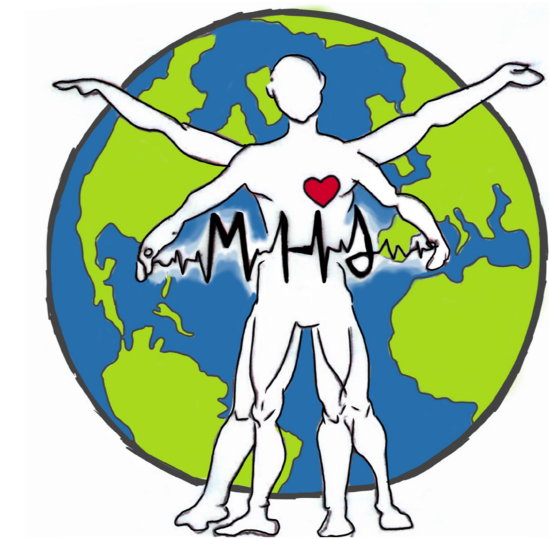




the
Medical Humanities
Journal
of Boston College

ISSUE 7 SPRING '22



The Medical Humanities Journal of Boston College seeks to:

- Initiate and engage in conversation in the Boston College community and beyond about the emergent field of Medical Humanities, Health and Culture.
- Provide students at Boston College with the opportunity to publish original work.
- Feature a variety of work from several disciplines.
- Examine critically and represent creatively ideas of health, illness, caregiving, and medicine.
- Connect students with alumni, professionals, and other Medical Humanities programs to extend and to engage in conversation beyond Boston College.



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CONTRIBUTIONS

To read the journal online or find out more information, please visit us at www.bcmhj.com. Please direct questions or submissions to bc.mhj.1@gmail.com

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I heard someone, somewhere, perhaps online, facetiously lament the fact that they “missed living inprecedented times.” While hilarious, I would like to challenge that statement.

The Medical Humanities Journal devotes itself to telling some of the most heartbreaking, intimate, raw, and personal stories from the Boston College community. We cried reading Thomas O’Rourke’s *Sunset*, chuckled at Sarah Hendren’s *What Can a Body Do?*, and have felt the gut-punch that is *Perfectionism*, submitted by an anonymous author and friend. After two short and two more virtual years at Boston College, I can only maintain that the students here never cease to amaze in every regard. Among the 15,000 minds active in our campus reside only a few stories that we have the privilege to showcase in a journal of reasonable length. The last edition of our journal was published under considerable duress, and I am happy to announce that our return to publication was met with a resounding response from the BC community. As with our recent issues, the journey from submissions to publication had its own set of hardships and pitfalls, but in the spirit of our authors we persevered to give a semblance of voice to some truly remarkable stories. We found them inspiring, and we hope that you do too.

The typical theme of this journal aims to address problems that span the worlds of both healthcare and individual experience: mental illness, identity, aging, and loss, to name a few. Doing so in a global setting rife with injustice seems a task fit for intrepid journalists and not a ragtag team of misfit science majors. From our level, every issue from race to reproduction seems poised to topple the delicate balance of everyday life, and anything from a viral particle to open war has proven itself more than capable of doing so. It really is both a privilege and a curse to publish in such increasingly unprecedented times.

Shifting from pre-Covid stories of healthcare to the overused rhetoric of a “post-pandemic world,” certain aspects were predictably different but a number of themes remained somewhat constant. Irma “Margarita” Velasquez and Patrick Weir remind us of the ever-present need to address mental illness, and Sofia Zinis spotlights the increasing power of the shadowy pharmaceutical industry. Despite reminders of constant problems and voices of new ones, however, the startling triumph of hope throughout these works is as infectious as it is necessary to our current situation. Some of these pieces will unsettle, and others will sadden. They are no less for the faint of heart than those who were bold enough to write them. It is this very boldness, though, that our journal was created to share with the world. The courage and hope woven into the fabric of these pages serves as an ongoing testament to the human spirit, and I personally have found joy sharing these stories through thick and thin these last four years. As such, I am thankful to our authors, to our editing team, and most of all, I am thankful to live in such unprecedented times.

Peter McCarthy
Senior Editor-in-Chief




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Old Mind, New Mind

Gracie Meijer

I have no memories prior to the age of fifteen. Whole vacations, family deaths, personal milestones have been lost in the swirling quagmire that is my mind. My parents will often ask me if I remember something we did together when I was young. For a brief moment, I board the ship and venture deep into my hippocampus. I turn the room in there upside down, ruffling through rows of files and manila folders, trying to find what I'm looking for. I search over, under, and through. I push back curtains, lift blinds, enter doors. Nowhere, not even in the closet where I keep the overflow, the miscellaneous, can I find the picture my parents want me to see. I return to the present, fingers to temples, and let out a heavy, not-this-again sigh. They say, really? You can't even remember that? We spent so much money and time to make that special for you. It's a kind of frustration I can't really describe. It's like putting together a piece of furniture by hand, carefully and lovingly adding each piece, only to realize at the end that it won't hold any weight because you forgot a screw. You're left wondering how you let this happen.

It took me twenty years to finally get help: 30 milligrams of Vyvanse in the morning and 10 milligrams of Adderall in the afternoon was all it took. Starting to take a controlled substance every day when you're my age is a peculiar experience. It's a sweet respite from the old mind I had -- the one that traveled so fast it could've knocked you over if you got too close. It's also like a kind of grieving. I think about all the times I talked over people, all of the times I was late to something important, all of the friends' birthdays I forgot. I think about the late penalties on assignments, the low self-esteem, the memories my parents tried to make with me that I couldn't hold onto because my brain was overbooked. How I must have looked so lazy, so arrogant, so ungrateful. I grow

resentful, even: I wonder how nobody noticed.

My new mind is squeaky clean, polished platinum, a churning producer of steady, coherent thoughts. My new mind holds a place for people so that their voices can be heard instead of mine. My new mind has replaced its sharp electric current with a slow, thoughtful breeze. I feel at home in it. But the sweetest part of it all is the breathless affairs I get to have with my old mind. On the weekends, when I skip my stimulant ritual, I return to it. I take care of it. I keep it warm and dry. I don't ask too much of it. I remind it that there's no one to please. The curtains are closed, the theater is empty; we can simply sit together and reminisce. I forgive it for forgetting what my grandmother's cigarette-smoke hugs felt like. I even forgive it for not telling me it needed help. I say that I know how hard it is to ask for help. And when I leave Old Mind for New Mind, sleepy in bed on Monday mornings, I pull it close and say, "I'll see you on Friday night".



Gracie Meijer is a junior in MCAS studying English and minoring in Medical Humanities, with a concentration in Creative Writing. She is on the pre-health track and will begin paramedic school this June. She is passionate about emergency medicine and the outdoors and hopes to be an ALS ski patroller during her gap year(s). She is known for rewatching old John Mulaney specials for the twentieth time and making her roommates kill spiders for her in the middle of the night.

The Sunset

Thomas O'Rourke

Day turned into night. The sounds of the hospital – the constant droning of the cardiac monitor, call bells, coughing – were all put to rest with the same CD my mom had played after tucking me into bed as a child. The acoustic lullaby I loved so much was now used to comfort my nana as she struggled to fall asleep, uncertain what the next day would bring. Would it be another scan? More radiation? Chemotherapy? I left the hospital every night that summer confident that remission was inevitable. However, this confidence slowly slipped as I watched my once youthful and kind-hearted sixty-nine-year-old nana rapidly decline into a stage IV cancer patient. Each day she aged what seemed to be an entire decade. The glow in her eyes faded as cancer overtook her brain. She was there, but at the same time, she wasn't. Feelings of helplessness turned into frustration as the cardiac monitor played one final, dreadful note. Had my nana's initial coughing fits been investigated further than her doctor's pretext diagnosis of "seasonal allergies," she may have had a fighting chance against her cancer. Now, whenever the sun sets, I'm encompassed not by the fateful hospital lullaby I know so well, but by the presence of my nana guiding me through this game of life.



