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| RESEARCH ARTICLE

## Reading Traumatized and Depressed Women: A Cognitive Study of Sylvia Plath's *The Bell Jar*

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| ABSTRACT

Depression is a mental disorder that disrupts people's thoughts and behaviors. Today, depression is recognized as one of the most common mental illnesses worldwide that need to be studied and investigated in some disciplines and through literature in particular. Anyone may develop depression regardless of age or social background, yet, women are most likely prone to depression. Numerous theories have studied the nature of depression, its causes, symptoms, and healing process; among these is Aaron T. Beck's model of depression. Beck's model gives a comprehensive examination of depression and provides a therapeutic theory based on the model, known as cognitive behavior therapy CBT. Therefore, to understand depression in terms of Beck's cognitive model and uncover the reasons that lead women to develop depression, the study utilizes the literary text *The Bell Jar* by Sylvia Plath, which is a semi-autobiographical novel; that recounts heroin's battle with depression. The research opens new horizons for psychological analysis in the literary domain and directs people's attention toward the threatening consequences of depression.

| KEYWORDS

Aaron T. Beck, CBT, Depression, psychological analysis, Sylvia Plath, *The Bell Jar*, mental illnesses

| ARTICLE INFORMATION

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### 1. Introduction

Since the dawn of humanity, many diseases have swept and killed a large number of people; some of these diseases have been worked on and eliminated, while others continue to threaten humans. Disorders are not only physical; there are also mental illnesses. Slade (2009) defines mental illness as a condition that has no known physical cause, it is rather a functional illness, and the subjective experience apparently lies at the center of mental diseases. One of the most commonly recognized mental disorders in the world today is depression. Gilbert (1997) states that depression has been a problem for humanity for a long time. It was identified as a condition over 2,400 years ago by Hippocrates, the renowned ancient Greek doctor known as the Father of Medicine, who labeled it melancholia. The term itself may refer to a sort of weather, a drop in the stock market, a hole in the ground, and, of course, states of mood. It was derived from the Latin *deprimere*, which meant to press down.

In clinical terms, depression is defined as a phrase used to describe any disorder in which a disruption in the person's mood is the primary aspect or problem. Clinical depression, also known as major depressive disorder MDD, is one of the most prevalent and significant types of depression (Pierce, 2018). Major depressive disorder is characterized by the co-occurrence of multiple distinct symptoms. Beginning with chronic grief, bad temper, anhedonia, drowsiness, low energy, feelings of worthlessness and low self-esteem, extreme self-blame, complications in appetite and weight, anxiety and tension, troubled sleep, which can be insomnia and hypersomnia, difficulties in concentration and decision-making, physical discomfort such as headaches and back pain, and last but not least, desperation, suicidal thoughts or behavior. Anhedonia is likely the most distinguishing symptom of major depression, which is the disappearance of the individuals' capacity to appreciate things that they would typically like (Nelson & Strakowski, 2015). Those who are depressed perceive life from the lenses of pessimism, thinking that any daily practices or social interactions

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are pointless in helping them to step aside from their dark zone. They prefer to be more isolated in their private world instead of exposing themselves to other people who cannot understand their misery and continue to judge them.

There are distinctive characteristics that can determine depression, like age and gender-specific depression, as well as the cultural factors that influence the complaint. This raises the critical question of whether the distinguishing characteristics of such depressions are caused by biological differences between men and women, the very young and the very old, Asians and Europeans, or gays and straights, or whether they are caused by sociological differences, or by patterns of expectation we place on people based on the population they represent? The answer is that both are correct in every circumstance. Depression is not a monolithic problem that can be handled with a monolithic solution; depressions are contextual and must be comprehended within the situations in which they occur (Solomon, 2001).

According to the American Psychiatric Association (2020), depression may strike anybody, including those who seem to live in reasonably good circumstances. There is a variety of factors that can contribute to causing depression. The first is biochemistry, which means an imbalance in some chemicals in the brain may lead to depressive feelings. The second is genetics, which depression may be passed down across generations. The third is people with poor self-esteem, who are easily stressed or usually tend to think of worst-case scenarios, are more likely to suffer from depression. Fourth are environmental factors; some people may be more vulnerable to depression if they are constantly exposed to violence, neglect, abuse, or poverty. Thus, depression does not affect an exclusive group of people; anyone can have it, regardless of their circumstances, their social background, or their age. Ingram (2009) believes that people with cognitive disorders are prone to depression. These cognitive factors include attributional style, perfectionism, dysfunctional attitudes, and self-criticism. Gotlib and Hammen (2009) point out that according to cognitive theories of depression, people's assumptions, attitudes, and judgments, as well as how they respond to and recall these experiences, impact their emotional reactions. As a result, cognitions play an important role in determining the extent to which people are influenced by unpleasant experiences, as well as whether these events result in a quick recovery or persistent depressive episodes.

One of the most highly known reasons for depression is stress. All diathesis-stress theories see stress as a significant factor in the formation of depression. It has been demonstrated that the majority of severe depressive episodes in adult samples are preceded by painful events. This defies the popular belief that most people do not experience depression following a traumatic occurrence. The form of stressors that may cause depression: is personal "loss," which might include deaths in the family, relationship breakdown, or endings. Loss has occasionally been extended beyond interpersonal loss to encompass loss of self-esteem, role loss, or loss of valued ideals. There is also chronic stress, defined as stress that lasts longer than a year; it is a better determinant of depressive symptoms than acute stressors (Hammen, 2005). Many episodes of depression are caused by a mix of stressors and setbacks. There may be financial concerns, concerns about jobs (or employment), disputes at home or at work, troubles with children, health concerns, and so forth. These accumulating pressures eventually boost stress arousal and push individuals into maladaptive feedback, where they start to obsess over all the issues and descend into depression (Gilbert, 2001).

These life stresses tend to diminish people's positive reinforcement, and therefore they start to withdraw, which leads to a decrease in reinforces, which results in greater withdrawal until establishing a self-perpetuating cycle (Nolen-Hoeksema, 1990). Depressed individuals who have experienced significant life stresses have been observed to have more severe depressive symptoms than depressed people who have not experienced such stresses (as cited in Gotlib & Hammen, 2009). There is also a substantial correlation between trauma exposure and depression rates, with persons who have experienced bad life events being more than twice as likely to display symptoms of depression as those who have no trauma history. These traumas often include but are not limited to car accidents, rape and sexual abuse, natural catastrophes, combat/war, childhood or adult physical abuse, or any other intense or extraordinary crises beyond the normal spectrum of human experience (as cited in Lilly et al., 2010).

Moreover, adolescence is known as the stage in which depression prevails the most. Adolescents are particularly vulnerable to environmental changes because of the social shifts that occur during maturity. This comes as a result of the alteration in family dynamics. As teenagers aspire for greater autonomy, peer relationships become increasingly important. Because of this, adolescents tend to develop a higher consciousness of personal interactions and events such as family disagreements, social withdrawal, bullying, relational aggression, and failed relationships. Depression can block these processes and create maladaptive thoughts, from which recovery can be tough. Adolescent depression is thought to have a long-term course that is marked by recurring depression, low academic performance, pregnancy, troubled peer and family relationships, and suicide (Ingram, 2009).

