

SYLVIA PLATH'S *THE BELL JAR* AS  
DISABILITY NARRATIVE

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Stillwater, OK

2009

Submitted to the Faculty of the  
Graduate College of the  
Oklahoma State University  
in partial fulfillment of  
the requirements for  
the Degree of  
MASTER OF ARTS  
December 2009

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DISABILITY NARRATIVE

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## ACKNOWLEDGMENTS

I am greatly indebted to a number of people for their help and support in completing this work. My deepest gratitude belongs to my academic and committee advisor Dr. Elizabeth Grubgeld, for without her guidance, patience, and encouragement, I could not have completed this project. In addition to helping me formulate and think through ideas, she has read countless drafts, each time providing thorough and thought-provoking feedback. She has reaffirmed for me just how collaborative the writing the process is. I am also grateful to the other members of my committee, who were also essential in completing this project. Dr. Rebecca Damron's constant guidance and encouragement have been essential to my growth as a student and as a scholar. I am also grateful to Dr. John Kinder for his invaluable insight and feedback on this project. Finally, I would like to express my appreciation for the continued love and support of my friends and family.

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## CHAPTER I

### INTRODUCTION

Since the 1963 publication of Sylvia Plath's *The Bell Jar*, literary scholars have consistently read this autobiographical novel as a story of a woman's struggle against the oppressive social atmosphere of the 1950s. For instance, Linda W. Wagner calls the novel a "testimony to the repressive cultural mold that trapped many mid-century women" (67), and Marjorie G. Perloff claims it is "one of the most acute analyses of the feminist problem that we have in contemporary fiction" (512). Scholarship on this novel, which seems to have declined since the 1980s, tends to focus on the ways in which the novel's protagonist Esther must struggle against social and cultural oppressions to construct her identity as a woman. Thus, these scholars primarily see her "mental illness"<sup>1</sup> as a response to the oppressions of a patriarchal society. However, by applying the lens of disability theory, we can understand how Esther's experience of mental distress is also a stigmatizing experience in itself, one that compounds and intensifies her experiences and struggles as a woman.

Most scholarship on *The Bell Jar* was written in the 1970s and 80s, before disability as an identity category was widely discussed in literary studies. This scholarship approaches the novel from a feminist perspective and reflects the particular concerns of the eras in which it was written. For instance, writing in 1987 when much feminist scholarship focused on the act and politics of writing,<sup>2</sup> E. Miller Budick examines Esther's struggle against male language, arguing that the novel embodies a "feminist aesthetic," or "a language and an art competent to secure women, especially the female writer, against male domination" (872). Diane S. Bonds (1990) also focuses on feminist concerns of the novel, exploring the ways in which the novel demonstrates the oppressive effects the "separative" (or autonomous) model of selfhood has for women.<sup>3</sup> In focusing on Esther's struggle as woman, these authors most often view her depression as a response to the oppressive forces of her society. For Budick, who claims the novel is constructed "out of uniquely feminine experiences concerning specifically female themes" (873), Esther's "madness" is one these major themes, along with "powerlessness, betrayal, and victimization" (872). Perloff (1972) recognizes that Esther's mental distress is undoubtedly a factor in the struggles she faces in the novel, but she asserts that Esther's "dilemma" is largely a result of "being a woman in a society whose guidelines for women she can neither accept nor reject" (511). As these scholars suggest, feminist concerns are the central

focus of the novel, for Plath clearly indicates that Esther's struggle against patriarchal oppression is at least a contributing factor to her breakdown. Yet many of the experiences and concerns that most scholars identify as specifically feminine in the novel are also common concerns and experiences of people with disabilities.

As many scholars have observed, there are numerous overlaps in experiences of femaleness and disability. As Rosemarie Garland Thomson notes, "Western thought has long conflated femaleness and disability, understanding both as defective departures from a valued standard. Aristotle, for example, defined women as 'mutilated males'" ("Integrating Disability" 260). G. Thomas Couser also notes that "femaleness" and "disability" are often seen as synonymous, pointing out that physical impairment is often associated with "emasculatation, even feminization" (185). In fact, Couser suggests that women are, in some sense, already considered disabled; he argues that more attention is generally given to stories of disabled men, while "the story of the disabled woman is ignored because of its apparent redundancy" (185). In addition to the historical conflation of femaleness and disability, many scholars have also explored the concerns and experiences shared by women and people with disabilities. For instance, Susan Wendell points out that many of "the same attitudes about the body which contribute to women's oppression generally also contribute to the social and psychological disablement of people who have physical disabilities" ("Toward a Feminist Theory of Disability" 243), such as the idea that the body can and should be controlled. In describing her experience of multiple sclerosis, Nancy Mairs identifies embodiment and cultural attitudes about the body as a concern shared by both women and people with disabilities. As Mairs points out, in Western cultures, bodies are treated as "subordinates, inferior in moral status" so that "[o]pen association with them shames us" (53). Bodies, then, are "viewed with suspicion," and Mairs argues this is especially true for the female body "since so much of it is in fact hidden, dark, secret" (54). As Mairs observes, these cultural assumptions about the body lead women to feel shame for their bodies. However, with M.S., Mairs says she feels additional shame for her body, for "it is a crippled body"; therefore, Mairs argues, her body "is doubly other, not merely by the homo-sexual standards of patriarchal culture but by the standards of physical desirability erected for every body in our world" (54). Thus, as Mairs suggests, her struggles as a woman are compounded and intensified by her experience of disability.

A growing number of scholars have begun examining the ways in which feminist theory and disability theory interact in describing the experiences of disabled women,<sup>4</sup> demonstrating that, as Wendell puts it, "disabled women struggle with both the oppressions of being women in male-dominated societies and the oppressions of being disabled in societies dominated by the able-bodied" (244). Although scholarship on *The Bell Jar* has traditionally viewed Esther's struggles and experiences as specifically feminine, disability theory offers an additional perspective, one that views Esther's mental distress not only a response to patriarchal oppression but also as an additional stigmatizing experience. Although "mental illness" is not always included in discussions of disability, many scholars argue for a more inclusive definition of the disability category, demonstrating that people with mental differences share many of the same concerns, oppressions, and experiences as people with physical differences.

This more inclusive definition is a recent development in disability theory, which is itself a relatively new field in cultural studies. As Lennard Davis notes, “[a]lthough the category has existed for a long time, its present form as a political and cultural formation has only been around since the 1970s, and has come into some kind of greater visibility since the late 1980s” (10). Writing in 1997, Thomson argues that disability as an identity category has still been largely ignored by scholars: “Although much recent scholarship explores how difference and identity operate in such politicized constructions as gender, race, and sexuality, cultural and literary criticism has generally overlooked the related perceptions of corporeal otherness” (*Extraordinary Bodies* 5). As disability theory continues to develop, many scholars still disagree as to which conditions are included in the category of disability; for instance, not all agree with the inclusion of acute and chronic illnesses, as well as mental distress. As Peter Beresford points out, “[t]here does not seem to be any agreement in disability discourse whether or not madness, distress and psychiatric system survivors are part of the discussion” (168). However, many leading disability scholars, including Thomson, adopt a much broader definition of the disability category while still retaining the differences between the various forms:

This is not to suggest that all forms of disability are interchangeable or that all disabled people experience their bodies or negotiate their identities in the same ways....Disability is an overarching and in some ways artificial category that encompasses congenital and acquired physical differences, mental illness and retardation, chronic and acute illnesses, fatal and progressive diseases, temporary and permanent injuries, and a wide range of bodily characteristics considered disfiguring, such as scars, birthmarks, unusual proportions, or obesity. (*Extraordinary Bodies* 13)

Like Thomson, Wendell prefers a more inclusive definition of disability; in critiquing the United Nations’ definition of disability,<sup>5</sup> she finds the fact that “they are general enough to include many conditions that are not always recognized by the general public as disabling” to be one of the two positive aspects of the definition<sup>6</sup> (*The Rejected Body* 13).