Thomas O'Rourke (MCAS '23) is studying biology and hopes to attend medical school to become an Army physician after graduating from BC. He wishes to pursue family medicine, where he feels he can have the greatest impact on America's soldiers and their families. Family medicine is unique in the way that it fosters a strong patient-provider relationship and allows for preventive healthcare before disease strikes; both of which are important to Thomas. Outside of the classroom, Thomas volunteers as an EMT with BCEMS, works in the McMenamain laboratory, and is a cadet in Army ROTC. In his free time, he enjoys cooking and spending time outdoors with friends and family.

Perfectionism

Anonymous

Oh, you're just really type A. What does that even mean? You're just really organized, like, wins "Most Organized" during Middle School Superlatives type organized. It's a good thing that you're this way. If anything, it's just healthy perfectionism. Why would caring about your grades so much be a bad thing?

No, that's not quite it.

Google says that perfectionism is "the need to be or to appear perfect, or to even believe that it's possible to achieve perfection. It is typically viewed as a positive trait rather than a flaw."

Yeah, that's definitely not it either.

A few more clicks on Google and you find that it can actually interfere with quality of life or can become an outsized desire to avoid mistakes, errors, and failures that are common. Psychcentral.com says the root of it all is believing your self-worth is based on your achievements, and is often present when there are rigid, high, parental expectations. You find that perfectionists can be self-critical, or at least that's what verywellmind.com thinks.

We're getting there.

It's filling out mazes for fun in the first grade, emphasis on for fun, yet tears stream down your face because you just can't get it right, so you have to erase and erase with the erasers on your \$1 Staples pencils, but the erasers don't work that well so the paper rips along with your 6-year-old heart. Your teacher is definitely going to call your mom to talk about this one later.

It's picking up the violin at age 8, another thing that's supposed to be fun, until there are constant concerts and music festivals and competitions. It's having to repeat the same four measures of "Stairway to Heaven" for an hour until your mom comes in telling you to take a break, before breaking the news that she couldn't tell that the song you were playing was supposed to be "Stairway to Heaven". What utter heartbreak. It's practicing until there are calluses on your fingers and you slam your bow against the wall at least once in frustration. I definitely would not want to be one of the people in that house that's for sure.

By high school, it becomes all about the numbers. Crunching the numbers of what your GPA might be after every single grade. Each number feels crucial, like it's life or death. Studying for hours even if you don't have to, but you know that if you don't, not doing it will lead to sleepless nights worrying about that exam that feels so important. Who's on honor roll? What's the average grade? How many people got a 5 on that AP test, how many APs have you even taken? Spoiler Alert: None of it really mattered that much.

Volleyball games become nerve-wracking (another thing that was meant to be fun), where every missed serve makes you feel like you might as well just ride the bench for the rest of the game and cut the cameras that are filming you for the highlight reel, because why would a coach want someone who can't even serve the ball? Every bad pass, every hit that's out of bounds, all make you feel like a failure.

By college, you leave your family and your hometown but pack your obsession with numbers in your backpack, because how could you go back to school without that, right? It's the same meticulous care for grades, but this time there's tuition and a good

post-grad job on the line. Great. There's even more pressure to not slip up. Every number becomes even more threatening than before. It's all that's on your mind. The numbers drown you, they wear you down, they drag you through the mud, and then, when they aren't validating enough for you, they defeat you.

That exhausting desire for the highest letters on papers and numbers on exams takes its complete reign. No more music, no more volleyball - just school. You edited that paper five times? Maybe you need one more for good measure. Class until 3, lab until 6, homework until maybe 11, maybe 12, some sleep, and finally that 7:30 am alarm to start it all again. It's tiring, and you're starting to get over it, but you can't really get over it because no matter how hard you try to just "go with the flow" or "not let the numbers define you," anything but a good grade ruins your day.

Yep, that sounds about right.



The Merciless Lady

Irma “Margarita” Velazquez

I met this lady once. I was at a Disney Park, Animal Kingdom if I remember correctly, and I was buying two of those ice cream treats that are shaped like Mickey Mouse for my sister and I when I heard someone aggressively demand a cigarette from some distance behind. The scene was quite heavy, so I looked back while waiting for my change and I saw her, this lady, screaming at her daughter. She kept yelling, “I need a cigarette, I need a cigarette, give me one right now” and her daughter was trying her best to calm her without conceding. “You already had one, and cigarettes are not good for you. I’m not giving you one,” she said, but the lady would not listen.

I took the change, grabbed the two treats from the cashier, and politely gave her my best “sorry, thank you.” With my head down, I walked toward the lady and told her, “Don’t worry, let’s go on the fun rides together, it’s okay,” but she did not relinquish her fight. I remember the confusion on her face, brows quizzed together, eyes looking around like she did not know where she was or what was happening. Moments later she came back to her senses, held my hand tight, and walked me to a ride line.

My last encounter with this lady was at my father’s childhood home. I opened the master bedroom door and instantly saw her. She was lying down in a hospital bed—those electric ones that recline up and down—and made no reaction to my arrival. I greeted her, terrified on the inside but keeping my chin up for my family, and walked to her side. I held her hand, lowered myself to meet her gaze, looked her in those empty eyes, and said “hi, it’s Margarita,” but she made no response. Family members came and left to the kitchen to socialize, but I stayed in the room until it was just me. I was alone in there, despite the fact that there were two breathing bodies. I was frightened and heartbroken. The lady, though...

she was there in her full might. She looked strong and victorious, mocking me so as to say, “I won.”

That lady was Alzheimer’s, and slowly but destructively she took my grandmother’s life. Between the first day I met her and this last encounter seven years had trespassed, and seven blue years they were. The first few years, when my sweet grandmother fought her back and resisted, I tried to push her away. I would spend hours with my grandmother, asking her to tell me stories and trying to make her remember minute details, as if that could stop my worst fear from coming true. I was innocently naïve. The less successful I felt, the less time I spent visiting her; I feared what I would encounter if I crept up on the monster that was progressive dementia. Every time I locked eyes with her, part of me broke because while maybe for a millisecond our eyes crossed, she did not see me. And so one day, I found myself sitting next to that reclined bed in my grandmother’s bedroom—a place that had symbolized safety and unwavering love for me all my life—, looking at those glorious eyes and finding no one home. This day I saw it all: nerve connections faltering, brain cells dying one by one, brain shrinking by the minute. I remembered the original symptoms I had not in the moment been alarmed by, like the paranoia and lack of behavioral skills, and realized what they had taken my grandmother to.