As Nolen-Hoeksema (2020) points out, sociocultural theorists have concentrated on the social conditions of the demographic groups and how they play a role in establishing differences in vulnerability to depression. The Cohort effects (generational differences, gender, and ethnicity/race) are three demographic factors that are particularly significant to sociocultural theories of depression. What is known as a cohort effect means that psychological differences among people are determined not by their age but by the era in which they were born and lived. Recent generations may be at a higher risk of depression than prior generations due to historical and cultural transformations. For instance, only around 20% of people born before 1915 are believed to have had

severe depression, but more than 40% of people born after 1955 tend to be at risk for major depression at some point in their lives.

According to the reports stated by The World Health Organization (2021), 3.8% of the population is affected by depression, including 5.0% among adults and 5.7% among adults older than 60 years. Approximately 280 million people in the world have depression. The worst case of depression is suicide; every year, around 700,000 individuals die by suicide. Suicide is the fourth highest cause of death among those aged from 15 to 29. According to the APA (2020), women are more prone than men to depression; one-third of women will have a severe depressive episode at some point in their lives. Nolen-Hoeksema and Hilt (2009) mention that girls' rates of symptoms and disorders increase between the ages of 13 and 15, while boys' rates stay rather consistent. Women are twice as likely as men to develop depression by the time they reach early adulthood.

Solomon (2001) speaks up that men rule the world, which makes things difficult for women. Physically, women are less capable of self-defense. They have a higher chance of being poor and a higher chance of being abused. They are less likely to obtain an education. They are more prone to being humiliated frequently. They are more prone to losing social status as a result of apparent aging indicators, and they are most likely to be submissive to their spouses. According to some feminists, women experience depression because they do not have enough autonomous arenas in which they can establish themselves and must rely on domestic accomplishments for all of their feelings of self-worth. Others argue that successful women who have more freedom than their peers in the domestic and work domains are constantly torn between work and home. Fact that all of these scenarios are stressful; married housewives and working married women have roughly the same rate of depression, a rate which is significantly greater than that of working married men.

According to behavioral and cognitive theories of depression, a persistent lack of control over one's environment leads to a generalized assumption that one cannot control events; this case then leads to depression symptoms such as decreased motivation, passivity, and self-esteem loss. Women's lack of social authority leads to their tendency to ruminate more than males when worried. Rumination is unconscious and repeated attention to one's sensations of despair, as well as the meanings and implications of the distress. Women may ruminate more because they are looking for methods to control their surroundings and their suffering, but they may not feel effective in exercising that control; therefore, they remain stuck in ruminating. As a consequence, several laboratory and field investigations find that those who ruminate when they are disturbed have longer and more severe episodes of depression symptoms and are more prone to acquiring complete depressive disorders than those who do not ruminate (Nolen-Hoeksema et al., 1999).

There is also a close relationship between depression and violence. Violence is any activity of gender-based violence that causes or is likely to cause bodily, sexual, or psychological harm or suffering to women, including threats of such actions, intimidation, or arbitrary limitation of liberty, whether in public or private life, including the effects on women's mental health. It is believed that one in every three women worldwide may face physical and/or sexual violence at some time in their life. As shown in multi-country research, mostly conducted in developing countries, between 15 and 71 percent of women aged 15–49 years have experienced physical and/or sexual abuse from an intimate partner at some time in their life. Gender-based violence against women has both short- and long-term consequences for women, involving physical harm and diseases, post-traumatic stress disorder, drug and alcohol abuse, poverty, homicide/femicide, and for sure mental illnesses. Depression is a substantial outcome of gender-based violence against women (Western, 2013). According to reports, more than 80% of women who join domestic violence shelters have moderate depression, and more than 50% of these women continue to have depression ten weeks after leaving the shelter and for up to six months (as cited in Lilly et al., 2010).

Teenage girls are also exposed to developing depressive disorder. Nolen-Hoeksema (2006) found that girls and boys are equally likely to develop depressive symptoms before the age of 13, but around the age of 13 to 15, girls' degrees of symptoms significantly increase, while boys' levels remain relatively steady and even seem to fade out a bit. Hammen (1997) asserts that some researchers believe that the activation of gonadal hormone systems during puberty contributes to the rise in female depression rates. Regular puberty hormonal imbalances may only cause depression in girls who are genetically predisposed to the condition. As cited in Keyes and Goodman (2006), female adolescence is a time when biology and psychosocial changes collide; that is, morphological changes such as breast growth and increased body fat have a psychosocial impact on self-image and perception by others. Thus, pubertal timing, age, self-image, morphological changes, and psychological support are all likely to impact women's depression vulnerability during this time.

Depression is not solely explained in psychological terms; literature has its fair share of using depressed characters in novels, poetry, or drama. Literature has contributed to drawing the attention of people to all mental disorders, including depression; it helps psychiatrists to diagnose it by portraying real characters who struggle with depression. Although medical guidelines are the simplest method to learn about depression, studying it via literary narratives will provide a more detailed outlook since what is

better than knowing it medically is witnessing someone who is directly affected by it. Moreover, most people do not comprehend clinical sources and do not understand medical terms unless they are specialists in the psychiatric domain.

In comparison to literary works, the goal of clinical sources is to produce a unified description of the condition. When it comes to patients, it's not about one person but about "them." The focus of clinical research is on the collective to have a better understanding of the disease as a whole. The standardization of results allows clinical sources to diagnose, treat, and advance research on the disease. Hence, individual perspectives are lost for the greater sake of broad comprehension as a result of this standardization. Alternatively, literary narratives are not devoted to giving a large overview of the condition; instead, they give an elaborated explanation of specific experiences. Each literary source portrays what it is like to be a mentally ill character; not only this, but some of them detail the process of visiting psychiatrists and hospitals, bringing into focus the idea of illnesses or madness. Others, on the other hand, may give a clinical description but in a brief while diving into how it manifests inside the particular person. As a result, in narrative works, the patient takes priority over the medical diagnosis, allowing the audience to understand depression through the lens of a personal experience rather than a broad description. Furthermore, because of the stigma attached to mental patients, some of those who have mental conditions believe they are insane. This has a deep impact on how they view themselves, how they approach others, and how they act in general. Analyzing the language used by depressed individuals to express themselves and their illnesses helps to understand the consequence of misunderstandings. It also gives the readers a sympathetic understanding of the situation (Williams, 2016).

Including psychological themes within the literary text aids not only the readers to have free access to the psyche of the depressed individuals but also these writings are considered as an outlet for their authors, who are personally affected by depression, to share their miseries, their outmost frightful moments and insert with it the reasons that may create mental illnesses. According to Nolen-Hoeksema (2020), depression is more prevalent among writers, artists, and composers. A study of 1,005 eminent 20th-century artists, writers, and other professionals confirms that writers and artists have a higher chance of experiencing mood disorders, psychosis, and suicide attempts than their peers who are caught up in business, science, and public life.