Wendell also discusses the exclusion of some chronic and life-threatening illnesses, as well as mental distress, from the disability category, noting that “some of the initial opposition...may have come from an understandable desire to avoid the additional stigma of illness,” including that associated with “psychological or developmental disorders” (21). And as Beresford, G. Gifford, and C. Harrison note in their 1996 essay “What Has Disability Got to Do with Psychiatric Survivors?” opposition to inclusion can come from both sides:

Many psychiatric system survivors are unwilling to see themselves as disabled. They associate disability with the medicalisation of their distress and experience. They reject the biological and genetic explanations of their distress imposed by medical experts. They may not see themselves as emotionally or mentally distressed either, but instead celebrate their difference and their particular perceptions. Similarly, some disabled people do not feel that psychiatric survivors are disabled, because they do not have a

physical impairment or their situation is not permanent. There are also fears and anxieties on both sides of being lined with the negatives that are often associated with the other. (qtd. in Beresford 169)

Despite such resistance to including “mental illness,” or mental distress, in the disability category, Beresford contends that the relationship between psychiatric system survivors and disability cannot be ignored. Not only are psychiatric system survivors most often lumped together with other people with disabilities by governmental and other externally imposed definitions, but Beresford also contends that there are “significant overlaps between the two populations” (169); for instance, many psychiatric system survivors develop physical impairments, often as a result of medications and other treatments, and many people with disabilities experience mental and emotional distress. Although Beresford emphasizes that there are also significant differences between people with physical disabilities and psychiatric system survivors, he contends that “this does not mean that survivors are outside of or separate from disability or should not be included as part of the discussion” (170), for differences exist even among people typically considered to be disabled. Similarly, Wendell points out that no disabled person is completely disabled; someone with a physical impairment may be completely healthy, and a person with a chronic and/or life-threatening illness may have no physical impairment. Even physical disability itself encompasses a wide range of conditions—including paraplegia, amputation, and deformities (21). Therefore, it is possible to include mental distress in the disability category without ignoring its inherent differences from physical disability.

The similarities in experiences of mental distress, like those of Esther Greenwood in *The Bell Jar*, and experiences of physical disability further complicate an absolute distinction between the two kinds of conditions. As Beresford points out, people with physical disabilities and psychiatric system survivors face similar oppressions, for “the denial of their human and civil rights is a shared experience of disabled people and survivors” (170-71). Like people with physical impairments, people with mental distress are stigmatized and cast as “other,” and as the social model of disability theory asserts, it is this exclusion of difference that creates and constructs disability. Scholars like Tom Shakespeare have explored the development and usefulness of the social model of disability, a term first coined in 1983 by Mike Oliver (Shakespeare 198). As Shakespeare explains, this model distinguishes between impairment and disability, defining impairment as the actual physical difference and disability as a social construction, “a relationship between people with impairments and a disabling society” (198). Thus, disability is not a direct result of the physical, mental, or emotional difference that defines the condition; instead, it is the result of an environment that does not accommodate all bodies equally. As Thomson argues, “Stairs, for example, create a functional ‘impairment’ for wheelchair users that ramps do not. Printed information accommodates the sighted but ‘limits’ blind persons” (*Extraordinary Bodies* 7). Furthermore, Wendell points out that “normal” ability is culturally dependent, for “[h]ow much ability is basic, like how much ability is normal, seems to depend on how much is necessary to perform the most common tasks of daily living in a particular physical and social environment” (*The Rejected Body* 16). For instance, living in societies without modern technological advancements requires more physical ability and stamina.



Although these scholars focus specifically on physical difference, Anne Wilson and Beresford demonstrate that a similar socially constructed nature exists in “mental illness.” Wilson and Beresford argue that although “madness and distress” are interpreted as mental illness by psychiatry and popular media, individuals should not be classified as either “normal” or “mentally ill”; instead, these scholars assert that the mental and emotional distress experienced by those considered to be “mentally ill” should be seen as “part of a broader continuum of distress and well-being; a continuum upon which *all* people would place themselves, in different positions and at different times in their lives” (144). In exploring the connections between psychiatry and disability activism, Bradley Lewis also addresses the social model in relation to “mental difference,” pointing out that the “task of undermining stereotyped representations of individualism, medicalization, and normality” (340), which is a goal of the social model in disability theory, is also a task central to psychiatry disability activism.

Although the social model still seems to dominate contemporary disability discourse,<sup>7</sup> some scholars have begun to question the continued usefulness of the social model for disability theory. For instance, Shakespeare recognizes many strengths of this model, including its political effectiveness, that it identifies social barriers, and that it improves the self-esteem of disabled people (199), but he also identifies numerous flaws. For example, he points out that this model’s distinction between impairment and disability is largely artificial, for “in everyday life, it is very hard to distinguish clearly between the impact of impairment, and the impact of social barriers” (201). Furthermore, although disabled people face both social discrimination and the “intrinsic limitations” of their impairments (202), the social model generally ignores the importance of impairment in the lives of disabled people, almost suggesting that impairment poses no problems. Tobin Siebers also points out that the social model largely ignores the reality of physical impairment, arguing that it does not fully address the “difficult realities faced by people with disabilities” (175), particularly the reality of pain. Considering this discussion in relation to *The Bell Jar* necessarily raises the question of whether Esther’s depression has any biological cause or if it is entirely a social construction. As scholars such as Phyllis Chesler have demonstrated, the mental health profession in the 1950s tended to view women “as somehow naturally mentally ill” (1). Speaking from her own experience as a psychiatrist, Chesler points out that “during the 1950s and 1960s, clinicians were still being taught that women suffer from penis envy” (1). Therefore, it is possible that Esther’s designation as “mentally ill” is largely a result of psychiatric practices of the time period. Furthermore, there is no indication in the novel of any biological cause for her mental distress—that she has any actual physical or mental impairment—for as scholars have long observed, Esther’s “mental illness” is at least in part a response to the oppressions she faces as a woman; if these oppressions did not exist, she might not suffer a breakdown or be labeled “mentally ill” at all.

However, Beresford and Wilson argue that the social model’s concept of impairment is problematic for psychiatric system survivors in general, particularly the distinction drawn “between impairment and disability, where impairment is taken to refer to assumed biological characteristics of the body and mind” (155). For instance, these scholars point out that psychiatry does not rely on biological

characteristics in diagnosing mental illnesses: “Though the psychiatric profession has continued its search for biological causes or ‘genetic markers’ for ‘mental illnesses’ such as ‘schizophrenia,’ there is still no definitive ‘laboratory test’ for any specific ‘mental illness’” (147). Instead, psychiatrists must rely on diagnostic tools, “[d]espite the fact that these tools lack validity” (147).<sup>8</sup> Therefore, Wilson and Beresford contend, mental illness cannot be seen “as the ‘given’ often accepted of physical/sensory impairment” (147), suggesting instead that impairment should be viewed as largely socially constructed as well.<sup>9</sup> Ultimately, the question of whether Esther’s mental distress is rooted in her body or completely a product of social construction is irrelevant, for she is labeled and stigmatized as mentally ill, which is a disabling experience.

Considering that Esther’s experience of mental distress is the central focus of *The Bell Jar*—a novel which the author described as the story of “a college girl building up for and going through a nervous breakdown” (Ames 304)—disability theory is an appropriate and necessary lens to apply in examining this novel. Some scholars have already noted that Esther’s psychological condition is, in fact, disabling; for instance, in her 2004 article “The Disabled Female Body as a Metaphor for Language in Sylvia Plath’s *The Bell Jar*,” Marilyn Boyer also points out that “the major depression that Esther experiences throws her body into a disabled state that affects all aspects of her being” (214). Esther also shares many of the common obstacles recognized in disability literature, such as stigmatization, contingency, alienation, and dissociation from the body. Although scholars like Susan Coyle have examined many of these aspects of the novel from the perspective of feminist criticism,<sup>10</sup> the implications of disability theory for *The Bell Jar* have not been explored.<sup>11</sup> However, such a reading is vital to a fuller understanding of the experiences and struggles of the novel’s protagonist, as well as those of Plath herself. As such a reading suggests, although this novel has been read specifically as a woman’s struggle, it is perhaps more accurately the story of a *disabled* woman’s struggle.

