The GAMHAA Ray

AUTUMN/WINTER 2018 ISSUE 3

Life After Trauma

PRESIDENT'S FOREWORD

(CONTENT WARNING: SUICIDE, TRAUMA)

Thank you for picking up the latest installment of The GAMHAA Ray. In response to the recent tragedies on our campus, we've dedicated this issue to talking about trauma care and suicide prevention. Our goal is two-fold: first, to make an incisive yet hopeful contribution to the growing conversation concerning our campus's lack of effective mental health and suicide prevention services; second, to stand witness to the individual and collective trauma we have experienced as a result of losing students, friends, colleagues, and family members.

Though we commend those who have made sincere efforts to address this crisis on our campus, we have been disappointed by our administration's inattention to the cultural and structural issues that contribute to suicide. Suicide is caused not just by individual factors such as genetic/chemical predispositions, but by institutional and structural neglect. We must therefore do more than reach out to those who are in distress—we must commit ourselves to social and economic justice.

As our campus community deliberates ideas like these in the pursuit of a larger "culture of care," we hope to shine some light on the efforts of faculty, students, staff, and members of the larger Columbus community to respond to suicide and trauma in humane ways. Included in this issue are an open letter to President Drake and the Mental Health Task Force, proceedings from Columbus Area Integrated Health Services' 10th Annual Clinical Conference, and an anonymous reflection on the difficulties of caring for ourselves while caring for others.

Sincerely,
Sean Kamperman
President

IN THIS ISSUE OF *THE GAMHAA RAY*

BIANNUAL PUBLICATION OF THE **GRADUATE ASSOCIATION FOR MENTAL HEALTH ACTION AND ADVOCACY (GAMHAA)**

Contact us at: gamhaa.osu@gmail.com

FROM THE AUDIENCE

THE 10TH ANNUAL CAIHS CLINICAL CONFERENCE

BY HILLARY DEGNER AND MELISSA GUADRÓN

On Wednesday, October 10, 2018, the Columbus Area Integrated Health Services' (CAIHS) 10th Annual Clinical Conference convened in the Ohio State Union. We, your dutiful reporters, will provide an overview of the "Interdisciplinary Presentation on Suicide Prevention, Trauma, and Structural Support for Mental Health" panel for those who were unable to attend. Panelists, in alphabetical order, were Lindsay Harper Cannon, PhD. Student, Dept. of English, VP GAMHAA; Appy Frykenberg, Social Justice Engagement Specialist; Dr. David Horn, Professor, Dept. of Comparative Studies; Sidney Jones, PhD. Candidate, Dept. of English; Dr. Dorothy Noyes, Professor, Depts. of English/Comparative Studies; and Dr. Margaret Price, Associate Professor, Dept. of English, Director of Disability Studies Program, the panel chair.

Jones, speaking about suicide prevention, wanted to know how we are to balance personal responsibility and holding structures accountable for their roles in creating mental health crises. According to Dr. Horn, students arrive on campuses such as OSU "inclined to think that the struggles they face in college are to a significant extent playing out within them[selves], rather than the environment they've just entered." Instead of locating the problem of mental health crises in pathologized individuals, Dr. Horn placed it within culture and neoliberalism. Responding to this discussion, one attendee, the father of a son who expressed suicidal thoughts, talked about how race plays a part in gaining access to care. He was hesitant to get help because of the mental illness stigma in the black community; admitting something is wrong and reaching out for help is "something you don't do." He reiterated an earlier point of Jones's—that suicide prevention discourse is white-centered and race needs to be considered in these discussions in order to gain inclusive, accessible knowledge.

The panelists addressed the language used to discuss trauma on campus. An attendee contrasted the suicides on the OSU campus with recent violence in Columbus's inner city. The black community had been traumatized, but the word trauma was not being used. She asked, is the language of trauma a privilege of academics? In response, Dr. Price responded that indeed, even being able to call something a trauma is a privilege, and to the extent that people want that term, it should be used. Anything less is a denial—gaslighting, a violence in and of itself.

