quilty, & Bagby, 2011). The Beck Depression Inventory includes self-report items that are characteristic of symptoms and attitudes of depressed patients. The BDI has demonstrated effectiveness in discriminating between varying degrees of depression, and demonstrates high reliability and validity (Beck, & Steer, 1984).

#### Treatment

The area of immediate concern to address would have been Plath's suicidality. Given her past hospitalizations and limited improvements, it would be inadvisable to hospitalize Plath. Instead, Plath may benefit from outpatient therapy, such as Collaborative Assessment and Management of Suicidality (CAMS). CAMS utilizes an interactive approach to assessment, in which the client is an active participant in the development of their treatment and safety plan. CAMS is an empirically supported treatment for suicide that has been found to diminish

symptom severity and increase hope, usually within four to twelve sessions (Jobes, Lento, & Brazaitis, 2012).

Once suicidality has been addressed, then Cognitive Behavioral Analysis System of Psychotherapy (CBASP) for depression would be implemented. CBASP is a type of therapy tailored for chronically depressed individuals, and it integrates aspects from interpersonal, cognitive, and behavioral therapies. CBASP is designed to assist individuals in improving interpersonal relationships and address disconnectedness from the environment (McCullough, 2003). Efficacy of CBASP has been demonstrated via strong research support in randomized clinical controlled trials, on its one as well as in combination with antidepressants (McCullough, 2003; Wiersma et al., 2008). Therefore, Plath might have benefitted from rebuilding positive relationships and engaging in her environment, while establishing adaptive coping mechanisms. If therapy alone was ineffective for Plath, medication in combination with therapy would be recommended.

#### Interpretive Summary

Overall, Plath suffered from chronic depression that affected her social and occupational functioning. Depression interfered with her ability write and left her with feelings of worthlessness. Despite the therapy Plath received during her lifetime, she still had reoccurring depression. Perhaps if the resources available today were available during Plath's time, her life may have been prolonged.

#### Hypothetical Psychological Assessment Report

Name: Virginia Woolf

Age: 59

Sex: Female



### Demographics and Historical Context

Adeline Virginia Stephen was a Caucasian female born January 25, 1882 in London, England, into an upper middle class family. Virginia was Leslie Stephen and Julia Duckworth Stephen's third child out of four. Vanessa and Thoby were Woolf's elder siblings and Adrian her younger sibling. Her mother, Julia had three children from a previous marriage: George, Gerald, and Stella Duckworth. Leslie also had a child from a previous marriage, Laura Stephen. Virginia married Leonard Woolf August 10, 1912 and started her career as a novelist in 1915 with the publication of her first book, *The Voyage Out*.

### Social History

The deaths of many of Woolf's immediate family members caused her significant distress. Woolf's mother died in 1895 when Woolf was only thirteen years old. Her passing resulted in Woolf's first breakdown and also significantly affected Leslie Stephen, Woolf's father. Stella Duckworth, Woolf's half-sister died two years later of pregnancy complications in 1887. When Woolf was only 22, her father died, and two years in 1906 later Woolf's brother Thoby passed due to Typhoid fever. These losses greatly affected Woolf and her fragile mental health.

Woolf also experienced trauma early in her life that left long term effects. Her half-brothers, Gerald and George Duckworth sexually abused Woolf and her sister Vanessa Stephen. Gerald Duckworth was sixteen years older than Woolf, and George Duckworth was fifteen years older. The abuse began when Woolf was age six and persisted for several years, though the frequency of the abuse is not known. This abuse may have influenced Woolf's sexual frigidity and lesbian affair with Vita Sackville West.

Despite the affair, Woolf had a good relationship with her husband. Leonard provided Woolf with support and reassurance during her periods of uncertainty and despair (Woolf, 1977). Woolf and Leonard wanted to start a family but were discouraged to do so considering Woolf's fragile mental health. Occasionally, Woolf (1977) felt envious of her sister, given that Vanessa and her husband were mentally and physically able to have children of their own. Nevertheless, Woolf described her and Leonard as "the happiest couple in England" (1977, p. 318).