## NOTES

<sup>1</sup>There has been some debate over Esther's condition among scholars, as no technical diagnosis is given in the novel. Some scholars, like Marilyn Boyer, refer to Esther's condition as "depression" (213), though Marjorie Perloff repeatedly identifies it as "schizophrenia" (521). Many scholars choose to use vague terms, including Linda W. Wagner, who refers to Esther's condition simply as "madness" (65). Luisa Pascual Garrido notes that there is also "no agreement as to Plath's mental condition" (1). This may be at least partially a result of the predominant psychiatric practices of Plath's time, which as scholars like Phyllis Chesler have demonstrated tended to view women as "somehow naturally mentally ill" (1).

<sup>2</sup>Citing scholars Elaine Showalter, Nelly Furman, Sandra M. Gilbert, and Barbara Hill Rigney, Budick notes that "in recent years, attention has shifted from the treatment of women in male fiction to the reconsideration of the act of writing and what feminist critics have variously called the 'politics of language' (Furman), 'sexual poetics' (Gilbert 31), or 'sexual politics' (Rigney)" (873).

<sup>3</sup>Bonds explores the notion of a "separative" or autonomous self, which she says is tied to "the cultural forces that oppress women" (49), in relation to *The Bell Jar*. According to Bonds, although feminist criticism has criticized this model of selfhood, most scholars approach Plath's novel with these very assumptions, so they do not recognize the ways in which the novel demonstrates the dangerous effects this model can have for women. For example, Bonds disagrees with the common reading of the novel's ending as positive, saying that Esther must "earn her exit from the asylum by committing herself, albeit unwittingly," to the oppressive forces that led to her breakdown in the first place (49).

<sup>4</sup>As scholars like Rosemarie Garland Thomson and Susan Wendell have demonstrated, although there are many connections between disability theory and feminist theory, feminist theory alone cannot address the experiences of disabled women. In her article "Integrating Disability, Transforming Feminist Theory," Thomson argues that although feminist theory "investigates how culture saturates the particularities of bodies with meanings and probes the consequences of those meanings," which is also the goal of disability theory, feminist theory has not considered the implications of the "ability/disability system" (258). Thomson argues that disability theory can deepen multiple aspects of feminist theory, largely because feminist issues are often "intricately entangled with disability" (257). Alexa Schriempf also notes the limitations of feminist theory for disabled women, asserting that when scholars include disabled women "under the general rubric of 'woman,'" they fail to recognize and acknowledge "the different experiences of disabled women in a sexist and ableist society" (54). Therefore, she argues, "the feminist critique cannot address disabled women's needs, experiences, or oppressions" without also considering the implications of disability theory (60).

<sup>5</sup>The following is the distinction between impairment, disability, and handicap as outlined by the UN in its World Programme of Action Concerning Disabled Persons:

**Impairment:** Any loss or abnormality of psychological, physiological, or anatomical structure or function.

**Disability:** Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

**Handicap:** A disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfillment of a role that is normal, depending on age, sex, social and cultural factors, for that individual. (6)

Further, the programme identifies that “handicap” is related not only to impairment but also to environment, for “it occurs when they encounter cultural, physical or social barriers which prevent their access to various systems of society that are available to other citizens” (7). The UN also recognizes that disability is a diverse category, consisting of various conditions, all that “encounter different barriers, of different kinds, which have to be overcome in different ways” (7).

<sup>6</sup>Wendell identifies two positive aspects of the UN definitions. In addition to the inclusion of many conditions not universally recognized as disability, she also appreciates that the definition of “handicap” “explicitly recognizes the possibility that the primary causes of a disabled person’s inability to do certain things may be social,” such as “lack of opportunities, lack of accessibility, lack of services,” etc. (13). However, Wendell also offers several criticisms of the UN definitions. First, she believes the definitions of “disability” and “impairment” suggest “that there is some universal, biologically or medically describable standards of structure, function, and human physical ability” (14). Yet she argues that such a standard does not exist, as “normal” structure, function, or ability varies between societies. She also finds the UN’s definition of “handicap” problematic, as it implies “that women can be disabled, but not handicapped, by being unable to do things which are not part of the ‘normal’ roles of women in their societies” (17). For instance, many societies may only expect women to “function well enough to perform household duties” (17). This definition of “handicap” has similar implications for disabilities that result from aging: “although we may lose some ability, we are not ‘handicapped’ unless we cannot fulfill the roles that are normal for our age” (18).

<sup>7</sup>Tobin Siebers notes that the “correctness and theoretical power” of the social model “are very nearly unchallenged on the current academic scene” (174).

<sup>8</sup>Wilson and Beresford cite Herb Kutchins and Stuart Kirk’s criticism of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in their 1999 book *Making Us Crazy: DSM—The Psychiatric Bible and the Creation of Mental Illness*. In this book, Kutchins and Kirk claim the DSM “is based on an illusion of science and is fundamentally flawed,” citing disagreements in creating and applying the DSM, as well as instances of the involvement of pharmaceutical companies in developing diagnostic categories (Wilson and Beresford 147).

Furthermore, Wilson and Beresford describe their own experiences of “psychiatrists’ enhanced interest in some aspects of our distress and the ‘playing down’ of other aspects in order that it, or we, conform to a specific diagnostic category and prescribed ‘treatment’” (146).

<sup>9</sup>Wilson and Beresford cite Paul Abberley’s 1987 article “The Concept of Oppression and the Development of a Social Theory of Disability,” arguing that such discussions which consider “the socially constructed nature of impairment” are more useful for psychiatric system survivors, “for our starting point cannot be the unquestioning acceptance of the reification of ‘mental illness’” (155).

<sup>10</sup>Susan Coyle, in examining metaphor in the novel, notes the recurring themes of alienation and dissociation, but she views them as reactions to the oppressions Esther’s faces as a woman, not as a response to her experience of mental distress.

<sup>11</sup>Although Marilyn Boyer does reference disability theory in relation to the novel, she focuses on disabilities “of a temporary nature” (200), including inebriation, poisoning, and assault, and argues that these images of “disabled” female bodies serve as “metaphors for a fractured language” (201).

## CHAPTER II

### *THE BELL JAR AS DISABILITY NARRATIVE*

The critical lens of disability theory offers a new perspective on many aspects of Esther's experiences, including the cultural responses she faces as a result of her difference. Additionally, by considering Arthur W. Frank's analysis of illness narratives, we can recognize many patterns and tendencies in Esther's self-perceptions that are common in disability narratives. As the social model demonstrates, the meanings attached to "disabled" individuals are largely a result of societal definitions and limitations, not of the physical, mental, or emotional differences themselves. Because these differences are constructed as "other," disabled individuals must face many forms of societal prejudice, from interest and curiosity to disgust and fear. As Rosemarie Garland Thompson asserts, since disability is "constructed as the embodiment of corporeal insufficiency and deviance," the disabled body "becomes a repository for social anxieties about such troubling concerns as vulnerability, control, and identity" (*Extraordinary Bodies* 6). This anxiety regarding difference is seen also in response to other stigmatized identity groups, but some scholars argue that the prejudice against disability is even more complex. For instance, Lennard Davis points out that disability serves as a reminder that "identity is not fixed but malleable," for anyone is capable of becoming ill or disabled (26). In fact, with modern medical advancements, life expectancy has increased, which will inevitably lead to an increase in rates of disability, and many scholars, including Davis and Thomson, assert that everyone who lives long enough will one day be disabled. Furthermore, Thomson argues that the fluidity of this category makes disability "more threatening...than such seemingly more stable marginal identities as femaleness, blackness, or nondominant ethnic identities" (14). Just as anyone can experience an injury resulting in physical impairment, no one is inherently exempt from mental and emotional distress.