Frykenberg acknowledged a similar denial of language for the LGBTQ community, which is increasingly turning away from structural supports in favor of their own communities of care. Frykenberg spoke from personal experience, sharing that even though he encourages LGBTQ students to seek out counseling services on campus, they keep returning to his office. To be treated as a therapist, whether you are one or not, opens the possibility of retraumatization on the part of the person providing care, an assertion that audience members affirmed.

Harper Cannon also discussed retraumatization; "Even though I work within an incredibly supportive and encouraging department...I still manage to feel weirdly re-traumatized by my own scholarship." She likened the rhetorical moves of her dissertation to her attempts as a high school student to convince administrators that even without physical violence, the abuse at home was traumatic. Additionally, this need for recognition was addressed by a current OSU graduate student in attendance who had witnessed one of the suicides earlier in the year. She was upset no one had checked on witnesses. But her question to the panelists concerned verbiage that was bothering her, "why are we still saying that someone fell for the fourth time in the last two years?"

Dr. Price answered this attendee's question by speaking about structural support within the institution. OSU has emphasized the need to create a culture of care; faculty would be expected to check on students and students would check on one another. Dr. Horn suggested that creating an "inclusive, supportive, and vigilant culture of care" should be among our highest

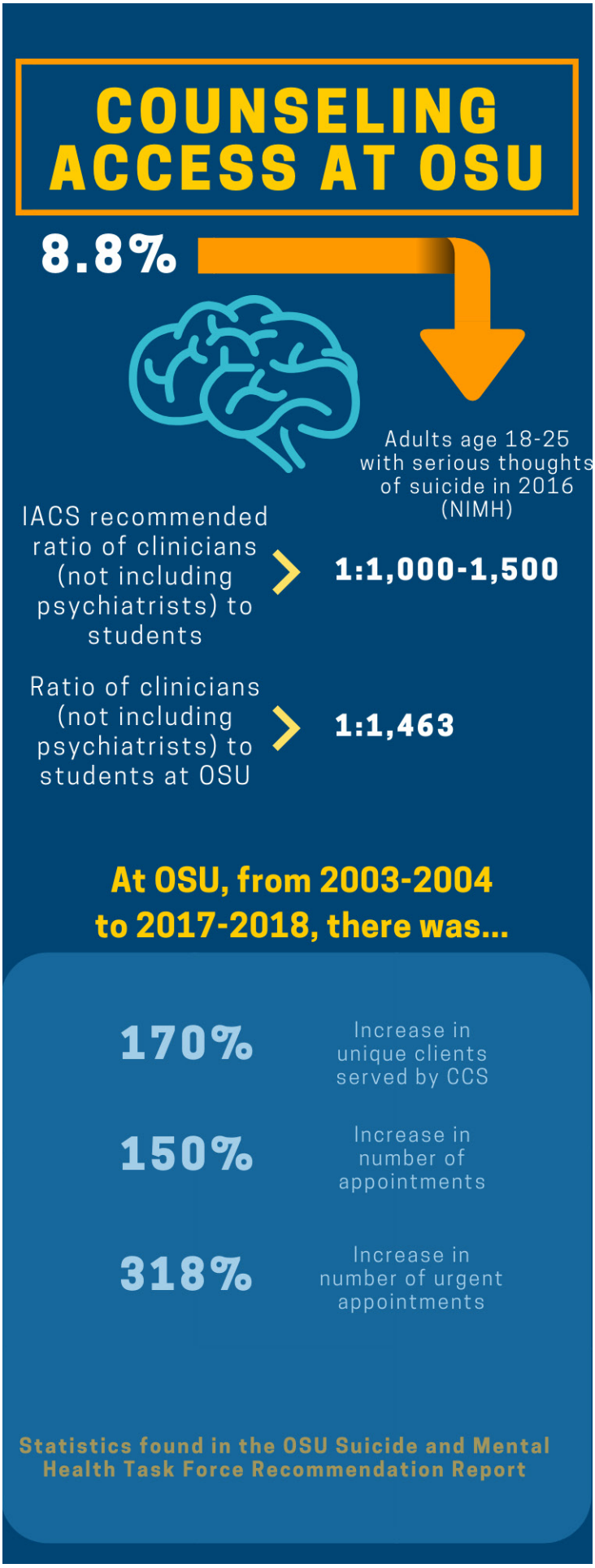
priorities, but it is not as simple as checking on one another. A culture of care needs to take into account resources, infrastructure, and disciplinary practices. Ideally, a culture of care evenly distributes labor; realistically, Dr. Price pointed out, certain individuals become responsible for more than others. Outside of academia, Frykenberg revealed that some clinicians feel unqualified to treat transpeople and instead ask them to go somewhere else. Frykenberg urged clinicians to think about how they are making an inclusive community where LGBTQ people can feel safe. Dr. Noyes discussed on a larger scale the ways in which the United States government failed to react appropriately after a community experienced trauma. Specifically, after Hurricane Katrina, people cared for each other when in ways the government did not. The government's response needed to be more trauma informed and comprehensive so that communities did not need to compensate.