Woolf's was highly absorbed in her writing process and focused with great intensity, which became mentally exhausting (Woolf, 1964). Woolf stated that she "corrected proofs 5, 6, or 7 hours a day" (Woolf, 1980, p. 186). After finishing *The Waves*, Woolf suffered from a headache and spent a few days in bed (Woolf, 1982). Her writing drained her so much so mentally that Woolf had to clarify her fatigue, saying "I am not physically tired so much as psychologically" (Woolf, 1980, p. 253).

#### Family History

Woolf was not the first in her family to demonstrate mood disruptions, as multiple members in her family tree exhibited some type of mood disorder (Caramagno, 1988, 1992; Boiera et al., 2017). Both of Woolf's parents struggled with mental disorders. Leslie Stephen was cyclothymic but diagnosed with "neurasthenia" by the family doctor, George Savage. Julia Stephen experienced bouts of depression. Laura Stephen, Woolf's half-sister, was institutionalized for "psychosis," though her specific disorder is unknown. Woolf's cousin, James Kenneth Stephen had "bipolar" symptoms manifest in his early twenties following a head injury and was institutionalized (Caramagno, 1992). Given the similarities in symptoms, it is likely that a genetic component played a role in Woolf's psychological disorder, but trauma may have aided in the manifestation.

### Mental Health History and Symptoms

Dr. George Savage also diagnosed Woolf with “neurasthenia,” a common label given to those who exhibited emotional disturbances. Woolf’s first symptoms included headache, insomnia, and racing thoughts, which tended to last from seven to ten days, if immediately recognized and treated, according to Leonard Woolf (1964). Treatment consisted of multiple days of bedrest and proper nutrition. Periodically, Woolf was hospitalized in a nursing home setting in which she was forced to rest and eat. Woolf spent six weeks in Miss Jean Thomas’s private nursing home for individuals with nervous disorders in 1910 and for a little over two weeks in 1913 (Woolf, 1977). If left untreated, Woolf’s symptoms intensified and had a duration of several weeks. In Woolf’s diary spanning 1931-1935, she documented frequent headaches, at one-point stating “I can’t write a word; too much headache” (1982, p. 361). Woolf was also susceptible to mental breakdowns that followed a characteristic pattern involving two stages: manic and depressive.

Woolf expressed symptoms of disorganized and racing thoughts. Woolf would speak almost unintelligibly. Leonard wrote of Woolf’s mania, describing the periods when she was “extremely excited; the mind raced; she talked volubly and, at the height of the attack, incoherently; she had delusions and heard voices” (Woolf, 1964, p.76-77). Woolf also experienced flight of ideas, as one of her diary entries illustrated her scattered thoughts. Woolf wrote, “I have come up here, trembling under the sense of complete failure – I mean *The Waves* – I mean Hugh Walpole doesn’t like it – I mean L. accuses me of sensibility verging on insanity – I mean I am acutely depressed” (1982, p. 43). Woolf exhibited difficulty in sustain a complete thought before she rushed onto the next one.

During some particular instances, Woolf exhibited psychotic features and believed the birds outside her window were talking Greek and that her doctors and nurse were in a conspiracy against her (Woolf, 1964). Another time, Woolf thought her deceased mother was in the room and proceeded to converse with her. During her third episode, in 1914, Woolf's mania lasted for months and did not come to an end until she fell into a coma that lasted two days (Woolf, 1964).

Following the manic stage, Woolf experienced depressive episodes that she perceived as consequences due to her personal faults rather than simply being ill. Leonard described her self-blaming as an irrational sense of guilt. Woolf experienced fatigue and would spend weeks in bed. During such instances, writing or reading was futile. She also refused to eat, claiming that eating only made her worse, and if nurses attempted to feed her she would become violent (Woolf, 1964). Woolf described one of depressive episodes in 1926 in her diary:

Here is a whole nervous breakdown in miniature. We came on Tuesday. Sank into a chair, could scarcely rise; everything insipid; tasteless, colourless. Enormous desire for rest. Wednesday – only wish to be alone in the open air. Air delicious – 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. . . . Difficulty in thinking what to say. Read automatically, like a cow chewing cud. Slept in chair. Friday. Sense of physical tiredness; but slight activity of the brain. (1980, p.103)

Woolf's changing emotional states caused distress, for she felt that "never was anyone so tossed up & down by the body as [she]" (1980, p. 174) Suicidal ideation and suicide attempts occurred during these depressive episodes as well. Her need for perfection in her writing resulted

in Woolf feeling suicidal, for she wrote in her diary that “all seems insipid and worthless” (1980, p. 186). In 1895, Woolf jumped out of a window. In 1915, she overdosed on Leonard’s veronal pills, but she was able to have her stomach pumped. In 1941, she completed suicide via drowning in the river Ouse.