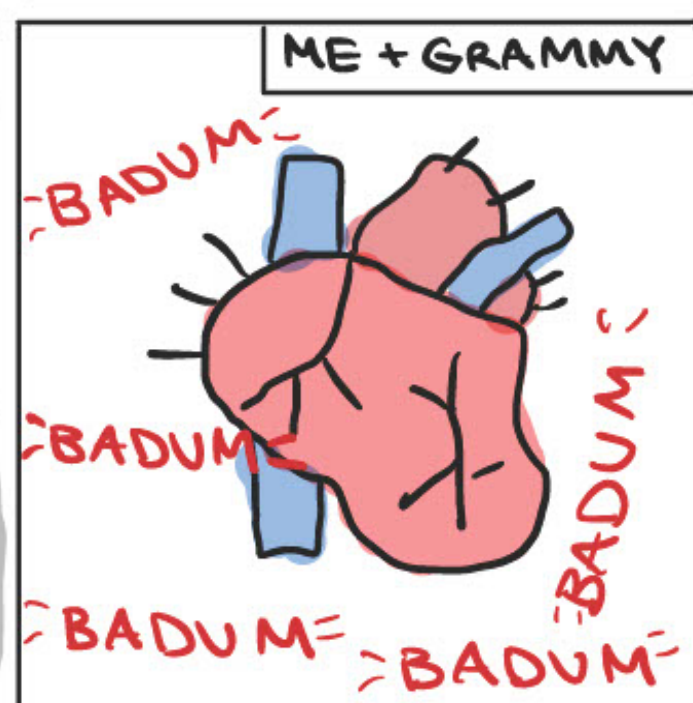
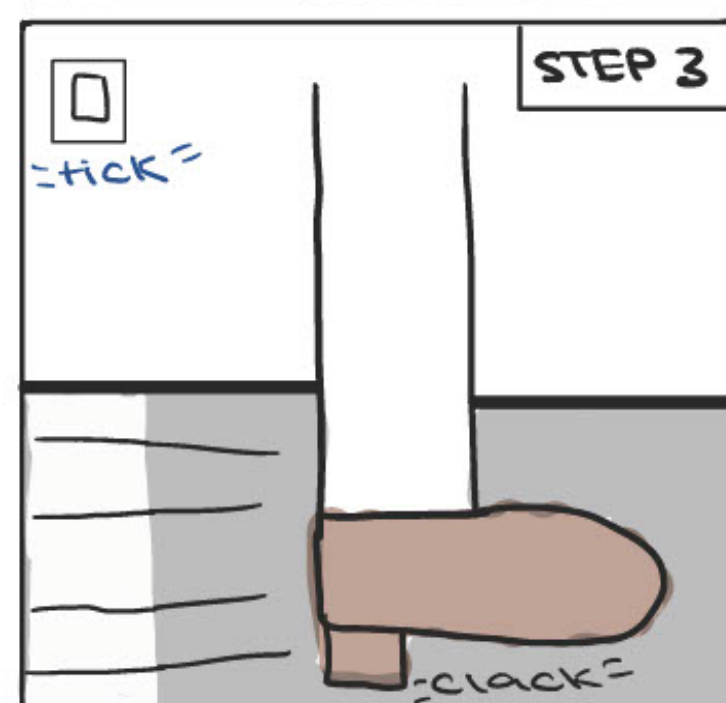
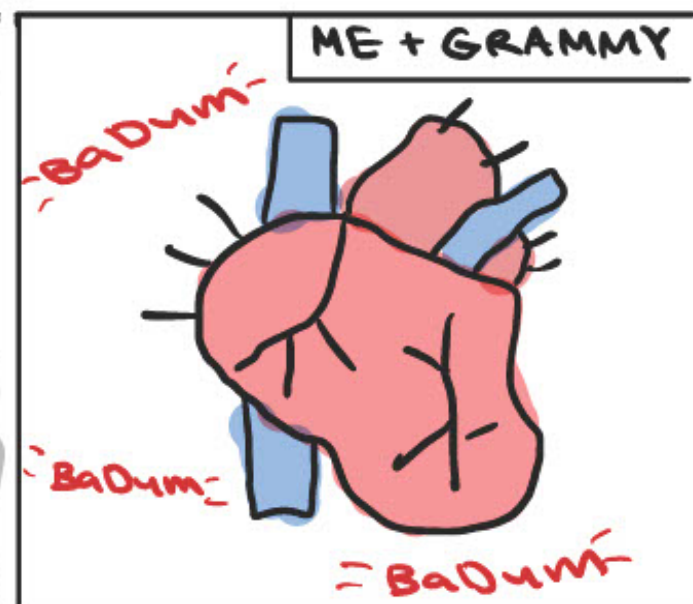
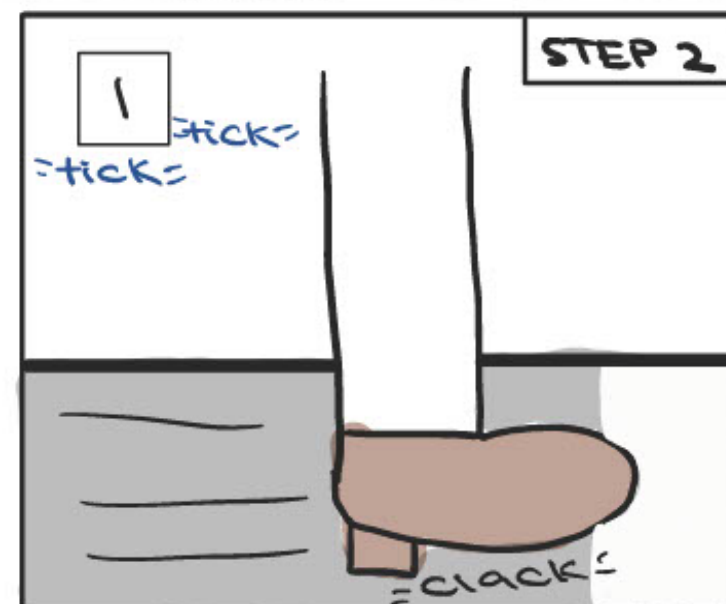
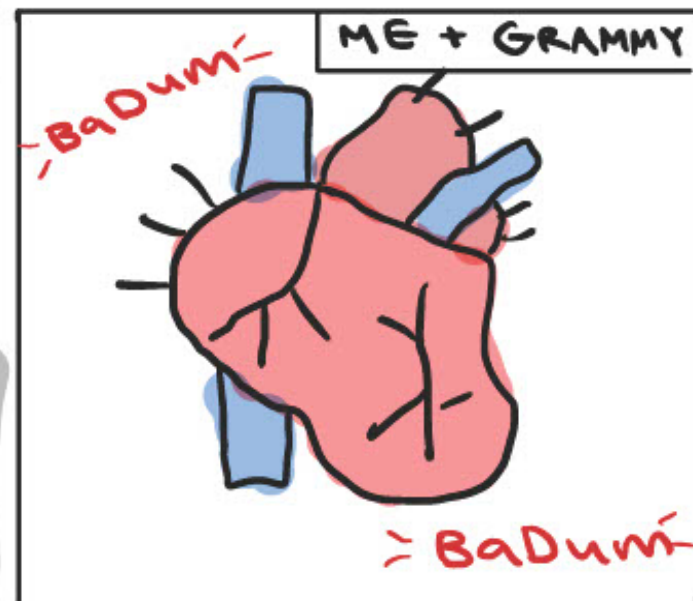
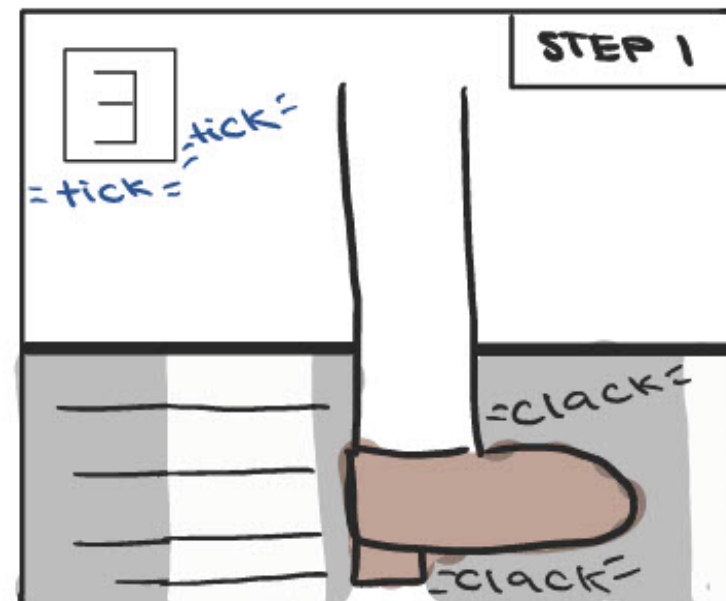
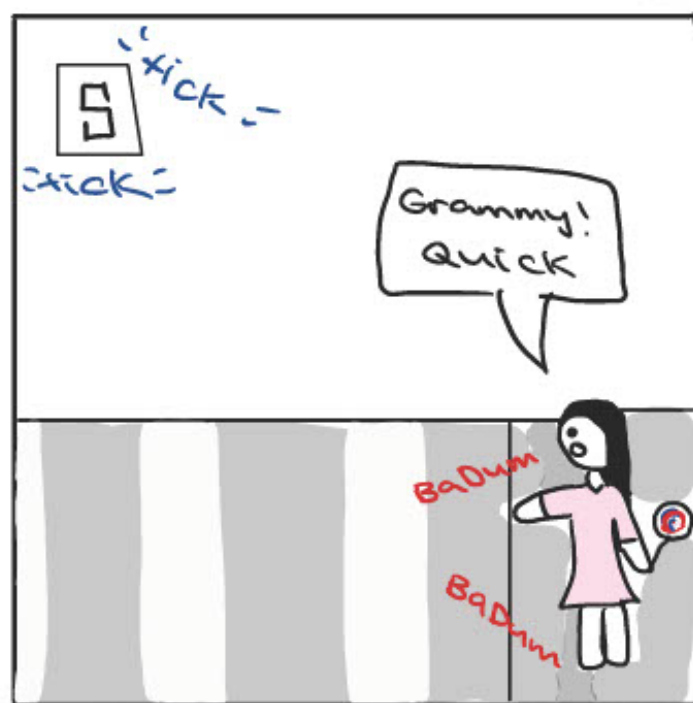
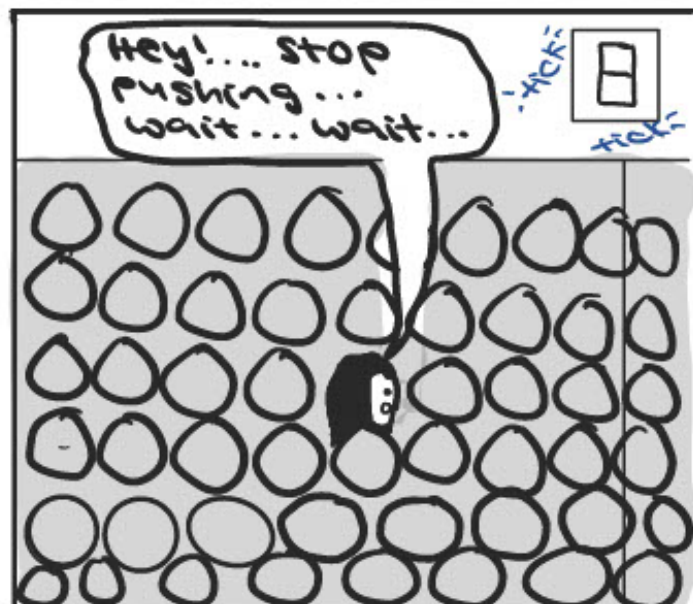
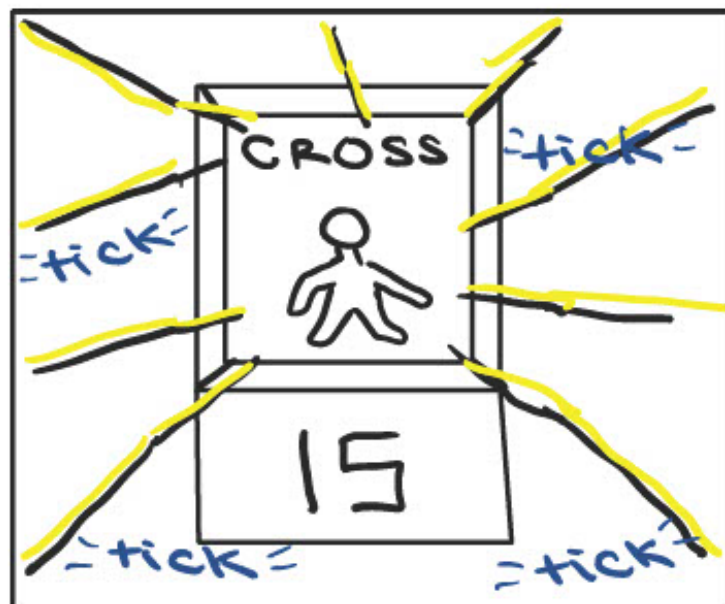
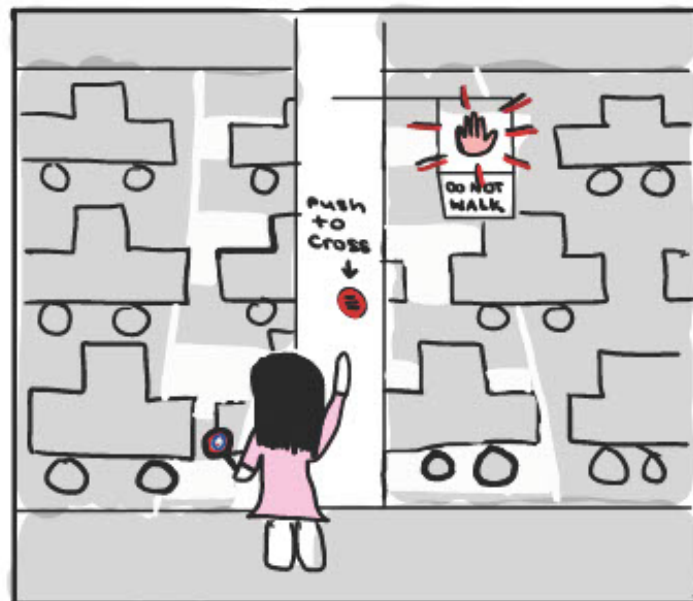
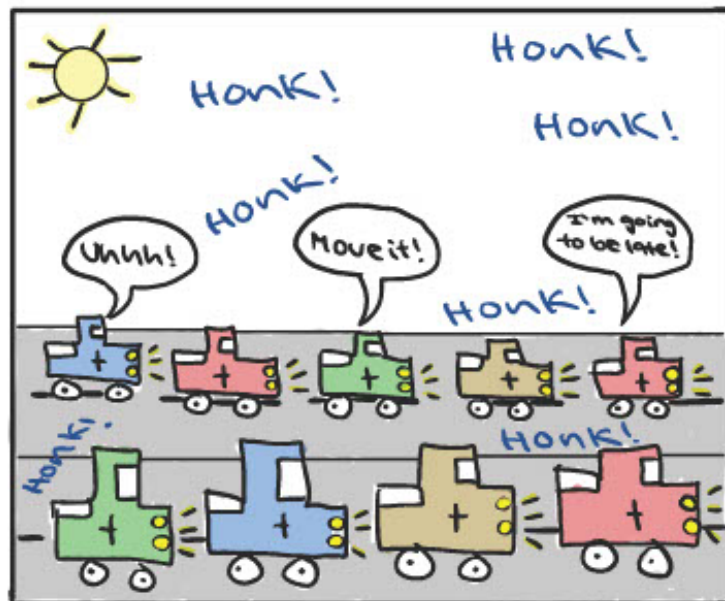
The human body is phenomenal. It’s capable, strong, powerful, and it opens doors for us. Yet in one instant, it can lead us to doom. Cells die, systems fail, signals stop getting transmitted... ladies like the one I met are born and then we become nothing. My grandmother went from not being able to finish a story, to not being able to finish a sentence, to not saying anything at all. She wrestled the thief of minds that is Alzheimer’s until her muscles tired out. She held