Besides this, those depressed individuals, or any kind of mental patients, find in psychological literature their comfort zone because they find in literature stories and characters they can relate to. They witness their inside conflicts verbalized in front of them, which may lessen their sense of loneliness because they will know that there is someone out there who can feel them. To take instance, Richmond (2019) states that When working with teenagers, therapists, counselors, and social workers find that employing young adult literature proved effective. Bibliotherapy, or the use of texts to help people to deal with mental illnesses, has long been a tactic employed by those in the helping professions. Through bibliotherapy, people can get insight into who they are, find therapeutic catharsis, feel more attached to others and less alone, as well as learn new ways to deal with their concerns. In his study, *Harry Potter and the Diagnostic and Statistical Manual: Muggle Disorders in the Wizarding World*, Freeman asserts that the psychological issues depicted in Harry Potter encourage readers to diminish the stigma associated with mental illness and offer empathy and tolerance to mental health patients and their loved ones. This proves as Lindauer (2009) mentions, that it is obvious that responses to literature, like other aesthetic works, are psychological; readers, while reading, pay attention, recall, comprehend, assess, empathize, identify, fantasize, search for meaning, summon pictures and feel aesthetically pleased.

In fact, Psychological matters have always been a part of literature. Interestingly enough, the writers have formed most of their main characters relying on a psychological complex, which is some kind of obsession that governs the characters' feelings, actions, and perceptions of life. Yimer (2019) gives examples from the writings of some authors like Charles Dickens, who mirrored the well-established conventions of psychological realism in his novel, *Great Expectations* (1861). George Bernard Shaw's *Pygmalion* (1913) was based on the Greek legendary figure Pygmalion, and the term Pygmalion effect was coined to underline the observable phenomena relating to men's psychology and performance. Likewise, Vladimir Nabokov's *Lolita* (1955) was a pivotal work in the development of the Lolita complex.

This type of fiction that is directed toward studying the psychology of humans is termed psychological realism or psychological novel. Logan(2011) defines the psychological novel as a type of prose fiction that concentrates heavily on a character's inner life, portraying their subjective thoughts, emotions, memories, and motivations. In its wider context, the term is highly connected to pieces of fictional narrative that feature considerably complex characters. It has been linked to literary trends, including psychological Realism in the 19<sup>th</sup> century, literary Modernism in the 20<sup>th</sup> century, and the stream-of-consciousness novel, as well as narrative methods like free indirect discourse and the interior monologue. The origin of the psychological novel is open to debate because the term has numerous interpretations. Some scholars assume that the genre dates back to the beginnings of the novel itself, while others declare that the genre began as a form of influence by multiple sources ranging from Miguel de Cervantes' *Don Quixote* (1605, 1615) to genres such as the historical Romance, the sentimental novel, the epistolary novel, and the spiritual autobiography. Scheuinger (1998) asserts that this concentration on the internal workings of the psyche became especially prominent in 18th-century epistolary novels. This form was linked to English literature by Samuel Richardson. He first used this method in his novel, *Pamela* (1740), as a means to elaborate on the character's inner life. Other figures like George Eliot, Henry

James, Virginia Woolf, and William Faulkner were all marked as pivotal in the development of the psychological novel in Britain and America.

Furthermore, what made the psychological novel more prominent in the 20th century was the official alliance between the fields of literature and psychology in a critical form, which is known as psychoanalysis, which was established by Sigmund Freud. Freud's psychoanalysis is regarded as the cornerstone of psychological theories in the literature. After his theory, various other psychological approaches that belonged to renowned psychiatrists in that era were applied in literature, like Holland's, Lacan's, and Jung's. Holland(1990) names the end of the 19th century is the official date on which psychological criticism came to light, to design experimental, clinical, or scientific psychology far away from the aesthetic and philosophical assertions about the nature of humans. Since then, psychological critique has generally relied on three psychologies: psychoanalysis (Freudian), archetypal (or analytic or Jungian), and cognitive psychology.

Adopting psychological theory to investigate the literary text makes it smoother for the critics and readers to understand the mindset of those mental characters without leaving exclamations inside the readers' heads about the characters' impulses and behaviors or without creating a fabricated analysis that may cross the essence of the text or the scientific reality of the human mind. Moreover, Guerin et al.(2005) assert that psychological inquiry may uncover most of the symbolic and thematic obscurities within the text. Emir (2016) adds the focus of the psychology-based study of literature is mainly on determining how the social environment affects the feelings, ideas, and actions of the characters in a story or novel.

Throughout the 20th century, there were countless writers who dealt with the issue of mental illnesses; among them was the American poet Sylvia Plath (1932-1963). Poetry foundation (N.D) asserts that Plath was a powerful poet of the 20<sup>th</sup>. Her literature is regarded as a record of her sorrows, deep passion, and preoccupation with death. Plath's poems are highly autobiographical, exposing her own mental torture, her tumultuous marriage, her unsolved problems with her parents, and her own self-image.

Though Plath is a poet, she has one novel, *The Bell Jar*, Which is a semi-autobiographical novel published in 1963, a month before her death. It recounts the story of Esther Greenwood, a young lady dealing with severe depression who eventually ends up in an asylum after her endeavor of committing suicide. Innes (1984) explains that Esther is a college student, a skilled writer, and a winner of a fashion magazine contest. She is a highly-educated, semi-liberated, emerging intellectual and a sexually confused late adolescent. Finally, she is mentally ill. Esther is from New England. She moves to New York City soon before her senior year of college and works as an apprentice for a fashion magazine. The year is 1953, before the birth control pill became widespread, before women's liberation, and before any of the 1960s' main social movements. Esther Greenwood has excelled in her academic pursuits and received awards for her writing. Her future, however, as well as her feminine role, remains unclear to her.

Esther's uncertainty about her role in life resembles that of Plath. In fact, most of the plots in the novel are paralleled with Plath's real-life experiences, her work in New York for a magazine, her battle with depression, her rejection from a writing course, her suicide, her shock treatment, and finally, her ambivalence caused by the social and cultural pressure. Gill (2008) explains that readers must be aware of both the specific and personal pressures Plath faced as a young woman at Smith University, as well as the ideals of the time, in order to fully comprehend her experience, especially in terms of how these ideals framed success as a student and as a young lady. During this whole phase, her letters and *Journal* entries reveal the strains on young women to be involved in relationships but remain chaste, to study hard and enjoy. Women were subjected to competing and sometimes incompatible pressures to be both intelligent and appealing, to be self-assured and obedient, to be top achievers while acknowledging that their greatest accomplishments would be marriage, children, and home.

Essentially, American women were divided into two groups: good girls and bad girls. The good girls have stable mirage life, raising two to five children. They maintained lovely homes, made decent, healthy, and cost-effective meals, attended PTA meetings, and were generally responsible wives. The bad girls, on the other hand, were sexy, bosomy, and most often blonde, and they didn't get any chance to marry decent attorneys, physicians, or politicians. Then there was a bunch of ladies who were not actually looked at as women at all; they were the ostracized half of women; the spinsters, librarians, social workers, and old maid school teachers were among them. These smart women did not fit into the previous categories because they did not seek male attention. They were doomed by society. As a result, the good girls and bad girls were classed and characterized based on their interactions with men and society rather than their own personalities, abilities, and achievements (Innes, 1984).