Many attendees were grateful for the diverse voices and points of view of panelists. The construction of the panel was deliberate in this way. We end this article with the hope that in our day to day lives, conference attendees and readers of this issue of the GAMHAA Ray alike can cultivate spaces in which these conversations and activist efforts can continue to create, add to, and sustain both micro- and macro-communities.

SUPPLY AND DEMAND

The Suicide & Mental Health Task Force Recommendation Report makes clear that demand for counseling services at OSU has gone up over the last 10-15 years. While OSU's ratio of clinicians to students falls within the range recommended by the International Association of Counseling Services—just barely—there have been frequent student complaints that the level of access to on-campus counseling services is not what it should be, measured in terms of wait times for services.

Depending on your insurance situation, you may have options besides CCS. Visit osuhealthplan.com/find-a-provider-search/ to search for providers both in and outside Franklin County. The site lets you filter your search by service type, expertise, cultural competency, doctor's gender, doctor's language, and facility type.



GRADUATE STUDENT STORIES

ADJUSTMENTS

BY ANONYMOUS

I know how to sit with someone when they're in pain. I listen, I affirm, I try to tease out what they need right now, and I never doubt what they share. I want to hold them and make it all go away. Instead, I hold them and let them know I know it's there. I started grad school here this fall, and I've already been working those toned muscles in care for a new friend. The feelings are always so shockingly hard, but the cradling of their truths comes easily now.

So it seems strange that I don't always know how to cradle my own truths.

I had to go off of a medication this fall. Not great timing, but these things rarely are. It was brutal. Even with an incredibly slow taper – my psychiatrist wondered aloud if I was just licking the pills toward the end – I was in an almost perpetual state of discomfort, pain, and emotional distress for three months. I say almost perpetual because, in reality, it was unpredictable. One day, I'd feel fine physically but useless emotionally. The next it'd swap. The next I'd feel like I could catch up on everything, cook five dishes, and clean the house, and I'd really try. The next it all piled on again and I couldn't get out of bed.

But this first semester hasn't been overly demanding, and my plethora of privilege gives me a leg up in school. My parents had time to read to me and help me with my homework as a kid, I was placed in magnet programs from 4th grade on, and I didn't have to work on the side to pay for college. I'm in a comfortable place with money these days, and I don't experience any kind of daily microaggressions. In other words, I can wholly focus my attention on school, and I've been trained to do well in it.

So when I had a perpetual migraine for five days this fall, it didn't even show up as a blip on the radar of my academic performance. I spent three of those days in bed, and I got up for the final two to take exams. I got above a 95% on both.
I'm completely off the medication now, and things are more or less back to what they were. Today, I feel normal. No headache, no nausea, no dizziness or sensitivity to light, no inexplicable sense of heartbreak. That is a blessing, and I try to remind myself of that before I forget it altogether.