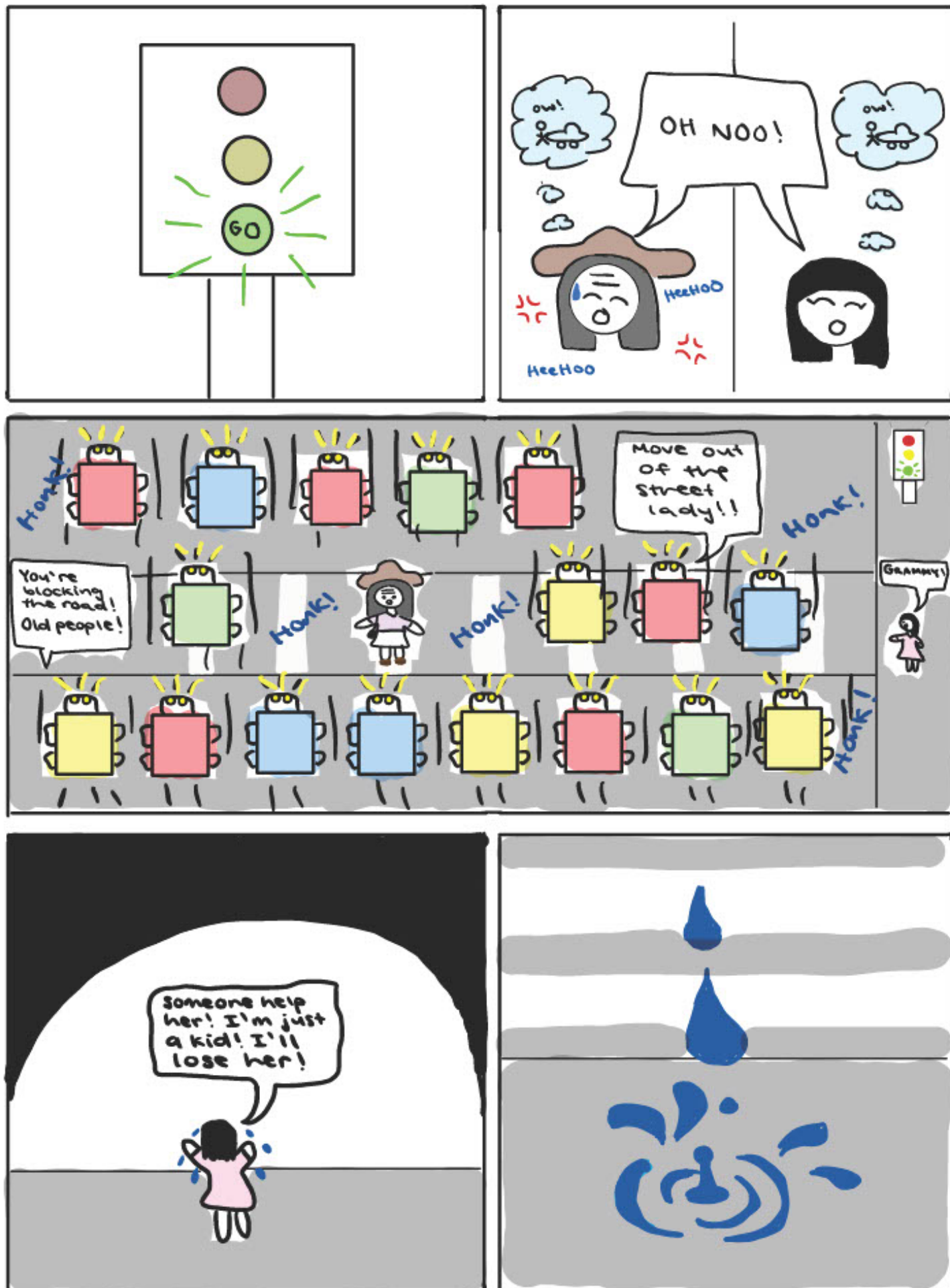
onto me until it was no longer possible, and for that I both thank and salute her. To hold my grandmother’s hand, the sweetest woman I ever knew, and not have her hold it back... that I blame on the lady.