A further limitation is the choice of profession. Most jobs and other activities were classified as male or female in the 1950s. Women from the middle class were permitted to join college in the 1950s but not to be scholars, and there were still a lot of male-dominated majors at the university level. Women made up less than one-fourth of college faculty in the United States, and they were confined to a few fields. As a result, the constraints were quite real. These limits irritated many women who had big dreams that would lead them outside the home (McCann, 2012). Many prominent critics welcome it as a powerful American novel that provides a voice to women who are often voiceless. Feminist reviewers have viewed the work as a forceful condemnation of women's suppression in the 1950s, as well as a representation of one woman's battle to establish control over her life within such

a society (Bloom, 2009). Through her novel, Plath dares to challenge the American system that relegates women to stereotypes and does not stop there; she delivers a powerful commentary on the tragic consequences of this social pressure on women and manifests it through Esther's mental breakdown. After her attempt of suicide, the plot shifts to Esther's psychiatric therapy, in which she is thrown into clinics and asylums. Indeed, Plath gives her readers a full, dimensional vision of what it is really like to be a mental patient inside closed asylums. Moreover, she demonstrates the struggles of those people who have depression. She conveys their misery to the whole world.

Hence, the core of the study focuses on investigating depression, its nature, its reasons, and its destructive consequences, specifically among women. Thus, to have a closer look at depressed women, the study employs a novel that features a female as the main character and investigates the reasons that lead women to develop depression and how depression can control their thoughts and behaviors. Going through the reasons that lead women to develop depression, the study raises crucial issues related to the various forms of social injustice which women deal with and how they are locked in patterns of stereotypes against their will. Additionally, employing an up-to-date psychological technique to study a literary work opens new avenues for psychological analysis in the literary field that go beyond the conventional and overused methods employed by literary critics. It provides literary scholars, especially those who are interested in interdisciplinary fields and psychological analysis, a new possibility of inquiry that tackles the subject scientifically without pivoting from the essence of the text. The paper's originality lies in using *The Bell Jar* in accordance with Beck's model. This helps to give a fresh look to the narratives that have never been presented before and extend the themes included within these texts, which serves to be a helpful source for further studies. The process of analysis is devoted to studying two stages; the first one is to illustrate the maladaptive cognitions and actions of the depressed character and the second stage is recovery.

## 2. Literature Review

*The Bell Jar* has been studied extensively, and each of the following mentioned studies has presented an illustration of different sides of the novel using multiple methods, including psychological ones; however, the current study is the first to study the theme of depression in the novel, using Beck's cognitive model as a means of analysis, which is the gap that it tends to fulfill, and this signifies the originality of the present study. Beck's cognitive model studies depression and how it is formed in the mind of depressed patients. Beck provides three key concepts in his approach, which are: the schema, cognitive triad, and cognitive errors. By applying these concepts to analyze the three novels, they facilitate bringing to the surface a reasonable elaboration of the character's lines of thinking and disoriented behaviors.

The first study that had written about the novel was by Renée Dowbniaa (2014). The study makes an effort to contextualize a food analysis in 1950s women's magazine advertisements and Sylvia Plath's *The Bell Jar*. The symbolic richness of food is especially evident in the work of female writers, whose diverse social positions and expectations result in a variety of complicated connections with food. The major aim behind choosing the theme of food is to present an in-depth analysis of the cultural dynamics driving women's consumerism, attitudes about their bodies, and conceptions of self-fulfillment in the 1950s. The second study is by Marilyn Boyer (2004). This article utilizes a mixture of feminist and disability studies to analyze the mind/body relationship, or more specifically, its disconnection, highlighted by the theoretical ideas of Julia Kristeva and Jacques Lacan.

Another study about *The Bell Jar* is conducted by Cliffs Notes(1984), titled *Plath's The Bell Jar*, which discusses Plath's life, gives an introduction to the novel along with a full-scale explanation of the plot's summary and characters, with a special concentration on the themes of suicide and death. There is also a paper by Susan Coyle (1984). The paper concentrates on the metaphors that are represented in the novel and show how these metaphors are connected to Esther's mental health, suicide attempt, and rebirth. One of the reviews written about the novel by Courtney Kratz (2019). It attempts to study the novel depending on Sandra Gilbert's approach in *Mad Woman In The Attic*. It explains how the novel articulates the struggle for female literary authority. Kratz attains that Plath demonstrates how claiming one's voice through narration is critical for women writing against patriarchal socialization, which is intensified when women are denied access to written means of expression.

Last but not least, there is a study by Kate Harding (2019). It tends to focus on cases of sexual and gendered violence perpetrated against and around Esther and how, in the context of 1953 New York and New England, these experiences specifically penalize her by stripping her of any aspirations to masculine autonomy, reinforcing her femininity, and defining it as a source of suffering and weakness.

## 3. Method

Dr. Aaron T. Beck is widely regarded as the father of Cognitive Behavior Therapy (CBT) and one of the world's foremost psychopathology investigators. He is acknowledged for helping to shape the character of American psychiatry, and American psychologists named him "one of the five most influential psychotherapists of all time." Dr. Beck's early research with depressed patients prompted him to establish a better explanation of depression, one that emphasized underlying negative ideas connected with loss and failure. Dr. Beck's patients revealed spontaneous, unpleasant ideas, which he later referred to as "automatic thoughts." He analyzed his patients' automatic thoughts and cognitive distortions collaboratively. He discovered that his patients' beliefs

about a situation influenced their behavior more than the situation itself, a concept he labeled the "cognitive model." He assisted his patients in changing the way they saw things and engaging in more adaptive behaviors, which made them feel well. He also helped them to confront underlying maladaptive assumptions about themselves, others, the world, and the future (Beck Institute CBT, 2022).

Beck's (1967) cognitive model of depression was the first well-articulated concept of a particular condition, and it continues to be quite effective nowadays. It suggests that the early loss promotes the creation of long-term cognitive structures, making the individual more exposed to depression in the future. As such, a person's depression is predisposed to basic beliefs gained from early experience and associated with conditional assumptions. Notably, depression is triggered by events that challenge basic beliefs and contradict underlying assumptions. The system (the schema), once triggered, colors the process and content of thinking in such a manner that it fosters low mood and other depressive symptoms (Bennett-Levy et al., 2004). To define the psychological basis of depression, the cognitive model proposes three distinct concepts: first, schema; second, the cognitive triad; third, cognitive errors (incorrect processing of information) (Beck et al., 1979).

To understand the whole model of depression, Beck defines each component individually. The first part of the model is the schema. In cognitive theory, confusing thinking grows when an underlying maladaptive schema is triggered by environmental variables. A schema is a framework that is employed to screen, code, and evaluate impinging stimuli. Thus, the schema's role here is to direct the premises that are utilized to make sense of the information delivered from the surrounding environment. They are formed as a result of frequent observations of cause-and-effect linkages and teachings about the nature of the universe. Maladaptive schemas are stated as conclusions about cause-and-effect connections that are based on incorrect information or insufficient testing. They can have a significant negative impact (Wright & Beck, 1983).