Because I felt normal yesterday, too, which led me to wonder if it had really been as bad as I made it out to be. Maybe I could have gotten out of bed on those days, taken off the sunglasses, and made it through a conversation, class, or meeting with my advisor without crying. After all, I crushed those tests.

I'm not quite sure why I gaslight myself. It shouldn't be that way. I grew up in a household where mental illness was discussed openly and caringly by necessity. By the time I hit my teens, there were two serious diagnoses in the house, and mine would come just a few years later. Now more than ever, I chat about it easily, without ever questioning its existence. My brother and I gush about our mood stabilizer as naturally as we would Paul Schrader's latest broody thriller.

And yet, this always happens.

I wish I could be a better friend, mentor, dad, sister, colleague to myself, and I wish you could be better to yourself too. Don't fret, my dear. We'll work on it. For now, though, to all of those who are able to be kind to someone when they just can't do it for themselves: May you realize your grace in our lives. We love you. So dearly.

OUTPATIENT MENTAL HEALTH CENTERS

- Center for Eating Disorders & Psychotherapy
- Nationwide Children's Hospital Behavioral Health Centers
- Pathfinder Progress, LLC

OPEN LETTER

TO PRESIDENT DRAKE AND THE MENTAL HEALTH TASK FORCE

BY ALYSSA CHRISMAN, ON BEHALF OF GAMHAA

Dear President Drake and the Mental Health Task Force,

As I write this letter, it is November, an infamous month in academia. It is the week after the time change, and while the extra hour of sleep was welcome, the shorter days take a toll. In addition to balancing multiple GA positions, I feel overwhelmed by the "norms" of graduate school— impending deadlines, pressure to perform, financial stress— as well as by larger adversities— the precarious political state, consistent violence in the news, and, on our campus and beyond, the mental health "crisis." Regardless of these challenges, I love my PhD program and am extremely grateful for my professors and peers because I cannot imagine being here without them. I feel the warmth of their care, from actions such as check-in e-mails to building in time for mindfulness at the beginning of class and meetings. Yet, I worry. I worry that these people who are working hard to make sure those around them are okay may not be doing okay themselves. As a female teacher, I know this experience well.

I chose to begin this letter writing about my own life because I think the stories of how mental health affects individual students at The Ohio State University are essential to tell. Ultimately, though, I am writing as one individual on behalf of the Graduate Association of Mental Health Action and Advocacy (GAMHAA) in response to the recent Mental Health Task Force Report. As a student organization whose purpose is to provide support to and advocate for the needs of OSU graduate students' mental health and wellness, we found it essential that we share our feedback with you.

While we believe that our group and your Task Force have similar missions, we have some disagreements with the recommendations made in the most recent report. As graduate and professional students, we would like our voices to be heard due to our concern about the student representation on the Task Force, which appears to be limited to 4 out of the 11 seats. All of these students have substantial leadership positions, which does not reflect the traditional student experience at OSU, and we are unsure about their stake in or experience with mental illness and suicide.

Our primary concern is with the recommendation to "advance and sustain a culture of care." While we believe that this recommendation is admirable, we are concerned that "culture of care" is ill-defined and wonder what it would look like. Throughout our time on campus, we have heard many stories of people who have needed psychiatric services and have had to wait. While these people may have not been in a "crisis"— i.e., they weren't actively planning suicide— their mental health status was negatively affecting their education and personal lives, and resources were not immediately available for them.