The day after my grandmother died, in the middle of cold and rainy February, the sun came out, the temperature rose, and people were happy on campus. The sweet sound of conversation and laughter filled the cafeteria, the quad, and even the classrooms. I don’t think it’s a coincidence that the two events happened sequentially, and though I am incredibly sad that she had to leave this world so much sooner than I had expected, the clear skies and joyful crowds of this day reminded me of the sweetness of my grandmother and to always approach life like she did, cheerful and lighthearted.



My name is Irma Velázquez—but I go by my middle name, Margarita— and I am a junior in the Morrissey College of Arts and Sciences studying biology and history. I’m from San Juan, Puerto Rico. My special talents are limited but my interests are many; I enjoy being with friends, petting strangers’ dogs, going to the beach, sitting in the lawns on campus on sunny days, reading for fun, spontaneous plans, meeting new people, Harry Potter, baking banana bread for my friends every Sunday, creating cool outfits, hyper fixating on one song and listening to that song only for two weeks, going away to the beach with my friends for the weekend, and hanging out with my grandparents. I aspire to work as a gynecologist in my home country Puerto Rico, but my true goal is empowering women from disadvantaged communities in their bodies and health and ensuring their access to healthcare that is responsive to gender.





The graphic narrative centers around the idea of “misfitting” found in *What Can a Body Do?* by Sarah Hendren. “Misfitting” is the idea that there is a disharmony in the world where the world is not built for certain people and certain people are not made for the world. In my piece, I touched on the idea of how a lot of the structures and technology used in the world, today, were intentionally designed (built) for “normalized” able bodied individuals whereas people with disabilities and even the elderly struggle with the need to adapt. One example of this that I encountered in my life is the tension that comes from crosswalks and crosswalk timers. My grandma has gotten slower with age and it has gotten difficult for her to safely cross the street while keeping up with the ticking time of the crosswalk. I tried to emphasize the anxiety that not only the individual faces in the problem of misfitting, but also the anxiety that their loved ones face as well when they can only focus on the fear of losing a loved one. These built creations that enhance misfitting not only induces anxiety, fear, and possibly trauma by those directly and indirectly affected, but also leaves room for biases and oppression for the marginalized groups in society today (especially pertaining to equal treatment in the healthcare industry).

Whitney Nguyen is majoring in biology with a minor in medical humanities on the premed track. She is from Worcester, MA and comes from a family of five (which includes her mother, Phuong Nguyen, father, Loi Nguyen, sister, Christine Nguyen, and grandmother, Cam Bui). In her free time, she enjoys reading, playing tennis, exploring new restaurants, and playing guitar. Whitney aspires to go into the medical field as a surgeon in order to help low-income communities who do not have access to proper healthcare.

“Reborn”: A Kids See Ghosts Anthem On Healing

Rachel Goldsborough

Dear Rachel,
It's my pleasure to congratulate you on having your piece *Darkness Visible* chosen for publication in the *Medical Humanities Journal of Boston College*! The editorial board is excited to publish your piece. Do you have time to do a quick zoom this week to discuss edits? Looking forward!

I stared in disbelief at the email on my laptop, resting on a table in a classroom at The Ohio State University College of Pharmacy, surrounded by the chatter of other pharmacy students discussing primary prevention of cardiovascular disease. The message came from LinkedIn, from a current student at Boston College, referencing a poem I had submitted over a year ago when I was still immersed in topics surrounding the brain, public health, and the morality of healthcare. My first thought was, *this can't be right*. So I replied: *Thank you so much for reaching out! I had submitted poems last year, and didn't know they could still be considered for future editions. I'd be happy to meet sometime this week or next.*

I remained unable to process this news. I told my friends, who congratulated me; told my roommate, also an avid writer, who exclaimed how proud she was in all caps. I set up a time to meet the editor the next day, after my shift at work. I even made a mental note to reread the poem in preparation.

Two years ago, I wrote *Darkness Visible*, a poem highlighting the experience of one of the hardest and darkest years of mine, and many others', lives. It was one of my original pieces; one of my favorite pieces.