As a result of social anxieties regarding difference, mental distress and other disabilities can elicit multiple cultural responses. In examining common historical responses to physical difference, Thomson cites Mary Douglas' "Concept of Dirt" from *Purity and Danger: An Analysis of Concepts of Pollution and Taboo*. In this study, Douglas asserts that cultural concerns with purity are at the foundation of every society, noting that purity is achieved through the absence of "dirt." For

Douglas, dirt is defined as any deviation from societal norms, or “the by-product of a systematic ordering and classification of matter, in so far as ordering involves rejecting inappropriate elements” (35). Although Douglas does not discuss disability in her study, Thomson argues her “interpretation of dirt as anomaly, as the extra-ordinary, can be extended to the body we call ‘disabled,’” for when compared with cultural expectations of the body, physical disability is clearly “aberrant” and “anomalous” (33). Likewise, cultural expectations of psychological and emotional norms cast mental distress as an anomaly or societal dirt. In her theory, Douglas also analyzes common cultural responses to dirt; according to Douglas, cultures provide a set of basic categories by which ideas and values are ordered, and “any system of classification must give rise to anomalies, and any given culture must confront events which seem to defy its assumptions” or it risks forfeiting confidence (48). With this assumption, Douglas identifies five ways in which cultures cope with societal dirt: reducing ambiguity by assigning an absolute interpretation of the anomaly, avoiding anomalous things, eliminating anomalies, labeling anomalies as dangerous, and incorporating anomalies into ritual to “enrich meaning or to call attention to other levels of existence” (41). In their discussion of psychiatric system survivors, Anne Wilson and Peter Beresford demonstrate that the “mentally ill” often face many of these cultural responses,<sup>1</sup> but of these typical responses, the one most prevalent in *The Bell Jar* is avoidance through such methods as segregation. In fact, segregation seems to be the standard cultural response to mental difference. In *Madness and Civilization: A History of Insanity in the Age of Reason*, Michel Foucault discusses multiple methods of segregating the mentally ill used throughout history, some of which he attributes in part to the disappearance of leprosy from the Western world at the end of the Middle Ages; for centuries, leprosariums had spread across Europe, but as leprosy disappeared from the 14<sup>th</sup> to the 17<sup>th</sup> century, “Poor vagabonds, criminals, and ‘deranged minds’ would take the part played by the leper” (7). Before this time, the mentally ill were regularly driven from towns, “allowed to wander in the open countryside,” and later handed over to seamen who conveyed “their insane cargo from town to town” (8). After the disappearance of leprosy, however, “madmen” began to be housed in the empty hospitals, though “they were not given treatment; they were simply thrown into prison” (9-10).

For Esther, the main character in *The Bell Jar*, this confinement involves two separate mental hospitals, not prisons, though she is admitted involuntarily following her suicide attempt, and she had already observed that “the more hopeless you were, the further away they hid you” (190). Even after she improves and has been accepted back to her college, “the doctors vetoed [her] living with [her] mother in the interim” (268), forcing her to remain in the asylum until the start of the semester. Susanna Kaysen describes a similar experience of confinement in a mental hospital during the late 1960s in her memoir *Girl, Interrupted* (1993). After one short session with a psychiatrist she has never even met before, Kaysen is admitted immediately to a mental hospital, despite her objections. Although she is told the hospitalization will be brief, only “a couple of weeks,” she says, “He [the psychiatrist] tricked me....It was closer to two years” (39). In response to the doctor’s dishonesty, it is no wonder that Kaysen uses prison images to describe her time in the institution, saying, “I was behind bars” (117). Wilson and Beresford also use crime metaphors for their

interactions with the psychiatric field, noting that “as a psychiatric patient, it can feel as if everything you say or do is being taken down as evidence against you” (148). At least initially, both Kaysen and Esther seem to view hospitalization, not as an avenue to treatment and recovery, but as a prison sentence.

Although Esther is given treatment, unlike the imprisoned madmen Foucault describes, it is not until she meets Dr. Nolan that the electroshock therapy seems to be effective. Her experiences with shock treatments even before her hospitalization are horrific and painful:

There was a brief silence, like an indrawn breath.

Then something bent down and took hold of me and shook me like the end of the world....it shrilled, through an air crackling with blue light, and with each flash a great jolt drubbed me till I thought my bones would break and the sap fly out of me like a split plant.

I wondered what terrible thing it was that I had done. (171)

This experience with electroshock therapy is reminiscent of the recurring references to the execution of the Rosenbergs, which is mentioned in the first sentence of the novel. The electrocution is all Esther can think about in New York City, wondering what it would be like to be “burned alive all along your nerves,” convinced “it must be the worst thing in the world” (1). Even the room where Dr. Gordon administers the treatments reminds of a prison cell presumably similar to the Rosenbergs’: “the windows in that part were indeed barred, and...everything that opened and shut was fitted with a keyhole so it could be locked up” (170). Although intended to help her, the electroshock therapy seems more punishment than treatment, at least to Esther. In fact, when she is moved to Caplan, where she meets Dr. Nolan, she is afraid of saying the wrong thing and being subjected to electroshock therapy again: “somewhere in this hospital, in a hidden corner, there reposed a machine exactly like Doctor Gordon’s, ready to jolt me out of my skin” (226). Esther clearly sees electroshock treatments as possible punishment for misbehavior, which is not surprising; before being moved from the medical hospital to the “special” psychiatric ward of another following her suicide attempt, she breaks a mirror, and in irritation, one nurse tells another, “At you-know-where they’ll take care of *her!*” (209). The lack of professionalism and empathy in this medical professional only heightens Esther’s sense of electroshock therapy as punishment rather than treatment.

In addition to experiencing common cultural responses to difference, particularly segregation, Esther also exhibits many of the same the reactions to her disability as are common throughout illness and disability narratives. In *The Wounded Storyteller: Body, Illness, and Ethics*, Arthur W. Frank examines illness narratives, both his own and those told by others, to demonstrate that storytelling is one way of coping with illness and disability, for stories help “[transform] fate into experience” (xi). Although fictional, *The Bell Jar* is Plath’s attempt to accomplish this transformation. According to A. Alvarez, a poet and critic who developed a friendship with Plath, she described *The*



*Bell Jar* “as an autobiographical apprentice-work which she had to write in order to free herself from the past” (19). Presumably, writing this novel enabled Plath to transform her own “fate” into “experience.” Although Frank is concerned with autobiographical stories, his “tool kit” can be useful in examining fictional representations of illness and disability as well. Furthermore, Frank recognizes any story can contain an element of fiction: “The stories we tell about our lives are not necessarily those lives as they were lived, but these stories become our experience of those lives” (22). And *The Bell Jar* certainly has an autobiographical element, for many of Esther’s experiences—the death of her father from illness, the guest editorship in New York City, the hospitalization and electroshock therapy—are based on Plath’s life (Ames).<sup>2</sup>

In his analysis of illness narratives, Frank identifies four problems bodies encounter in illness: control, the ability to control one’s body; body-relatedness, the relationship of one’s body to one’s sense of self; other-relatedness, the relationship of one’s body to other bodies; and desire, both the act of wanting and the ways in which that desire is expressed for, with, and through one’s body. Esther faces each of these problems in her struggle with depression, and while Esther’s encounters with these problems may also be related to the oppressions she faces as a woman, these problems are also intensified by her experience of mental distress. Frank emphasizes that although “illness requires new and more self-conscious solutions to these problems,” they are “*general* body problems” that everyone—well or ill, able-bodied or disabled—faces throughout life (29). But because bodies demand extra attention in illness or disability, these general body problems can become more acute in narratives of experiences with illness and disability.