The second unit is the cognitive triad which is made up of three key cognitive processes that cause the patients to have a specific perspective of themselves, their future, and their experiences. The first unit is centered on the individuals' negative perception of themselves. They perceive themselves to be imperfect, insufficient, diseased, or deprived. They are always apt to ascribe their appalling experiences to a moral, psychological or physical defect in themselves. They keep criticizing themselves and look down upon themselves because they deem that this flaw inside them causes them to be worthless and undesirable. Finally, they are certain that they miss the key factors that provide them with happiness and satisfaction. The second element of the cognitive triad is the depressed people's inability to interpret the experiences they positively face in their life. They perceive the world as placing unreasonable expectations on them and imposing tremendous barriers to achieving their life goals. In this case, the patients cannot think of less negative alternative explanations. The third part of the triad is the patients' distorted view of the future. When sad people draw long-term projections, they predict their current problems or sorrows are endless. They always anticipate the worse, and they will likely end up living in hardships, frustrations, and deprivation (Beck et al., 1979).

These anticipations are the automatic thoughts that are generally referred to as the third concept of the model and are the faulty information processing. These systemic mistakes are wrapped up around the patients' belief in the plausibility of their incorrect assumptions, despite the presence of positive substitutes. They include:

1. Arbitrary interference means the process of forming unrealistic conclusions without having any evidence.
2. Selective abstraction which is concentrating on an out-of-context detail, neglecting other important aspects of the scenario, and conceiving the entire experience based on this fragment.
3. Overgeneralization, is the practice of forming a general rule or conclusion based on one or more isolated instances and then extending the notion to similar and unconnected circumstances.
4. Magnification and minimization refer to evaluative flaws that are sufficiently severe that they cause distortions. Underestimation of an individual's performance, success, or aptitude, as well as the exaggeration of the enormity of their issues and duties, were all signs of these processes.
5. Personalization which alludes to the patients' tendency to connect external events to themselves when there is no justification for doing so.
6. Absolutistic thinking that is seen in the inclination to classify all events into one of two categories, for instance, saint or sinner, perfect or flawed. The patients choose the most severe, unfavorable category when defining themselves (Beck et al., 1979).

The symptoms attributed to depression that occurs consequently lead to the construction of the three units of the model ( schema, cognitive triad, automatic thoughts) are separated into categories; each one of them leads to the other; more accurately, they have an effective interchangeable relationship. These categories include: Emotional Manifestations; some of the symptoms that fall under this category are negative feelings toward self, reduction in gratification, distortion of body image, and crying spells. The second category is cognitive manifestations which involve low self-evaluation, negative expectations, and indecisiveness. The third group is named motivational manifestations, and it involves symptoms like paralysis of the will, withdrawal wishes, suicidal wishes,

and increased dependency. Lastly, vegetative and physical manifestations consist of loss of appetite, sleep disturbance, loss of libido, and fatigability (Beck & Alford, 2009).

Thereafter elaborating on the theoretical part of the model, Beck follows his discussion by giving a panoramic image of cognitive therapy CT (Cognitive therapy). Cognitive therapy is a series of processes oriented toward a patient's cognitions (verbal or visual) as well as the dysfunctional premises, beliefs, and attitudes that underlay these cognitions (Beck, 1970). In the 1960s and 1970s, Aaron Beck created a type of psychotherapy that he called "cognitive therapy," a word that is now sometimes used as a synonym with "cognitive behavior therapy"(CBT) (As cited in J. Beck, 2021). Both are widely used interchangeably to represent cognitive-model-based psychotherapies. The term CBT is often employed to allude to a series of approaches that combine a cognitive approach and a set of behavioral procedures (As cited in Knapp & Beck, 2008). Based on cognitive theory, cognitive therapy aims to change individuals' distinctive, maladaptive ideation. The fundamental cognitive method identifies individuals' misconceptions, distortions, and maladaptive beliefs and puts their validity and reasonableness to the test. Therefore, patients can articulate their experiences more genuinely by giving up their persistent and distorted thoughts (Beck, 1970).

The distinction between cognitive and behavioral strategies in CT therapies is purely informative, as many of the techniques alter both the patient's mental processes and behavioral patterns. Cognitive change leads to behavioral change and vice versa. Depending on the cognitive profile of the condition, the period of therapy, and the unique cognitive conceptualization of a given case, a variety of approaches may be applied. Behavioral approaches may be more effective in situations of severe depression when the patients' behavioral activation is needed. When the activity level of chronic and severely depressed individuals is lowered, they are hesitant to devote themselves to any objective state because they have low expectations for their successes. Otherwise, when the patients do not require predominantly behavioral stimulation, more purely cognitively directed techniques may be performed (Knapp & Beck, 2008).

As Beck points out, it is critical to create a healthy working relationship with the patients first and foremost to accomplish the therapeutic process in the right manner; this therapeutic procedure is called collaborative empiricism. The patients and therapist should build a team-like collaboration to assess the patients' beliefs, test them to determine whether they are valid, and adjust them based on reality. Second, the therapists follow what Beck calls guided discovery; the therapists use Socratic Questioning to lead the patients through a thoughtful questioning process that allows them to gain insight into their erroneous thinking (Knapp & Beck, 2008). The cognitive method entails dissecting depressive syndrome into its many components. The therapists may theoretically begin by addressing any of the symptoms: emotional, motivational, cognitive, behavioral, or physiological, and target their efforts on resolving that particular symptom cluster. Because each of the components of depression interacts with the others, it's reasonable to assume that improving one issue area will lead to improvements in others (Beck, 1976).

Because depressed patients are usually confused, worried, and distracted, the therapists assist the patients in putting a system in place and teaching them specific techniques to organize their minds and behavior so that they may resume their normal activities. During the process of therapy, the therapists provide the patients to be actively engaged in the journey of their treatment. Beck asserts that if the patients take the lead in their therapy, they will be more engulfed with the morass of their unrealistic thoughts (Beck et al., 1979). Finally, after applying the appropriate techniques to treat the patient, Beck asserts that to have an adequate evaluation of the patient's improvements, the psychiatrist must check the patient's changes in affect, motivation, cognition, and physiological functions (sleep and appetite) with their overall behavior (Beck, 1976).

#### 4. Analysis

*The Bell Jar* is told from the perspective of its heroine, Esther Greenwood. In the opening, the readers learn nothing about the character except that she resides in New York. However, the reader will undoubtedly realize that something is wrong with this persona. She starts her narration by saying, "I didn't know what I was doing in New York" (Plath, 1971, 1). She manifests to the readers that she feels a sense of loss. This fulfills the first part of the cognitive triad, which is, according to Beck, perceiving one's experience negatively. Depressed patients view their involvement in their surroundings as disparagement (Beck & Alford, 2009). Then the story starts to unfold itself; Esther is a 19 years college girl. She is in New York for a month working for a fashion magazine as a guest editor:

They gave us jobs in New York for a month, expenses paid, and piles and piles of free bonuses, like ballet tickets and passes to fashion shows and hair stylings at a famous expensive salon, and chances to meet successful people in the field of our desire and advice about what to do with our particular complexion (P. 3).