A year ago, I submitted a few poems to the *Medical Humanities Journal* to be considered for publication. While I liked all of them, *Darkness Visible* was the one I was banking on; was hoping would be good enough. To the point that when another piece, *Midnight*, had been chosen instead, I was surprised. At the end of the day, I was elated to have anything of mine be good enough to be published- I was and still am by no means someone that ever thought that writing would become an art form to which I would turn; to purge emotions I could not describe unless through verse and metaphor. By no means did I think I was talented. However, *Darkness Visible* was the one I was most proud of, and wanted seen. Now, here it was- the moment I'd been waiting for. When I got home that evening, I opened up the poem to read it over like I had planned... then immediately closed the document again. I couldn't fathom reading it; couldn't bear what felt like a confrontation.

Because here's the thing: everything has changed.

Two years ago, I was trapped at home in the middle of a new and frightening challenge to public health, our community's health, and my own mental health. I recall the feelings of loneliness; disconnection; uncertainty about everything and what in the world any of my choices meant. In such a confusing time, I felt like I had no power to decide definitively who I was and what my values were. So I went into autopilot. I pushed through the last month or so of class, sitting on my computer for hours staring at slides and lecture videos. Entering the summer, I traded pictures of the brain and computer code for

readings on philosophy and recordings of myself for an online public speaking course. Knowing pharmacy school required the PCAT, I skimmed through a Kaplan test prep book for about a month before masking up in a cramped cubicle for four hours. I spent a lot of time outside, and though at times the Maryland heat made me feel like I was in an oven, it was better than sitting inside with my thoughts (one plus? I got *incredibly* tan).

When we (miraculously) came back to campus, I decided to schedule and take the GRE, because I still had no solid plan. I stared at a five-pound book of practice questions for about a month, then sat in my room to be proctored on camera while doing math completely in my head. I struggled to name hills and valleys on bones, while happily diving into psychopharmacology. My roommates and I still tried to go out, to socialize, to have fun and laugh away our stress. On the surface, considering the circumstances, it all seemed okay.

If you looked closer, things were truly ugly. 2020 was hands down the worst year of my life. Drowning in anxiety and depression, I defined myself with indecision. I didn't know how to act around my friends anymore; didn't know what was and wasn't the right thing to do. Lived in fear of hurting loved ones. Worried about not being good enough. I no longer had faith I was putting my time into the right work or people. The only certainty was that I was so incredibly scared of losing any singular thing I deemed 'good' that I was willing to become only a fraction of myself if it meant I could hold on to *something*.

I ruminated. I cried. I walked for hours at a time. I drowned out thoughts with music. I couldn't stop the trembling in my hands and body. I constantly questioned myself. Everything felt wrong and I couldn't understand why. Even just trying to go through the motions, the road I was on was covered in broken glass.

It was when Thanksgiving rolled around and I saw myself in the photos with my friends that it clicked. Standing there, peering over my friend's shoulder at the phone, I felt my whole body go cold; felt the sound rush out of my ears; felt everyone around me disappear as I stared in horror at my hollowed-out

face.

As it turns out, the reason I thought my roommates were whispering behind my back and exchanging looks when they didn't think I noticed wasn't paranoia on my part at all. They knew I had had an eating disorder, and they thought I had relapsed. They just didn't know how to talk to me about it. I had completely stopped taking care of myself; doing right by myself; and in that moment, I decided to shift back into manual.

When 2020 became 2021, I no longer tolerated being passive. If I wanted to feel like I deserved anything, I needed to take action; and that meant making some of the biggest decisions that, to this day, culminated into a new era for myself. One decision left me heartbroken. Another made me braver. A third made me feel like I had a voice again. Still more helped me practice gratitude for what I already had but couldn't see before. Funnily enough, though, the most important decision I made was not to decide: instead of pursuing one future, I put in the legwork to pursue... options. Electing to be open-minded offered up door after door of possibilities, and in the comfort and freedom of allowing things to be left unknown, I was led straight to an answer I never saw coming: that someone would choose for me.

When I sat down for (the) Ohio State University's interview day, I was somewhat set against pharmacy school. Mental health was a passion of mine, and I felt sure that I needed time to pursue other opportunities that would show me how to make that my life. Pharmacy didn't seem like the (white) coat I wanted to wear, and after years of considering it, I was ready to walk away.

(The) OSU turned me right back around. Despite being on Zoom, the staff's personality and warmth jumped off the screen, and other prospective students left me smiling and laughing, presenting the same kind of humor, values, and opinions on life and the show *New Girl*. The day was flying by and I barely noticed until I got to the final portion: a professional interview with the Associate Dean of Academic Affairs. At the time, I knew nothing about him, and he knew nothing about

me- only my name and a list of questions for me to answer that I needed to use to pitch myself. On a rush from the day and everything I'd been doing the last few months, I animatedly talked to him about my life, feeling like I was in a casual conversation more so than an interview. As we worked through his questions and I gave my responses, I noticed his face changing; reflecting.

Looking at his computer, he asked me, "Do you have any more questions for me? Because I have one more question for you."

I felt a small bit of panic at that, and said I didn't think so. I sat in a moment of silence, anxiously waiting for him to call me out, or somehow find something inauthentic. Instead, he said, "You know, in these interviews, sometimes there's a point at which I realize I need to stop interviewing, and start recruiting."

He then looked directly at me and asked, "How do I get you to come here for pharmacy school?"

I froze; felt my eyes widen. He went on to say that based on what he was hearing, I'd be an asset to the College of Pharmacy, and that I could bring something new to the student body. I was astonished- here it was. Everything I'd done to heal; to make a name for myself. Here was someone who could see it- the work I'd put in to feel like I had the potential to be someone important.

Still on the spot, I blurted out some response I can no longer remember, and he sent me on my way with a final statement that he hoped I would choose Ohio.

And I did. As soon as I ended the phone call accepting the open seat in the Class of 2025, my roommates screamed and rushed over to hug me as I broke down in tears. I remember thinking with overwhelming triumph, I *did* it. Come August of last year, I proudly slipped my arms through my white coat and elbow-bumped the Associate Dean on my way off the stage.

Did I still worry for months before school started that I was making a mistake? Sure. Was I terrified of moving to a new city where I knew *no one* and *nothing* about what it was like to work in a

pharmacy?

Oh yes.

Did I remind myself and find peace in the knowledge that I could always change my mind and figure out another way? Absolutely.

But I haven't had to.

One of my jobs is as a pharmacy intern at OSU's Student Health Services, a role I absolutely love. The day of my meeting to go over my piece, all hell broke loose: prescription after prescription, patient after patient, consultation after consultation; two *different* students coming from the hospital, each with a list of prescriptions the length of a CVS receipt. All the while, myself, the technicians, and the pharmacists behind the scenes struggled to keep up- typing, filling, running insurance, answering the phone, and more.

We dove into hour after hour of chaos, and at one point I heard my supervisor, one of the pharmacists, go, "What is going *on*? This has to be the *weirdest* Friday ever."

Then, in a small lull, I was asked how long I was supposed to stay. The end of my scheduled shift was fast approaching at this point. I hadn't stopped moving since I'd punched in, had barely remembered to drink water, hadn't had time to get coffee, didn't bring food with me, and knew I had another obligation soon.

But I also knew this day wasn't like other days. So I told them I'd be happy to stay.

I left over an hour after I was supposed to, and after assurances that they would be okay without me, I reluctantly packed up my things and rushed out. When I got back, I caught my roommate on her way out. Working on her Master's in Fine Arts, she and I quickly became close friends with a shared love of writing, and have been able to see and appreciate how our personal styles have evolved with time. She asked about my day, and still running on the adrenaline, I excitedly told her what had happened. She looked at me with incredulity, and her response spoke volumes: "You know, if someone else had had the day you'd had, that would have been their breaking point; but the fact that you see that as the

best day of work you've ever had? *That's* how you know you're in the right career."