### Diagnosis

Woolf’s mental health history aligns with the requirements for Bipolar I disorder with psychotic features. Woolf meets the criteria for a manic episode, given her pressured speech, flight of ideas, incoherency, and decreased need for sleep which lasted for weeks. Woolf also meets the criteria for a depressive episode since she exhibited a depressed mood, decrease in appetite, fatigue, inappropriate guilt, and suicidal ideation.

Woolf may have also met the criteria for posttraumatic stress disorder or another trauma related disorder, given the prolonged sexual abuse inflicted by her half-brothers and the small time gap between the multiple deaths in her immediate family. However, there is limited primary source evidence, and what is available is ambiguous. Specifics of Woolf’s sexual abuse is unclear. It could have been rape, unwanted touching, or both. Woolf also did not indicate the duration of the abuse, some sources claim the abuse lasted from age six to twenty-three, while other sources merely state that the abuse lasted nine years (Boeira et al., 2017).

### Assessments

Woolf meets the diagnostic criteria for Bipolar I disorder, in current DSM-5 criteria; however, it would have been advantageous to give Woolf some assessments in order to clarify her condition. Empirical assessment items such as the MMPI-2-RF, Altman Self-Rating Mania Scale (ASRMS), Bipolar Depression Rating Scale (BDRS), Clinician-Administered PTSD Scale for DSM-5 (CAPS-5), and the Trauma History Questionnaire. The MMPI-2-RF assesses

multiple dimensions of an individual's personality and would have aided in differentiating between bipolar disorder or major depressive disorder (Watson, Quilty, & Bagby, 2011). The ASRMS would be used to assess Woolf's manic symptoms. The ASRMS has test-retest reliability and internal reliability as well as concurrent validity (Altman, Hedeker, Peterson, & Davis, 1997). The BDRS has demonstrated good internal validity in measuring depression in bipolar individuals, which would be useful in examining Woolf's depressive periods (Berk et al., 2007).

Next, it would have been ideal to assess Woolf for PTSD and trauma, given that she does not disclose much information concerning her childhood trauma. The Trauma History Questionnaire would be used to identify the instances of trauma in Woolf's life, especially those she may not have included in her writings. The Trauma History Questionnaire is a self-report measure that identifies lifetime exposure to various forms of trauma; it has good reliability and construct validity (Hooper, Stockton, Krupnick, & Green, 2011). After identifying instances of trauma, then symptoms of PTSD can be assessed. CAPS-5 is an interview style assessment for PTSD that demonstrates good interrater reliability, test-retest reliability, and convergent validity. This assessment would assist in determining if Woolf developed PTSD from her prolonged sexual abuse and traumatic losses.

#### Treatment

Woolf's past treatments focused on living a vegetative life, in which she rested and ate often; however, this method of treatment is not empirical and does not address the important symptoms Woolf exhibited. Therefore, similarly to Plath, suicidality would be the first of Woolf's symptoms to address. Woolf may also benefit from CAMS as opposed to further hospitalizations. CAMS would allow Woolf to be a contributor to the treatment planning. Woolf would also benefit from psychotherapy combined with medication to treat her mania and

depression. CAMS is an empirically supported treatment for suicide that has been found to diminish symptom severity and increase hope, usually within four to twelve sessions (Jobes, Lento, & Brazaitis, 2012).