While reading these words, one might think that Esther is living a charming life "I was supposed to be the envy of thousands of other college girls just like me all over America" (p.2). She is a well-read and aspiring lady, and before coming to New York, she had high expectations for herself and dreamed of accomplishing prosperity. Nevertheless, Esther is not enjoying this experience whatsoever. She believes that she is wasting her time for nothing (Bloom, 2009). In fact, Esther's high hopes clashed with what she experienced in New York, as she perceived it as trivial to what she was planning for. All she is doing now is "just bumped from my



hotel to work and to parties and from parties to my hotel and back to work like a numb trolleybus" (p.3). she is stuck in a place where she is controlled like a puppet, unable to fulfill her progress as an educated, successful writer. Brain (2019) explains that she starts to diminish her level of aspirations and wishes to fit a feminine size "Only I wasn't steering anything, not even myself." (p. 3). Beck states that depressed patients are significantly sensitive to anything that may stand in the way of their goals. Any kind of obstacle the patients may find in their way takes it as a fiasco, which finally ends up interpreting the whole experience in a negative way (Beck& Alford, 2009).

However, Esther's experience is not completely negative; there is a positive side. The character of Jay Cee, Esther's boss at the magazine. She is the kind of work and knowledgeable woman. "Jay Cee had brains, so her plug-ugly looks didn't seem to matter; she read a couple of languages and knew all the quality writers in the business" (p.7). Jay Cee is the only one who pays great attention to directing Esther in the right way, yet Esther can not comprehend anything anymore. "Jay Cee wanted to teach me something" she further exposes that "Jay Cee took me to lunch with a famous poet." (p.32). "You can learn a lot in this month on the magazine; you know if you just roll up your shirtsleeves. The girl who was here before you didn't bother with any of the fashion-show stuff. She went straight from this office on to *Time*." (p.38). Jay Cee is trying to convince Esther that it is a transitional phase, but in vain; Esther has already doomed herself to failure. She has distorted cognition, referred to by Beck as faulty information processing. Esther is experiencing what is called a selective abstraction which is one side of the situation lies to be the center of attention while excluding its other aspects; she tends to highlight the negative and ignores the remains (Knapp& Beck, 2008). She is judging Jay Cee to be part of her negative experience in New York.

Esther disfavors herself, and thus she poorly describes herself "I was skinny as a boy and barely rippled." (9). She recurrently depicts herself negatively, "I looked yellow as a Chinaman"(p. 9). "I felt myself melting into the shadows"(p.12). Low self-esteem is a common symptom of depression. Depressed patients' patterns of self-evaluation appear to include self-devaluation, which forms a part of a pattern in which depressed individuals see themselves as lacking such traits that are significant to them as capability, productivity, intelligence, health, strength, physical beauty, popularity, or financial resources (Beck& Alford, 2009). Bit by bit Esther starts to show signs of depression in her behaviors. Having negative perspectives toward herself and her experience begin to cause her a slow reduction of interest in social activities; as Beck and Alford (2009) point out, a typical symptom of depression is a desire to break out from the regular pattern or routine of life. Depressed people see their responsibilities as tedious, useless, or heavy, and the desire to escape to a relaxing or calming pastime:

But that I would not go to Coney Island either; I would stay in bed. After Doreen left, I wondered why I couldn't go the whole way doing what I should anymore. This made me sad and tired. Then I wondered why I couldn't go the whole way doing what I shouldn't, the way Doreen did, and this made me even sadder and more tired (P. 35).

Esther is now starting to act indecisively about her scholarly future. She becomes increasingly disoriented and insecure. Before this moment, she was a successful young woman who constantly achieved excellent scores. She is a college correspondent for the town *Gazette* and editor of the literary magazine. She had always been a bright person, destined for great things, but her future now appears hazy and unclear. She has been fighting for success, anticipating for herself to be a poet or a professor, but at the present moment, she thinks that her accomplishments would be in vain (Bloom, 2009) "What do you have in mind after you graduate?" "I don't know," I heard myself say. I felt a deep shock, hearing myself say that." (p. 38). Depressive symptoms such as difficulty in making judgments, vacillating between options, and altering decisions are predominantly motivational and are linked to will paralysis. Patients lack the drive to do the mental activities that are necessary to reach a decision (Beck & Alford, 2009). In fact, Esther's motivation drops low when she arrives in New York because everything around her is below her expectations. She believes that her opportunity to fulfill her dreams is slipping away from her "and now I was apprenticed to the best editor on an intellectual fashion magazine, and what did I do but balk and balk like a dull cart horse?" (p.38).

These thoughts come as a result of her sensation of being inadequate; her shock of the New York experience grows inside her the belief that she will fail, and she starts to imagine herself as a loser "I felt dreadfully inadequate" (p. 91). Since she is incapable of success, then she cannot reach anywhere in the future; she will always be surrounded by failure "The one thing I was good at was winning scholarships and prizes, and that era was coming to an end" (p. 91). Notably, Esther is developing the third component of the cognitive triad, which Beck calls negative expectations about the future. Pessimism and negative outlooks are linked to emotions of hopelessness and poor self-esteem. Depressed patients see the future in which their current state of deficiency (financial, social, and physical) will persist or worsen (Beck& Alford, 2009). Esther is throwing away all her accomplishments and concentrating on her only time of experiencing failure; she is unable to see any positive side of her experience or think of the possibility of adjusting to this situation in the future; the only thing she is doing now is condemning herself. In fact, this situation reflects the cognitive distortions she is having. By calling herself inadequate, she is forming the automatic thought of what Knapp and Beck(2008) call labeling, which means imposing a broad, harsh label on oneself instead of labeling the individual event or action.

While going through the story, readers will notice that Esther keeps mentioning a fig tree quit often. The symbol of the fig tree is one of the vital symbols in the novel. She pictures her life choices as branches of a fig tree "I saw my life branching out before me like the green fig tree. One fig was a husband and a happy home and children, and another fig was a famous poet, and another fig was a brilliant professor, and another fig was Ee Gee, the amazing editor" (p. 91). Each branch represents a distinct feminine position, and she is unable to choose just one. As a result, she is concerned that they will all shrivel and fall from the tree before she can determine which one to pick. She can't reconcile her academic achievements with the role of the feminine creature that her society desires her to be (Inness, 1984).

Esther's time in New York now is about to end, and her low mood is clearly increasing because she spends her whole month wondering aimlessly from one social occasion to another without figuring out what to do with her professional career; she does express this disappointment through crying while visiting the magazine for the last time "I could feel the tears brimming and sloshing in me like water in a glass that is unsteady and too full" (p.121). There is a higher tendency for depressed patients to cry or weep. Stimuli or circumstances that would not normally evoke tears in the patient may suddenly do so (Beck& Alford, 2009). In this particular situation, Esther is reinforcing her helplessness and hopelessness; she is tied and unable to act and end this miserable situation. When she thinks that things cannot get worse than this, the unexpected happens, the oppression set upon her is now turning to be physical, and she experiences a rape attempt. Brain(2019) states that Esther and her contemporaries' feminine limitations are maintained – both figuratively and practically – throughout the story by progressively brutal punishments for the characters, ranging from physical sickness to attempted rape to electric shock therapy and death. These boundaries deprive her of her wish for any independence, which establishes her femininity to be as a source of sorrow and fragility. Here, the researcher suggests that Plath wants to manifest that when women give up their wishes in life and live by society's standards, they will face terrible consequences that will eventually threaten and destroy their lives, their bodies, and their mental state.