As the bodies of wounded storytellers are embodiments of contingency, control is an obvious problem for ill and disabled bodies. Even before her breakdown, Esther’s lack of control is emphasized outwardly in such events as her rejection from the writing course or Marco’s near-rape of her in New York City. From almost the first moment she meets Marco, his intentions are clear; in handing her his diamond stick pin, he says, “Perhaps...I shall perform some small service...worthy of a diamond” (125). By giving Esther this gift (which he later takes back), Marco assumes he will be reimbursed, and his use of physical force suggests he will receive payment, one way or another; he even threatens, “You see, I am quite serious” as he squeezes her arm so tightly his fingerprints “purpled into view” (125). After pouring daiquiris into her, Marco forces Esther to the dance floor against her will where she is completely in his control, “without any will or knowledge of [her] own” and feeling herself “blow and bend like a tree in the wind” (126). She continues to succumb to his will until he leads her outside and almost immediately pushes her to the ground, rips her clothes, and throws himself on top of her “as if he would grind his body through [her] and into the mud” (128). The helplessness she feels in her environment not only emphasizes but also contributes to the inner turmoil Esther faces in forging her own identity.

Esther’s lack of control cannot be solely attributed to her illness, for as her encounter with Marco demonstrates, this body problem is also intertwined with her identity as a woman. In her article “(Re)fusing the Amputated Body: An Interactionist Bridge for Feminism and Disability,” Alexa Schriempf argues that disabled women face compounded oppressions, for they often encounter

both a “sexist bias” and an “ableist bias” (54). This is also true for Esther; in addition to the stigmatization she faces in response to her mental distress, Marco is a reminder of the sexist bias she must face as well. Schriempf primarily discusses visible physical disabilities, describing how a disabled woman often “must not only fight to be the author of her own sexuality” but must fight to “establish a sexuality in the first place” (57). Although Esther does not have to establish her sexuality in the same way as physically disabled women (who are often denied any sexuality at all), she does fight against the conventions and expectations of her society to be the author of it. For instance, after learning that Buddy Willard has already had sex, she decides she must have sex with someone as well, despite her mother’s insistence that she wait until marriage, but “Buddy wouldn’t count, though, because he would still be one person ahead of [her], it would have to be someone else” (92). First she fantasizes about being seduced by Constantin, the simultaneous interpreter she meets in New York City, and even when Marco throws himself on top of her, she thinks, “If I just lie here and do nothing it will happen” (129). Her quest to establish her sexuality does not end with Marco, though, for she manages to fight him off. Then, when she returns to her room, she throws her clothes from a balcony, watching them float away beyond her control: “Piece by piece, I fed my wardrobe to the night wind, and flutteringly, like a loved one’s ashes, the gray scraps were ferried off, to settle here, there, exactly where I would never know, in the dark heart of New York” (132). Perhaps, as Linda W. Wagner suggests, the act of “[t]hrowing out her clothes is tantamount to rejecting the traditional image of pretty, smart girl, object for man’s acquisition” (61). This traditional image, and the expectations of that role, further complicate Esther’s attempt at establishing her identity.

Yet Esther’s search for her own identity as a woman extends far beyond authoring her sexuality and is complicated by the time period in which she lives. Many scholars have discussed Esther’s struggle against the oppression young women faced in the 1950s. Wagner, for instance, identifies Esther’s “battle against submission to the authority of both older people and, more pertinently, men” as one of the primary themes of the novel<sup>3</sup> (57). Esther feels many of the people in her life encouraging her to inhabit an identity she is not comfortable with, one of domesticity and submission to men. Her mother tries to convince Esther to learn shorthand, so that she can find a job after graduation, “transcrib[ing] letter after thrilling letter” for employers (presumably men), but Esther “hated the idea of serving men in any way” (89). Buddy Willard also tries to shape her into a suitable wife, telling her that she “wouldn’t want to write poems any more” after she got married and had children (100). However, to Esther, the example of domestic life she saw in her mother and Mrs. Willard “seemed a dreary and wasted life for a girl with fifteen years of straight A’s” (99), and she decided that getting married and having children was “like being brainwashed, and afterward you went about numb as a slave” (100). As Marjorie Perloff argues, Esther’s “repeated attempts...to find both a female model whom she can emulate and a man whom she need not despise” (512) are unsuccessful. Although she has many choices for both a female model—such her mother and Mrs. Willard—as well as for potential husbands, including her boyfriend Buddy who has already proposed, none offers a life free of patriarchal oppression. Her inability to construct a suitable, acceptable identity for herself within the context of societal expectations only heightens Esther’s problem with control.

Frank reminds that contingency, the “condition of being subject to forces that cannot be controlled” (31), is a condition of life for everyone though it is not commonly recognized as such. As Frank points out, “[p]eople define themselves in terms of their body’s varying capacity for control” (30). Susan Wendell also discusses cultural desires for control: “A physical ideal gives us the goal of our efforts to control the body, and the myth that total control is possible deceives us into striving for the ideal” (“Toward a Feminist Theory” 249). However, as Frank notes, recognition of the inherent contingency of life—most often brought on by disability—can be overwhelming, often involving “a crisis of control” (30). Esther is not the first young woman to suffer disappointment or even rape, but the contingency she experiences extends beyond these outside forces. As she returns home from her guest editorship in New York City and edges closer to the nervous breakdown, she begins to lose control of her own body and mind in multiple ways. For instance, when she tries to read, her “eyes sank through an alphabet soup of letters” (147), and when she attempts to write a letter, her “hand made big, jerky letters like those of a child” (154). Furthermore, she cannot sleep, even after her family doctor prescribes sleeping medication. Then, when she tries to articulate her condition to this doctor, Esther finds herself unable to do so: “the zombie voice rose up in my throat and choked me off” (149). In her depression, Esther continually loses control of her body, fostering her sense of separation from it.

Frank sums up this problem of body-relatedness with a question: “Do I *have* a body, or *am* I a body?” describing the two possible reactions as associating with or dissociating from the body (33). Although Frank places more value in associating with one’s body, he does recognize dissociation as a common response to illness/disability, and Esther’s character offers multiple examples of such a reaction. For instance, before her admission to the hospitals, she repeatedly refers to her own voice as “the zombie voice” or “the hollow voice” (140), as though it does not belong to her at all. Furthermore, in considering methods of suicide, she quickly rules out slitting her wrists: “the skin of my wrist looked so white and defenseless that I couldn’t do it. It was as if what I wanted to kill wasn’t in that skin...but somewhere else, deeper, more secret, and a whole lot harder to get at” (176). When she decides to do it anyway, she is unable to will her body to move and perceives “the person in the mirror” as someone separate from herself, “paralyzed and too stupid to do a thing” (176). Susan Coyle, in examining metaphors in the novel, notes that the physical images with which Esther describes herself show that she is “increasingly dissociated from herself, until a sense of the ‘other’ is clearly established” (162). As her depression worsens, Esther’s sense of identity becomes more separated from her body, situating herself as “having a body” rather than “being a body.”