Woolf might have also benefited from psychoeducation about Bipolar I Disorder, given that she interpreted her symptoms as a form of self-manifested punishment. Woolf could also undergo cognitive behavioral therapy or interpersonal therapy for her depressive symptoms. Therapy alone is not effective for bipolar disorder; therefore, antipsychotic medication such as lithium may have alleviated Woolf's symptoms. Lithium is one of the recommended mood stabilizers, for it demonstrates efficacy in bipolar patients and reduces suicide rates associated with mood disorders (Grandjean, & Aubry, 2009).

#### Interpretive Summary

Woolf endured multiple hardships throughout her life, which took a toll on her mental health. Woolf also had a family history of mental disorders, which added a genetic component that left predisposed to bipolar disorder. Woolf's mood disturbances affected her social and occupational functioning. Woolf's vegetative treatment only provided minimal relief, but her mood cycling persisted. Perhaps Woolf might have benefited from current treatments for bipolar disorder if the knowledge of today was available during her lifetime.

#### Discussion

It is evident that these proposed evaluations, assessments, and treatment plans are of no use to Plath and Woolf now; however, these psychohistories do provide valuable information for researchers and clinicians. Looking at the lives of Plath and Woolf illustrates the impact of cultural and personal events on psychological disorders. Plath lived during a time when women were essentially housewives only concerned with domestic duties, while men were the

breadwinners with careers. Plath despised the fact that men were the dominant sex and deemed necessary for a woman. Plath wanted the sexual and occupational freedom that men were gifted by society. She constantly struggled with being second best in comparison to her husband and other men in her field of writing. Plath constantly sought validation via men, because she thought that was the only way to earn respect. The culture of the 30s to the 60s felt oppressive to Plath and contributed to her depression. Personal events in her life also contributed, such as the death of her father and her relationship with her mother.

Woolf lived before Plath, so she came from an even more restricted culture for women. Woolf wrote many feminist writing about the privileges ascribed to men simply because of their sex not skill. Personal events in Woolf's life also contributed to the manifestation and development of her psychological disorder. Woolf had a family history of mental illness, which already predisposed her to the possibility of developing a disorder. The series of traumatic events in Woolf's childhood and emerging adulthood could also be attributed to her development of bipolar disorder. Woolf was subjected to years of sexual abuse, and the deaths in her immediate family resulted in several of her mental breakdowns.

Furthermore, Plath and Woolf reiterate the social stigma surrounding mental illness. Stigma of mental illness was heavily ingrained in the societies that Plath and Woolf lived in, and it still exists today. Plath, before her first suicide attempt and hospitalization, chose to fake her emotions rather than to seek help, due to stigma and the price of treatment. In Woolf's time, individuals that had attempted suicide were certified and hospitalized. Luckily for Woolf, her husband did not certify her, for he knew of the consequences. Woolf would not have been able to publish more books, for her career would have been over if she was certified as mentally ill and suicidal. Hospitalization would have ostracized Woolf. Both of these women would have rather



faced their disorders alone, because of the lack of understanding, education, and empathy during their lifetimes. Woolf wrote of this, saying she felt like she was “fighting something alone” (1980, p. 260).

In modern society, there is more education concerning psychological disorders, but we still view these disorders as a weakness, something that can be persevered through simply by one’s willpower. Even though psychological services are more readily available, people still refrain from going because of the stigma. Payment for psychological services is still an issue as well. Insurances companies typically pay only if a diagnosis is given after the first visit, but only a certain number of therapy sessions are paid for. More often than not, individuals will seek treatment from their primary care physicians instead of seeking out a mental health professional, which usual results in prescribing medication without the individual having learned any self-care or coping mechanisms.

Finally, the evaluations of Plath and Woolf may aid in diminishing the stereotype of the mad genius. Plath’s and Woolf’s mood disorders did not contribute to their creativity. Both women, when experiencing symptoms, were unable to concentrate on their writing. However, their disorders did provide inspiration for some of their writings. Most authors do write from experience so they are not so different from writers without psychological disorders. Therefore, these women should be considered creative geniuses apart from their disorders. Further research should be conducted to examine the nature of creativity and psychopathology because it is still unclear. Is creative talent the cause of certain psychological symptoms, or is psychopathology contributing to the creative mind? Perhaps there is a third variable involved such as trauma or culture. These are questions that further research need to elaborate upon.

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