Though the first nine chapters are dedicated to recounting Esther's time in New York, Plath includes something more significant within these chapters. She narrates the reasons why Esther developed depression in the first place. One may think that Esther's depression starts when she arrives in New York, but this is not the complete truth. Through the use of flash backs and stream of consciousness, Esther demonstrates the fact that she has already had what Beck calls the predisposition of depression or schemas. Wright and Beck (1983) demonstrate that depression is distinguished by the activation of primitive negative schemas, which results in a selective negative bias in interpreting experiences. These schemas, which are normally latent, are awakened by unpleasant events, biological changes, or both. What has created the negative schemas inside Esther's mind is the death of her father. She lost him at the age of eight. This loss left a huge emptiness inside Esther's soul. "My German-speaking father, dead since I was nine" (p. 39). "I thought how strange it had never occurred to me before that I was only purely happy until I was nine years old." (p. 88).

Therefore, Esther finds her only solace in life is writing as a way of liberating herself from the past, and she makes her decision clear to be a poet "I said I wanted to be a poet" (p. 122). Because Esther stands as a representation of Sylvia, in fact, Plath personally confessed this truth in one of her recorded interviews:

I think I was happy up to the age of about nine, very carefree, and believed in magic which influenced me a good bit. And then, at nine, I was rather disillusioned; I stopped believing in elves and Santa Claus and all these little beneficent powers and became more realistic and depressed, and then gradually began to become more adjusted about the age of 16 and 17. But I certainly did not have adolescence, and perhaps that's partly why I turned especially to writing (The Narrative Art, 2021).

Beck states that a perceived or actual loss is one of the chief causes of depression (Beck et al., 1979). This leads to the conclusion that Esther's depression is based on unresolved childhood grief, which entails an unwillingness to accept the truth of a loss (Shulman, 1998). Depending on a study that has been conducted by Beck on a total of 297 patients, it was shown that those who were extremely depressed had a much greater likelihood of parental death (Beck and Alford 196). Therefore, Esther's loss of her father left her shocked and depressed, and the only way to escape these negative feelings was through writing. Shulman (1998) stresses that Sylvia grew preoccupied with accomplishments soon after her father's death, and she found that writing was her finest outlet for authentic self-expression.

Thus, when she arrives in New York, her depression becomes worse because she feels that her only solace in life is about to be taken away from her. Bad things do not stop here; after coming back home, her mother informs her that her application for a writing course has been rejected "All through June, the writing course had stretched before me like a bright, safe bridge over the dull gulf of the summer. Now I saw it totter and dissolve"(p.140). Esther watches her last bit of hope dissolve in front of her eyes and cannot do anything to fix it. As a consequence, her depression turns to a serious level. "I couldn't see the point of getting up. I had nothing to look forward to" (p.144). Esther is showing symptoms of paralysis of the will. A prominent aspect of depression is the loss of positive motivation. Patients may struggle to mobilize themselves to accomplish even the most basic and essential tasks, such as eating (Beck& Alford, 2009). Esther is consumed, out of motivation, and possessed by depression. Eventually, she

loses even her ability to sleep and eat. Fisiak (2011) asserts that she loses control over herself on several levels; seemingly, her body and mind no longer work together. Finally, she loses the only thing she is good at, which is reading and writing. This proves that Esther is on the edge of severe mental collapse. Beck et al. (1979) reveal that extremely depressed patients are trapped in a vicious cycle in which their diminished level of activity pushes them to label themselves as ineffective. This labeling, in turn, results in increased discouragement and eventually to a condition of immobility. They, therefore, have difficulty performing intellectual functions.

In a desperate attempt, Esther's mother takes her daughter to see a psychiatrist named Doctor Gordon. In the beginning, Esther has high hopes that Doctor Gordon will help her. Yet, the moment she sees him, she immediately understands she is wrong "I hated him the minute I walked in through the door." (p.159). Dr. Gordon, who represents the patriarchal power of the medical establishment, seems unconcerned by Esther's complaints. He seldom ever speaks to her. She continues to see him despite the fact that she believes the visits do nothing to heal her. Instead, she starts to show signs of obsession with death and begins to gather suicide articles (Bloom, 2009). In fact, Esther's thoughts of death and suicide are not recent. Through her flashbacks, one can notice her preoccupation with death vividly, even before heading to New York. In one of her flashbacks with Buddy Wilard, whom she went skiing and broke her leg, and instead of feeling hurt, she commented:

The interior voice nagging me not to be a fool- to save my skin and take off my skis and walk down, camouflaged by the scrub pines bordering the slope- fled like a disconsolate mosquito. The thought that I might kill myself formed in my mind coolly as a tree or a flower (p.117).

This is the second proof that Esther has the schema of depression before settling in New York. Regarding suicide, Beck and Alford (2009) assert that suicidal thoughts in patients might manifest themselves in a variety of ways. It might emerge as a passive wish ("I wish I were dead"); an activity wish ("I want to kill myself"); as persistent, obsessive thinking devoid of volition; as a daydream; or as a carefully devised plan. Suicidal thoughts may occur in certain individuals throughout the course of the disorder, and the patients may have to fight them off on a daily basis. Esther's thoughts of suicide are the kind of obsessive and persistent, but without taking any serious action.

Nevertheless, Esther does not take any action toward suicide until she undergoes electroshock therapy by order from Dr. Gordon, who takes this decision without any effort to understand his patient. This experience of therapy is brutal and inhuman "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" (p 178). When reading these words, one can understand the agony which Esther is feeling. After this situation, Esther's obsession with death has increased, and her depression is now at its highest level. She starts to hallucinate, which is seeing things that do not exist; she thinks she glances at the figure of her dead father "I could feel the tears start to spurt from the screwed-up nozzles of my eyes. 'It's my father'" (p.186). Through his study of hallucination in depressed patients, Beck declares that seeing the figure of a dead person is one of the sample of the types of hallucinations (Beck& Alford, 2009). Therefore, after two attempts of suicide, she finally reaches the best plan to end her life. Yet, before she does, she goes for unfinished business. She visits the grave of her father in order to have the last moment with him as a kind of final closure:

My mother hadn't let us come to his funeral because we were only children then, so the graveyard and even his death had always seemed unreal to me. I have had a great yearning lately to pay my father back for all the years of neglect and start tending his grave. I had always been my father's favourite, and it seemed fitting I should take on mourning my mother had never bothered with (p. 207).

Esther did not only lose her father, but she could not mourn his loss or express her agony. Instead, this pain of loss grows up with her until it becomes an illness that consumes her soul. After this visit, she commits suicide and leaves her mother a note that she is going for a long walk, hides in the basement, and swallows loads of pills. Esther's hunt for death represents her desire for rebirth (Bloom, 2009). She needs to escape her fated reality, and death is the only way that can assure this for her. Esther's wish of death is not fulfilled, as she rather awakens in a hospital, being hopeless and desperate that there has been no change, and this renders her even more paranoid. She finds herself trapped in another place she does not want to be in, dragged from one hospital to another, and constantly thinking of a plan to escape, "I've got to get out of here" (p. 226). She is depressed and held in a mental asylum against her will. It is like she is trapped under a bell jar, isolated from the whole world, living her own misery without knowing a way out:

If Mrs. Guinea had given me a ticket to Europe, or a round-the-world cruise, it wouldn't have made one scrap of difference to me because wherever I sat—on the deck of a ship or at a street cafe in Paris or Bangkok—I would be sitting under the same glass bell jar, stewing in my own sour air (p. 233).