That wasn't the first time something in my current life had put a smile on my face; made me feel like I was doing something right.

And it certainly won't be the last.



Darkness Visible

Rachel Goldsborough

Fear.

Dark clouds;
A storm
On the Horizon,
Slowly rolling in.

I feel it.
Just a whisper.
A warning.

But,
I feel it.
Rising
From behind.

I stand in a grassy field,
Vibrant green
Beneath my feet.
My face upturned
To the warmth
Of the Sun.

Happiness.
Contentment.
Peace.

All is well.

Eyes closed,
Unable
To see.

But
Suddenly,

Could it be?
I hope not.
Not again.

From among the storm,
A hooded figure
Shrouded in
Darkness.
Footsteps matching
The beat of my Heart.

Closer.
Only
One
Heartbeat
Away.

Right?
But
I feel
Her.

One
Heartbeat
Away.

If I know
This time,
Can I prepare?

I picture
All that is
Good.

Friends.
Family.
The being I name
Divine.

Who am I?
I am smart.
I am strong.
I am resilient.
I am passionate.
I am funny.
I am sweet.
I am loving.
I am giving.

I am Good.
I am Light.

Hope
That I may

Black clouds
Follow Her.
Darker,
Larger,
More terrifying.
She is the Storm.
Her steps
Announce
An ugly Homecoming.

With Her pace.

One
Heartbeat
Away.

Closer.

Closer.

Closer.

Closer.

Closer.

She is only a
Shadow

Bask myself
In Light.
Grab it.
Hold it
Close
To my vulnerable
Heart.
Beating in time

I can do this.
The clouds
Broke
Before.
They will break again.

I can fight.
A mantra,
An affirmation,
Rings powerful:
Hold strong.

Must warn those I love.

I won't be the same.

She'll try to change me.

She will change me.

But I am not Her.

She embodies
Darkness
That cannot
Be Seen
With the Naked Eye.

She hides
The sound of Her feet
Using my heart's
Beat;
Using the very thing

I can feel Her.

She wants to
Destroy.

Still
One
Heartbeat-

We are swallowed
Whole.

Of who I really am.

But I still see
Light.

She grabs my shoulders.
Cold
Washes over me.
Dark
Wraps around me.

The Light
Is shrinking.

I cannot see Her,
But I know Her.

She is Me.
And Together,

A note from the author:

Although I know my taste in music will never be universal, I will proudly stand by Mumford and Son's album Delta as an incredible compilation of art from beginning to end. It is from this album that I was able to find the inspiration for "Darkness Visible" during a visibly dark time. Picture You transitions seamlessly into the song Darkness Visible using only a drum resonating like a heartbeat. In Picture You, the singer confesses to a fear of something unlikable yet familiar on its way, and desperately warns the person he is addressing "you don't know me like this". From here, a drum leads us into Darkness Visible, a mostly instrumental song that leaves so much space for the imagination; to visualize what you will, feel what you will. It is from those few chords; the dips and swells; the quiet murmuring of a passage from Paradise Lost in the background; the consistent, persistent drumbeat; that I try my best to write in verse what I see when I listen.

Darkness Visible is my mural of the onset of depression. The song was my paint, my words were the brushstrokes. I cannot say that when you listen to the song you won't see something different. But I do hope that were you to read my piece and follow along with the song, you'd see where my writing aligns. The way depression seems to creep up on you in a way that you can recognize, but is so subconscious and subtle that you allow yourself to doubt what's happening.

The way you start to panic as the noise of deprecating voices gets louder. The sudden pause of tension as you name what it is you're experiencing.

Then the overwhelming crash and descent into complete darkness that seems to choke off all sense of hope.

Darkness Visible offers no resolution for how we move through depression. It only offers a voice to how beautifully ugly mental illness can be. I only hope that in this writing, those who struggle with their mental health can read, interpret, and understand: the way you feel?

You are not alone.

Affective, Cognitive, and Behavioral Impacts on Decision Making

Christina Farmer

Stigma disrupts society's vital functions such as progress, innovation, and unity. In her essay, "Stigma: An Enigma Demystified," Lerita Coleman-Brown offers a comprehensive examination of the origins and operations of stigma. Her analysis centers around a two-pronged theory: stigma is a response to difference, and carried out by three psychological processes (affect, cognition, and behavior). Affect refers to feelings of dislike or fear of people that are different, cognition plays a role in creating stereotypes about perceived differences, and behavior involves using social control to isolate stigmatized people. These three forces come together to affect how people make decisions to stigmatize others in social situations. However, difference is arbitrary; any trait can be "different" depending on the context. In modern society, people are stigmatized for differences such as race, gender identity, sexual orientation, and disability. The stigma around disability plays an important role in Mitchell Zuckoff's book, *Choosing Naia*. This book tells the true story of Tierney and Greg's decision to have their unborn child after finding out that she has Down syndrome. The first part of the book describes their long and complicated process of making their decision. They approached their situation methodically by gathering as much information as possible from their family, friends, doctors, and counselors. It was a morally complicated choice to make, and they listened to many arguments from each side of the issue. They knew that they could afford to have the baby, but were unsure if they would be capable of taking on the responsibility of having a child with Down Syndrome. Greg's parents are very religious, and urged Tierney and Greg to keep the baby. In contrast, Tierney's family members (George, Tara, and Ernie) were the main proponents of abort-

ing the baby, but they expressed their prejudices toward Down Syndrome in roundabout ways. The second part of the book shows that although Tierney and Greg face challenges as a result of Naia's disability, they are grateful for their decision to have the child. Ultimately, Tierney and Greg's story exemplifies Coleman-Brown's three functions of stigma (affect, cognition, and behavior) in George, Tara, and Ernie's arguments for aborting a child with Down syndrome.

Stigma is driven by affect in the sense that the innate fear of the unknown can cause people to avoid those that are different. People often stigmatize the disabled community in indirect ways because they do not want to admit to their discomfort and fear. For example, Tierney's brother, George, argued that she should choose abortion because the baby would likely die from a heart defect. He told her that she could prevent the inevitable grief by aborting the baby. Later, Tierney's doctor informed her that the baby had a high chance of surviving, proving George's warning to be completely misinformed. George had used exaggerated medical concerns in order to hide his fear of having a niece with Down syndrome. Greg explained George's behavior by reflecting, "people don't want to give up the shield they have from discrimination... And people know that a child with Down syndrome will feel discrimination. And because they don't want to deal with that, people will tend to seek out information that confirms their belief that this is something you shouldn't do" (Zuckoff, 55). George was unwilling to admit that he was afraid of having a niece with Down syndrome, so he found another way to justify the abortion. George let his affect get the best of him, and gave Tierney and Greg advice based on his own fears. Luckily, Tierney and Greg were able to see through his misconceptions, and

did not let his discrimination impact their decision.

Humans have the inherent need to create order in a chaotic world. Unfortunately, this gives rise to the harmful perception of differences, and social categorization. Stigma comes into play when groups of people are stereotyped and socially rejected due to what makes them different. Stereotyped people are treated categorically, rather than individually. There are many hurtful stereotypes associated with Down syndrome, which often result in social isolation. Coleman-Brown notes that this social rejection does not end with the stigmatized individual, but extends to their family, friends, and relatives. Tierney's sister, Tara, voiced a concern for being socially excluded on the basis of having a niece with Down syndrome. She said, "I was wondering how I'm going to feel in public with this child at age two or five or ten...I knew i was going to be called on in some way to support this child, and I was thinking, 'Can I do this?' They were selfish feelings, about how this was going to affect me" (Zuckoff, 56). Tara knew that people would think differently of her when she was in public with her niece. She did not want to face the social repercussions of being associated with a disabled person. This worry motivated Tara to advise Tierney to get an abortion. Tara's reasoning exemplifies that social perception is incredibly important in today's society, and that people with disabilities are categorized in a negative way. Tierney and Greg, again, did not let Tara's personal worries and prejudices affect their decision.