I cannot speak for all of the members of GAMHAA here, but I have personally used and benefitted from a number of the mental health services offered at our university, including individual and group therapy, psychiatry, and wellness coaching. In a way, I am lucky because I knew I would need these services upon the start of my graduate program, but people who are experiencing mental distress for the first time may not have engaged in preventative measures, thus having to wait when services are needed. In your report, you write: "The Task Force was presented with no data that would lead to the conclusion that death by suicide at our

institution is related to problems accessing mental health services at Ohio State. This statement is not meant to imply that there is not more that can and should be done to support mental health services for the students at Ohio State, but rather that it is important to not conflate the issues of mental health access and death by suicide at Ohio State" (9). In the same section, you write that Ohio State needs to promote a culture of care— "one that encourages students to seek help, promotes acceptance and support for those struggling and assists students in finding the appropriate resources to assist them in their recovery" (10). We assert that a true culture of care would be one that makes a serious effort at expanding and improving available campus resources. We have noticed efforts to improve marketing available resources, but we would also like to see a more robust tiered system of care. While some student populations, such as athletes, have dedicated counseling staff, these services are less accessible to the majority of the student body. Advocating for a culture of care that does not take expansion of resources seriously indicates that mental health is not a priority on our campus.

Dedication to a culture of care can be illustrated in other ways as well, such as better outreach to individuals who witnessed or were traumatized by the recent tragedies. During a recent panel we hosted at the Columbus Area Integrated Health Services Conference in the Union, the topic of suicide on campus was addressed. This panel had representation from GAMHAA, graduate students, and faculty— including one member of the Task Force. During the Question and Answer session, discussion about the verbiage of the word "fall" was brought up. One student shared that she had witnessed one of the recent suicides, and she was concerned at how witnesses were treated. She reported that this experience was troubling for her, and in the aftermath witnesses were simply asked to wait and report what they saw. No one asked if they were okay then, nor have they been followed up with. While I did not personally witness one of these events, I was near the Union during one of the suicides this semester and could immediately tell something bad had happened, although I was not sure what. I heard a loud noise, and saw students pointing. Out of fear, I quickly made my way to my car in the Arps Parking Garage, where I was passed by multiple police cars who were blocking off the road. As I walked, I checked my phone for a Buckeye Safety alert. I texted my friends that I did not know what was happening and that I was scared. Later that night, I found out what had happened through a news source, and I returned to campus the next day to find suicide prevention posters haphazardly duct-taped on every level of my parking garage, something I personally found triggering. We understand that reporting of and responding to suicide needs to be handled carefully and recognize that we are not experts in this topic. Ultimately, it is unlikely for any response to be perfect to all, but in the future, a true culture of care would consider the traumatic effect on-campus suicides may have and address those aspects in addition to efforts of prevention.

Our final concern regarding a culture of care is about who the burden may be placed on. In the report's summary, a culture of care "includes faculty proactively reaching out to students; administrators and staff extending their care and time to students in ongoing interactions; and encouraging students to check-in on their friends and peers" (25). Institutional infrastructure is named, but we worry that the burden of care will be unfairly placed on those who already devote considerable labor and efforts to this task: students, faculty/staff (especially female and minority faculty/staff), etc. Additionally, the framing of a culture of care in this way implicitly suggests a relationship where a "well" person is reaching out to a person who is "unwell." In reality, many of the people invested in this labor may not be well themselves—including faculty, staff, and administration. In fact, these people may be best equipped to understand the access needs of others given their personal experience. We want to affirm that the most beneficial culture of care would be one that not only prioritizes infrastructural sup-

ports, but also recognizes the larger picture of university life. Mental health problems are normalized in academic culture. A true culture of care would examine the aspects of university life that are disabling to students and think about education in terms of access. Aspects of academia that are normalized yet so often detrimental to mental health should be analyzed and restructured, such as through using a model of universal design for learning campus wide.

In conclusion, we want to reiterate that we believe this work is necessary and that we understand that different groups will not always agree on the best solution to problems, especially ones as sensitive as suicide. However, we believe that offering you our perspective on a culture of care is important, as a culture of care would be initiated and sustained by everyone together. We hope that you take our feedback seriously as you work to enact the recommendations presented by the Mental Health Task Force. Ultimately, we hope that different stakeholders at OSU, who have similar goals, will all have voices in this matter.

Sincerely,
Alyssa Chrisman, on behalf of The Graduate Association of Mental Health Action and Advocacy

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