Other disability scholars have observed the recurring issue of body-relatedness in disability narratives. Kristen Lindgren argues that dissociation from the body is not unique to the experience of disability; in fact, for a healthy, nondisabled person, ignoring the body is easy. However, Lindgren notes that illness and disability complicate this assumption of dissociation, for “[t]he notion of *having* a body implies that the self exercises control over and even ownership of the body. Illness and disability reveal that the body has a mind of its own” (151-52). Likewise, Esther continually describes her body as something separate from and opposed to herself; when she attempts to hang

herself, she finds her will sabotaged by her body's: "Then I saw that my body had all sorts of little tricks...which would save it, time and again, whereas if I had the whole say, I would be dead in a flash" (189). Esther continually sees her body as not only separate from her sense of self, but also as antagonist, interfering with her plans, from writing a letter to committing suicide. Nancy Mairs also describes a similar relationship with her body as she developed M.S.:

In effect, living with this mysterious mechanism feels like having your present self, and the past selves it embodies, haunted by a capricious and meanspirited ghost, unseen except for its footprints, which trips you even when you're watching where you're going, knocks glassware out of your hand, squeezes the urine out of your bladder before you reach the bathroom, and weights your whole body with a weariness no amount of rest can relieve. An alien invader must be at work. But of course it's not. It's your own body. That is, it's you. (53)

Like Esther, Mairs at least initially perceives her body as separate from herself, as an antagonistic "other." As Mairs notes, disassociation and bodily self-hatred are common experiences for women in patriarchal societies; for instance, she describes the shame she feels from "falling short of an unattainable standard" of feminine beauty (55). However, these phenomena become even more intense in the experiences of disabled women.

Like body-relatedness, the problem of other-relatedness also produces two typical reactions, becoming a dyadic body, recognizing the interconnectedness of itself with other bodies, and becoming a monadic body, "understanding itself as existentially separate and alone" (Frank 36). Esther, a monadic body, begins to withdraw from those around her after returning from New York, passing on the opportunity to attend summer school despite her rejection from the writing class and ending her relationship with her boyfriend Buddy Willard. She believes her condition is hopeless, "incurable" (189), and will only leave her isolated and alone. For instance, when beginning therapy with Dr. Gordon, she can only anticipate being hospitalized, visited at first by family and friends until "their visits would slacken off, and they would give up hope" (190). She feels alienated not only from herself, but also from those around her.

As with all disability and illness narratives, Esther's perception of herself as her depression worsens is largely affected by the perceptions and reactions of others. By many strangers, Esther is continually regarded with either fear or interest. For instance, after attempting suicide, she is moved from one hospital to another that has a ward for mental illnesses. Though her roommate in this new hospital is initially friendly, she quickly changes upon learning that Esther has tried to kill herself, for "she lowered her voice and whispered something [Esther] couldn't hear...and somebody stepped out and pulled the bed curtain between [them] like a white wall" (212). Although this woman is also a patient in the mental hospital (which she says is "on account of [her] French-Canadian mother-in-law"), she exhibits an unnatural fear of Esther. For other strangers, however, Esther serves as a sort of spectacle, similar to the American freak show phenomenon which Thomson discusses at length. Freak shows presented the disabled body as "a spectacle—sympathetic, grotesque, wondrous, or

pathological,” the object of the “stare” (*Extraordinary Bodies* 136).<sup>4</sup> Esther is often the object of the stare, as when a black hospital employee comes to deliver the patients’ meals and “he gawked at us with big, rolling eyes. I could tell we were his first crazy people” (215). Furthermore, when George Bakewell, a boy from Esther’s church whom she barely knew, comes to visit her in the hospital, she receives the same stare, “as if I were some exciting new zoo animal,” and says, “He didn’t really know me, either. He just wanted to see what a girl who was crazy enough to kill herself looked like” (207). Even since the decline of the American freak show, Thomson notes that “the stare is the dominant mode of looking at disability in this culture” (“Dares to Stares” 31). The stare is also the most common response to “invisible disabilities” such as Esther’s, for such conditions “always threaten to disclose some inexplicable stigma, however subtle, that undoes the social order by its presence” (31). Although her mental distress is an invisible disability, her hospitalization reveals its existence, eliciting both fear and curiosity from those around her.

The reactions of those who knew her before the breakdown, particularly those of her mother, are markedly different but equally prejudicial, often laying blame on Esther for her condition. Thomson, citing Melvin Lerner’s “just world” theory, argues that such reactions are common; there is often the assumption that “if something ‘bad’—like having a disability—happens to someone, then there must be some ‘good’ reason” (36), some fault on the part of the victim. After Esther’s first electroshock treatment, her mother is elated to hear Esther proclaim that she no longer wants to see Dr. Gordon, assuming Esther had “decide[d] to be all right again,” unlike “those awful dead people at that hospital” (174). Her mother seems to believe that Esther could “get better” by sheer force of will, ignoring the reality of her daughter’s mental distress. Then, after her suicide attempt, Esther objects to being moved to another hospital against her will, and her mother says, “You should have behaved better, then” (210). Her mother does not recognize the lack of control Esther feels. In fact, she initially assumes that volunteer work will cure Esther depression, as “the cure for thinking too much about yourself was helping somebody who was worse off than you” (192). By identifying the cause of Esther’s distress as a preoccupation with herself, Mrs. Greenwood is also blaming Esther for her condition.

Esther’s perception of herself and her illness is also largely shaped by her interactions with the medical/mental health field. As G. Thomas Couser discusses in his book *Recovering Bodies: Illness Disability, and Life Writing*, there are many ways modern medicine complicates bodily experiences for the ill and disabled. Couser notes that “as the efficacy of U.S. medicine has increased public confidence in the medical establishment has decreased,” (10-11) and this dissatisfaction is expressed in numerous illness and disability narratives. Frank also recognizes that many such narratives “express suspicion of medicine’s reduction of their suffering to its general unifying view” (11). This same dissatisfaction is also seen in mental health users; as Wilson and Beresford point out, with the continued development of the “mental health service users/psychiatric system survivors movement” since the 1980s, “there are now clear and well-argued challenges to psychiatric orthodoxies from users’ perspectives” (143). Part of the problem is the language of medicine, or medical discourse, which Couser says “may obstruct rather than enhance empathy” (19). Esther

experiences this obstruction to empathy in her first session with Dr. Gordon, when he asks her to explain what she *thinks* is wrong. Esther's suspicions are raised instantly: "What did I *think* was wrong? That made it sound as if nothing was *really* wrong, I only *thought* it was wrong" (154). While it can be argued that Esther's interactions with Dr. Gordon are also shaded by gender bias, for perhaps he would speak to her differently if she were a man, disability narratives demonstrates that such interactions with medical professionals are common in disability experiences. Esther is further alienated from Dr. Gordon when, in future sessions, he continually asks about her college and the WAC station they used to have, as though he is more interested in her school than her. In fact, it seems Dr. Gordon says little else to her, for he does not explain her condition, or even describe her diagnosis to her. Couser argues that "one manifestation of medical authority is the control of information, keeping it from nonprofessional competitors and patients alike" (20). Similarly, Wilson and Beresford describe the tendency of psychiatric professionals to withhold information from patients as well, noting that in the UK prior to 1991, patients were not legally granted access to their medical records, and even now, this access is not absolute.<sup>5</sup> This same tendency to withhold information from patients is also exhibited by Dr. Gordon, for even when Esther fails to show improvement and he decides she needs electroshock therapy, he does not explain anything to Esther. Instead, he tells her mother, and Esther does not know what to expect of the treatments until they begin.