After being locked up, she now realizes the importance of freedom; thus, when they give her privileges to engage in certain activities, she begins to actually have a good time, which is something she cannot feel for a long time, "OT and walks and badminton

matches and even the weekly movies, which I enjoyed" (p. 243). It is the first time Esther pronounces the word enjoy, which signifies she is at the beginning of recovery. In fact, this is a helpful way of therapy, and Beck (1976) calls it Scheduling Activities. Since the patient perceives himself/herself to be unproductive, it is essentially important to make them active in order to see themselves as possibly more effective and needful. An activity schedule aids the patient in organizing his day. It is important, too, to employ a range of motivators, such as the idea that being more active can help him feel better. Therefore, the first sign of recovery she shows is regaining her ability to sleep and eat.

The second step of recovery happens when Esther's psychiatrist prevents visitors from her. Esther is quite glad of this decision "I hated these visits because I kept feeling the visitors measuring my fat and stringy hair against what I had been and what they wanted me to be" (p.255). In fact, Esther is cutting off people who do not contribute to her wellness. She begins to regain leadership over her life, starting with her relationships with people. As Beck (1976) clarifies, despite the fact that the process of healing is based on cognitive change, it is critical to address a range of symptoms, including those that are primarily emotional or motivational in nature. People are one of the reasons for Esther's depressive emotions; she cannot find anyone who is trustworthy to support her and help her to recover. For this reason, she excludes them from her life. Bloom (2009) mentions that the visits make her feel less valuable and make her hyper-aware of her current position. She believes she is being judged and regarded in terms of the all-American girl she used to be, which is another way she feels compelled to adhere to a cultural ideal. Esther prioritizes herself over others.

As a consequence, Esther grows more decisive, leaving the institution and taking the lead in her recovery. She wants to gain control over her body. While she is out wondering the town, "I had town privileges" (p. 272), she meets a man named Irwin, with whom she has a sexual relationship and loses her virginity. Beck (1976) reveals that if the whole of the depression is to be impacted, the underlying attitude is the component that must be modified. As a result, cognitive modification is the target. Esther's main reason for developing negative cognitions is due to her inability to control her life, her choices, and her body. Therefore, helping herself in the recovery to leave the mental asylum represents her first conscious choice which she is working to fulfill without any hesitation. In consequence, her first step in restoring control over her life and fulfill her resolution is by losing her virginity "my virginity weighed like a millstone around my neck, I had been defending it for five years, and I was sick of it" (p.287).

In the eyes of her society, staying a virgin means being pure, yet the idea of purity for Esther means getting rid of restraints that tire her soul; she needs to regain her sense of self. As Gill (2008) mentions, Esther's loss of virginity is followed by a major bleed in the sex scene. This is a pivotal symbolic moment in Esther's recovery and might be seen as a ritual of purgation. The purgation here means that Ester is regaining her sense of self. After sensing that she is reclaiming control over her life, she begins to get better. Her self-doubt and low self-esteem are, bit by bit, fading away. She makes a huge move from suspecting herself and always trying to be a version rather than herself to meet others' expectations to saying, "I was my own woman"(p.281). Now Esther has a better appreciation of life. Going from having a sarcastic and negative view toward life and people to valuing the simplest details around her:

The sun emerged from its grey shrouds of cloud and shone with summer brilliance on the untouched slopes. Pausing in my work to overlook that pristine expanse, I felt the same profound thrill it gives me to see trees and grassland waist high under flood water—as if the usual order of the world had shifted slightly and entered a new phase. (p.302)

Indeed, a new phase is about to start with Esther. Now she is waiting for the asylum's board decision to wither to leave or to stay. "There ought, I thought, to be a ritual for being born twice—patched, retreaded and approved for the road." (p.309). The novel ends with Esther making her entrance inside the room to meet the board members to hear their refrain. Though Plath left an open ending, the researcher suggests that Esther is completely healed and released from the asylum. In fact, Esther gives a clear sign that in the present time, she is all better, and the bell jar has been lifted "How did I know that someday—at college, in Europe, somewhere, anywhere—the bell jar, with its stifling distortions, wouldn't descend again?"(p.304).

Beck (1976) asserts the accurate evaluation of depression improvement necessitates an examination of changes in mood, motivation, cognition, and physiological functions (sleep and appetite), as well as overt behavior. Throughout the last chapters of the novel, Esther shows significant improvements as she begins to eat and sleep well; positive cognitions start to take place instead of negative ones. For instance, her suicidal tendencies begin to dissolve, and readers notice her describing herself in a way that signifies she is now better; she uses words like "I was perfectly free" (P.306) and "I was my own woman" (p.281). Moreover, her mood is now completely modified; the girl who used to be immobile, gloomy, and unable even to read is now active, paying attention to the way she looks, gives special visits to the library, has a better connection with people; she does not expect anything from any one, and fully motivated. Her motivation sparks when she resolves to leave the asylum and resume her life; therefore, she tries all she can to heal herself. At the end of the novel, she gives some hints about what she is planning to do after she is released from the asylum "But I wasn't getting married" (p. 309). These words signify that she picks her scholarly career over anything else; she is sure now which branch of the fig tree she will hold. This leads to the fact that Esther is now fully equipped to live in her society, but with a new version of herself, the new Esther is the master of her life, her choices, and her future.

## 5. Conclusion

Depression is like a demon that possesses the patients' minds, attacks their thoughts, and disturbs their behaviors. By utilizing Beck's model to study the mindset of the depressed character (Esther) in the selected novel, the analysis can give a more clear picture of the character's thoughts and sometimes unreasonable actions, such as committing suicide after going through what may be called a passing phase. This fulfills Beck's notion that patients' negative thoughts are the prime reason for causing depression more than life experiences. *The Bell Jar* presents an authentic description of depression. Most of the symptoms stated by Beck in his model are depicted in Esther, the novel's heroine. She developed the schema of depression in her childhood due to her father's death; this schema is activated when she arrives in New York, where she is shocked and disappointed because of the pressure of society. Esther is not the kind of a girl who compromises; she is a strong-headed and goal-oriented girl. Therefore, when she fails to direct her life according to her plans, her life goes upside down, and she develops severe depression; she starts to view herself, her life, and her future negatively and desperately until she ends up committing suicide. Plath's aim is to show the world the harmful consequences of creating feminine stereotypes for women and oblige them to follow them. At the same time, the novel portrays how powerful women can be. In spite of all the harsh experiences Esther goes through, she is able to heal herself and stand her ground. The limitations of this study are related to the cognitive theory, which is mistakenly known to be applicable only in linguistic research, not in literary studies. The novel handles multiple key themes; hence, recommendations for further studies:

1. Studying the corruption of the psychiatric field in 1950s America in Sylvia Plath's *The Bell Jar*.
2. Elaborating on the shock of great expectations in Sylvia Plath's *The Bell Jar*.

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