Sometimes the very language a doctor uses causes alienation from patients. Couser notes that physicians "establish, exercise, and perpetuate their power by means of the development and deployment of specialized language ('expert-ese')" (19). Often, this is most evident during diagnosis, when "doctors provide patients with an interpretation of their lives" (10). Kaysen describes this process of reinterpretation, as well as the way it complicates her experience:

They had a special language: *regression, acting out, hostility, withdrawal, indulging in behavior*. This last phrase could be attached to any activity and make it sound suspicious: indulging in eating behavior, talking behavior, writing behavior. In the outside world people ate and talked and wrote, but nothing we did was simple. (84)

When described using the doctors' "special language," Kaysen finds her own experiences complicated, even suspicious. One of the negative effects of modern medical advancements and technologies that Couser identifies is the tendency "to discount patient testimony" (21). Wilson and Beresford also note that medical professionals, both psychiatrists and general practitioners, generally do not allow patients "to contribute to the writing of 'their own' record" (148), offering an example in which one of the authors' own written account of "the events leading to her diagnosis" was omitted from her file with the explanation that "to have made reference to it or included it 'would have sanctioned its content'" (149). This tendency of medical professionals to discount patient testimony can lead patients to distrust their own feelings and experiences, as in Kaysen's case. Esther also has her own testimony discounted by doctors, first by Dr. Gordon when she tells him she is "the same" and he "quirked an eyebrow, as if he didn't believe it" (160). Then, when she is being moved from Caplan to Belsize in the final hospital, she voices concern that she is not ready,

but her concerns are quickly dismissed: “Of course, you’re well enough. Don’t worry, they wouldn’t be moving you if you weren’t” (245). Here Esther is expected to ignore her own feelings and trust the decision of the doctors.

Medical institutions often have other effects on their patients. For instance, Wendell argues that “there are often hierarchies of power and value in rehabilitative institutions, with those who act most like the non-disabled at the top, and those who have least control of their bodies at the bottom” (*The Rejected Body* 61). Esther noticed this in Caplan, when a fellow patient was being moved to Wymark, a building for more severe cases, and the nurse told her, “I’m afraid Miss Norris isn’t moving up like you” (232). By blatantly comparing the progress of the two patients, the nurse is perpetuating a hierarchy of patients based on severity of condition and progress. Furthermore, when Esther begins to “improve” and is moved to Belsize, she finds herself on the bottom of this system again, for compared to the other patients in this ward, her condition is the most severe. Although the nurse in Belsize is much more friendly with the patients than the staff in the other wards, Esther is treated differently. The nurse chats and jokes with the other patients, even playing games with them, but Esther is not included. When attempting to participate in the conversation, Esther is reminded of her place: “The nurse gave me a straight look, and I could see she thought I had no business in Belsize at all” (250).

As Wendell points out, these hierarchies can also be internalized by the patients themselves, causing ill/disabled people to “make each other ‘the Other’” (*The Rejected Body* 61). Esther experiences such treatment from her friend Joan, who was a fellow patient in Caplan. Joan seemed to improve faster and is moved to Belsize before Esther, but when Esther joins her there, Joan regards Esther very differently: “She [Joan] seemed perfectly at home among these women and treated me coolly, with a slight sneer, like a dim and inferior acquaintance” (247). Because Esther has not progressed at the same rate, she has not “moved up” as fast, Joan now feels superior to her. However, once Esther begins electroshock treatments again and improves, she surpasses Joan, and the dynamics of their relationship are reversed, as Joan began to hang around Esther “like a large and breathless fruitfly—as if the sweetness of recovery were something she could suck up by mere nearness” (258). The same division among patients is seen in *Girl, Interrupted*, for Kaysen describes one girl who had set herself on fire and was now disfigured, saying “Who would kiss a person like that, a person with no skin?” (18). This girl is not a part of Kaysen’s group, for she and her friends knew they “might get out sometime, but she was locked up forever in that body” (19), imagining a superiority in this distinction. As both Esther’s and Kaysen’s experiences demonstrate, the hierarchies established by medical discourse often translate into prejudice among patients.

The final body problem Frank identifies is that of desire. Frank says that for most bodies, desire can never be satisfied, for “desire is always wanting more” (38). However, he argues that for ill and disabled bodies, desire is sometimes lacking, and “the initial loss of desire is expressed in indifference to such mundane acts as keeping up one’s footwear and teeth” because “the ill person fears he is no longer worth clean teeth and new shoes” (38-39). It is not surprising, given her condition, that Esther exhibits a lack of desire, for depression is almost by definition a lack of desire.

By her last night in New York City, Esther is already experiencing a loss of desire, as she lacks motivation to complete even simple tasks. Even packing her suitcase is a difficult act, for she says her clothes “seemed to have a separate, mulish identity of their own that refused to be washed and folded and stowed” (123). Although she displaces the blame to inanimate objects, Esther’s problem with desire is evident. After returning home, Esther seems to have lost all desire, finding herself unable to even get out of bed: “I couldn’t see the point of getting up. I had nothing to look forward to” (139). Any task she undertakes, from writing a novel to working on her thesis, seems futile and useless. By the time she is referred to her first psychiatrist, her personal hygiene has begun to suffer as well:

I was still wearing Betsy’s white blouse and dirndl skirt. They drooped a bit now, as I hadn’t washed them in my three weeks at home. The sweaty cotton gave off a sour but friendly smell. I hadn’t washed my hair for three weeks, either...The reason I hadn’t washed my clothes or my hair was because it seemed so silly....It seemed silly to wash one day when I would only have to wash again the next. It made me tired just to think of it. (151-52)

Because of her almost complete lack of desire, Esther can no longer bring herself to bathe or change her clothes. Unlike dyadic bodies, who Frank says remain productive of desire through service, Esther is unable to “be a body for other bodies” (40). Even when her mother pushes her to volunteer at the local hospital, she finds no joy in service; she is disappointed that the patients are awake, having hoped “they would be sleeping, or lying quiet and pale, so [she] could tiptoe round without any trouble” (193). As she does not even make it through her first full day as a volunteer, it is clear that before Esther can become productive of desire, she must regain some amount of desire for herself.



## NOTES

<sup>1</sup>Wilson and Beresford describe many responses to “mental illness” that demonstrate Douglas’ theory. For instance, they note that mental health users are assigned absolute labels, saying that in their own experience, “our transgressions from the ‘psychonorm’ have been documented and preserved in perpetuity in medical/psychiatric records which continue to impact upon our lives long after they were written” (145). Furthermore, they describe the media and general public “emphasis on the ‘dangerousness’ of mental health users” (143). In fact, according to Beresford in his 2000 article “What Have Madness and Psychiatric System Survivors Got to Do with Disability and Disability Studies?” “‘Public safety’ is now explicitly the central concern of government mental health policy” (168). As evidence, Beresford points to imposed “compulsory treatments,” a “renewed commitment” to institutionalization, and “planned provisions to imprison people included in the junk category of ‘personality disorder’ who have not been convicted of any offense” (168).

<sup>2</sup>Ames notes that Plath described her novel as autobiographical, and many of the elements of Esther’s life are true to Plath’s own experiences. For instance, Plath “spent her early years in Winthrop, a seaside town close to Boston” (293), and Esther also lives in a suburb of Boston. The family make-up is also similar, for like Esther, Plath’s father died when she was young, leaving her a mother and brother. Although Esther’s brother does not appear in the novel, she does refer to him occasionally. The description of Esther’s father, however, is very similar to Plath own father, for, when visiting her father’s grave, Esther thinks that if her father hadn’t died, “he would have taught [her] all about insects, which was his specialty as the university” (196-97). Plath’s own father, who was also a professor, was “an internationally known authority on bees” (293). Furthermore, just as Plath’s father died from a long, difficult illness, Esther’s father died mercifully (according to her mother), for “if he had lived he would have been crippled an invalid for life” (198). Like Esther, Plath was also awarded a guest editorship in New York City; in 1952, Plath “was chosen to be a guest editor in *Mademoiselle’s* College Board Contest” (296). Plath also suffered a nervous breakdown and received electroshock therapy before returning to college to reconquer “old broncos that threw me for a loop last year” (qtd. in Ames 301). We are told that Esther has been accepted back to her college for the next semester, and we can only assume that she also reconquered “old broncos.” After submitting her manuscript of *The Bell Jar* and moving to London, Plath describes the novel to a friend as “an autobiographical apprentice work” (qtd. in Ames 308), and the similarities between her own experiences and Esther’s certainly serve of evidence of this.

<sup>3</sup>Linda W. Wagner argues in “Plath’s *The Bell Jar* as Female Bildungsroman” that this novel has two primary themes: that of Esther’s “battle against submission” and that of her “developing identity, or lack of it” (56-57).

<sup>4</sup>In the third chapter of her book *Extraordinary Bodies*, Thomson discusses American freak shows in which the disabled body was treated as “a spectacle—sympathetic, grotesque, wondrous, or pathological” (136). Offering numerous examples, Thomson outlines the history of the freak show of museums and circuses from 1835 to 1940, which she argues “descended from a tradition of reading

the extraordinary body” that she traces back as far as Stone Age cave drawing that “record the births of the mysterious and marvelous bodies the Greeks and early scientists would later call ‘monsters,’ the culture of P.T. Barnum would call ‘freaks,’ and we now call ‘the congenitally physically disabled’” (56). By the mid-twentieth century, modern medicine began to “[govern] the production of freaks,” replacing the American freak show (75).

<sup>5</sup>Wilson and Beresford note that before 1991, patients were not granted access to their medical records, and even with the passing of Access to Medical Reports Act (1988) and Access to Medical Records Act (1990) in the UK, this access is not absolute. For instance, the authors point out that the Access to Medical Records Act generally does not apply to records before 1991. Furthermore, under each of these acts, information may be withheld “if, ‘in the opinion of the practitioner, such information would be likely to cause serious harm to the physical or mental health of the individual’” (148).

## CHAPTER III

## CONCLUSION

Despite the uncertainty which clouds the conclusion of *The Bell Jar*, most scholars read the ending as an optimistic one.<sup>1</sup> As Esther is waiting nervously for her interview with the board of doctors, hoping to be released, the description of her appearance shows marked improvement from her first meeting with Dr. Gordon: “My stocking seams were straight, my black shoes cracked, but polished, and my red wool suit flamboyant as my plans” (290). She has replaced the drooping clothes and sour smell and now appears “polished” and “flamboyant,” ready to re-enter society and restart her own life. However, she also expresses anxiety, despite her desire to “feel sure and knowledgeable about everything that lay ahead”; instead, she says, “all I could see were question marks” (290). But even question marks and uncertainty are preferable to the despair from which she is returning. She also describes herself as “being born twice—patched, retreaded and approved for the road,” ready to walk through the open door before her (290), which Wagner says “are surely positive images” (64). Likewise, Perloff assumes Esther’s treatment has been successful, hailing her “an authentic, indeed an exemplary heroine of the seventies” (521-22), and E. Miller Budick argues that the tire imagery signals Esther’s rebirth, claiming that “Esther realizes that she cannot be born anew. But she can be healed” (883). Much of the apprehension Esther faces in the hospital and returning to her life are related to the task of finding a role in society free of patriarchal oppression, but this anxiety is also related to her experience of mental distress; while the tone of the final chapter does seem hopeful at the very least, the question marks Esther sees in her future remind that there is no guarantee she is, in fact, “healed.”

Such uncertainty regarding the body’s future is common for many ill and disabled people. According to Frank, people with conditions similar to that of Esther’s are part of what he terms the remission society, those who are “effectively well but could never be considered cured” (8). This category includes many conditions:

Members of the remission society include those who have had almost any cancer, those living in cardiac recovery programs, diabetics, those whose allergies and environmental sensitivities require dietary and other self-monitoring, those with

prostheses and mechanical body regulators, the chronically ill, the disabled, those 'recovering' from abuses and addictions, and for all these people, the families that share the worries and daily triumph of staying well. (8)

Although Frank does not explicitly name mental distress in this list, a glance at the other conditions identified suggests its implicit inclusion. Furthermore, if the remission society includes anyone who is concerned with "staying well," Esther clearly qualifies. In contemplating her pending release, she says, "I wasn't sure at all. How did I know that someday—at college, in Europe, somewhere, anywhere—the bell jar, with its stifling distortions, wouldn't descend again? (286). She is not merely uncertain about the life she is returning to, with college and relationships, but she is also worried about remaining well and staying out from under the bell jar. Kaysen also describes similar concerns with staying well, often wondering if she is crazy: "I still think about it. I'll always have to think about it" (159). Although they have undergone treatment and been released, both Esther and Kaysen have become members of the remission society, sharing "the worries and daily triumph of staying well."

In many ways, Esther's experiences in *The Bell Jar* correlate with common experiences of disability, and for this reason, disability theory can also be a useful critical tool in reading this novel. In addition to enriching our understanding of the novel, such a reading demonstrates the interconnections and overlap between Esther's struggles as a woman and her experience of mental distress. These apparent overlaps between experiences of disability and femaleness may seem to suggest that to be female in a patriarchal society is in some sense disabling; in fact, according to Thomson, "[m]ore recently, feminist theorists have argued that female embodiment is a disabling condition in sexist culture" (260).<sup>2</sup> However, despite the parallels between femaleness and disability, these parallels are not absolute. As scholars such as Thomson, Wendell, and Schriempf argue, disabled women face compounded oppressions, as they are stigmatized not only for their difference as women but also for their physical, mental, or emotional differences. Schriempf argues that when scholars include disabled women "under the general rubric of 'woman,'" they fail to recognize and acknowledge "the different experiences of disabled women in a sexist and ableist society" (54). Likewise, to include all women in the category of "disabled" ignores the unique experiences, struggles, and concerns of disabled women. Although Esther's disabling experience of mental distress is largely shaped by the oppressions she faces as a woman, to view her as "disabled" because she is a woman is to ignore the ways in which her experience of mental distress is a stigmatizing experience in itself, one that complicates and intensifies her already-complicated experience of being a woman.

## NOTES

<sup>1</sup>One scholar who disagrees with such an optimistic reading of the ending is Diane S. Bonds. In her article, "The Separative Self in Sylvia Plath's *The Bell Jar*," she is critical of other scholars who accept the "retreaded tire" image as at face value as a purely positive image, ignoring that the tire "presents us with a utilitarian object, easily repaired or replaced, as a metaphor for woman" (54). She goes on to point out that a "patched, retreaded tire may be ready for the road, but somewhere down the highway the owner can expect a flat" (54), suggesting that Esther's "cure" may not be absolute. Ultimately, Bonds argues that Esther's new life following her rebirth is not so new after all, associating "Esther's new lease on life with the role expectations that contributed to her breakdown in the first place"—marriage and family, or "domestic servitude" (54).

<sup>2</sup>As an example, Thomson discusses Iris Marion Young, who asserts that, in a patriarchal society, women are "physically handicapped" by culturally enforced expectations of femaleness, which rob women of their "sense of embodied agency" (260).

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Scope and Method of Study: The purpose of this study was to explore the implications of disability theory for Sylvia Plath's *The Bell Jar*, a novel which has traditionally been read from a feminist perspective. Drawing on the work of many scholars in contemporary disability theory, including Rosemarie Garland Thomson, Arthur W. Frank, and G. Thomas Couser, this study seeks to examine the parallels between the experiences and struggles of the novel's protagonist Esther Greenwood and those commonly described in disability narratives.

Findings and Conclusions: Although *The Bell Jar* is not typically read from through the critical lens of disability theory, such a reading offers a new perspective on the protagonist's depression and nervous breakdown, suggesting that Esther's mental distress should be understood not just as a response to patriarchal oppression but as an additional stigmatizing experience, one that compounds and intensifies her struggles and experiences as a woman. Such a reading also demonstrates many overlaps between experiences of femaleness and experiences of disability. However, these parallels are not absolute; to lump all women in the category of "disabled" is to ignore the unique concerns and experiences of disabled women, who face compounded oppressions, of both a patriarchal society and an ableist society. Thus, to say that Esther is "disabled" by patriarchal oppressions ignores the ways in which her experience of mental distress is also a stigmatizing and disabling experience.

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