The last, and most apparent method of stigmatization is behavior in the form of social control. Coleman-Brown argues that "stigmatization only occurs when the social control component is imposed, or when the undesired differentness leads to some restriction in physical and social mobility and access to opportunities that allow an individual to develop his or her potential" (155). People behave in ways that keep societal structure in order, thus limiting the opportunity for stigmatized groups to thrive. Tierney's father, Ernie, was blunt with his advice for the baby. He remarked that the "child will cause trauma and tragedy from the first breath" (Zuckoff, 71). Ernie implied that the technology used to detect Down syndrome early in pregnancy exists for the purpose of aborting babies with disabilities. He argued that since they had the knowledge and means to abort, it was their social

responsibility to not burden tax payers by using state resources. In other words, Ernie's solution to discrimination was to rid the world stigmatized people. This pattern of behavior mirrors the eugenics model of social control. In a eugenicist's eyes, people with disabilities should not be allowed to live, or have access to the resources that they need in order to thrive. Tierney and Greg were horrified by Ernie's comments and ultimately motivated to oppose his views.

Tierney and Greg's story perfectly illustrates Coleman-Brown's model of stigma, as George, Tara, and Ernie stigmatized their baby in affective, cognitive, and behavioral ways, respectively. George was afraid of having a niece with a disability, because he did not know how it would affect his future. Tara got caught up in the way people would perceive her as a result of having a niece with Down syndrome. Ernie figured that terminating the pregnancy would be for the greater good of society. In the face of this trifecta of discrimination, Tierney and Greg were able to sort out the prejudice from genuine concern, and decided to have their baby. They realized that the best way to deal with discrimination was to face it head-on, instead of shying away from it. If people with disabilities were not marginalized like they are today, Tierney and Greg would not have found their situation so difficult to navigate. They would not have worried about having a child that would be isolated and unaccommodated. The issue of being ignored goes beyond disability, affecting all marginalized communities. Although a woman should have the right to choose to abort an unwanted pregnancy, the line between abortion and eugenics gets murky when the decision to abort is based on stigma against the child. This is why the stigma against people that do not fit the mold of "normal" must come to an end. In order to eradicate stigma, society must change its ways. Coleman-Brown describes a society without stigma as being a "system in which every member of society is permitted to develop one's talents and experience one's full potential regardless of any particular attribute" (158). Once people can overcome their affective, cognitive, and behavioral urges to stigmatize, we will know an inclusive, cooperative society.

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Christina Farmer is a junior at Boston College, majoring in Neuroscience and minoring in Medical Humanities. She grew up in North Andover, Massachusetts. She hopes to one day get a PhD in Neuroscience, and work as a professor and researcher at a university. She is particularly interested in studying cognitive and learning disabilities, such as autism, dyslexia, and ADHD. Outside of school, Christina enjoys reading, knitting, playing guitar, and hiking with her two dogs, Bear and Scout.

Divided Health: The Negative Effect of Wrongful Mental Illness Stigmatization

Patrick Weir

Imagine someone has a bad back. One day they might wake up and say, "Ow, I need to take it easy today." If they wake up the next day and it is worse, they might say, "Maybe I need to take some medicine today." Should it get any worse, they might say, "Okay, maybe I should go see a doctor about this pain." This is a pretty common train of thought when analyzing someone's physical health. But mental and physical health are wrongfully deemed unequal to the point of mental health stigmatization, which negatively impacts the lives of those with mental illnesses.

Why can't these same self-check questions be applied to mental health? Why can't mental health be prioritized in the same way? Historically, ideal health has been believed to be a perfect equilibrium between oneself and the outside world. Since the introduction of "an ideal human form", societies have focused on prime physical health, failing to acknowledge the equal importance of mental health. But more importantly, societies are responsible for stigmatizing mental health. Those who have suffered from mental health illnesses have been stereotyped, ostracized, and cast off by others for centuries.

Stigma towards mental health arises through the idea that mental illnesses make those who are affected, different from the unaffected. These stigmas cause the general public to build up a wall of fear and caution towards others affected by mental health. Only in the last fifty to sixty years have professional sociologists and psychologists begun publishing analyses, hypotheses, and data on the stigma that surrounds these illnesses. However, stigma drastically causes those affected by mental illness to continuously suffer without an outlet.

While mental health issues and their impact

have become far more popularized by pop culture, media, and news outlets, they can contrastingly cause more stigma. Take last year's award-winning film, *Joker*, as a prime example. Throughout the entire movie, it is very obvious how the general public views a mentally ill individual like Arthur Fleck, played by Joaquin Phoenix. He is regarded as a degenerate of society, with a palpable sense of fear in the air surrounding him. Fear that arises out of ignorance and misunderstanding of mental illness. The film reflects the inability of people to recognize mental health, and in turn, how their polarizing actions cause Arthur to stop taking medication, and embrace the madness. When the horribly traumatic events of Arthur's childhood are revealed, it should become clear to the audience that leaving the mentally ill with no outlet can permanently damage the psyche. In the case of this film, constantly feeling ostracized by society leads Arthur down the path of insanity, which in some ways accurately depicts our reality. In this way, the film raises awareness for mental health illnesses and how they can affect every aspect of one's life. Yet at the same time, it also amplifies the stigma that people have about mental health when Arthur turns violent, reinforcing the false narrative that mental illness always leads to destructive and dangerous behavior. However, it must be understood that this film simply personifies mental health stigma. What matters far more is how stigma occurs in the real world, and the actual effect it has on its victims.

Only 20% of adults with either a diagnosed or self-reported AMI (any mental illness) sought out mental health treatment in the year the illness began (CDC 2012), according to the Center for Disease Control's 2012 *Attitudes Towards Mental Illnesses*.

The CDC claims that the other 80% who did not see a professional did so out of embarrassment and fear of what others will think (CDC 2012). Simply put, the most common reason why people do not access a mental health service is the stigma that surrounds it (CDC 2012). In severe cases of mental illness, people may even permanently fall below the poverty line or commit suicide (CDC 2012). As the stigma seeps into the already suffering brain of the affected person, that individual may find it necessary to bury their symptoms or issues rather than seek help. When it roots itself deeper and deeper, the mental illness only worsens and begins to pollute the persons' entire life.

Some individuals may choose to cope with their illness by engaging in excessive eating or drinking, smoking, or drug use, instead of seeking professional help. In short, these people may adopt self-destructive tendencies as a result of stigmas that hinder their potential recovery. The stigmas cause people with mental health illnesses to feel isolated from the rest of society, even though they are just like anyone else. They eat the same food, breathe the same air, drink the same water, and have the same interests. But the fact that they struggle with anxiety or depression instantly makes them not a normal human? The lack of an outlet, and the continuous reminder that mental health issues make someone inhumane, can cause the person to develop even more life-threatening illnesses.

Craig W. Colton and Ronald W. Manderscheid's studies from 2006 reflect an increased risk of death at younger ages for people with mental illness (Colton & Manderscheid, 2006). The two doctors write in their studies, "In all eight states (tested/recorded), we found that public mental health clients had a higher relative risk of death than the general populations of their states. Deceased public mental health clients had died at much younger ages and lost decades of potential life when compared with their living cohorts nationwide" (Colton & Manderscheid, 2006). The information shows how unjust stigma prevents someone's mental recovery, and in turn, how this can alter any physical recovery or well-being. It should become clear to anyone how an imbalance in mental and physical health leads someone into a damaging spiral, where physical health suffers because of stigmatized mental health. This dependent

relationship between physical and mental health reflects how crucial each is to balancing a person's life.

Even medical professionals have been found guilty of stigmatizing patients with mental health illnesses. According to Christina Pellegrini of the Canadian Medical Association Journal, "patients who seek help for mental health problems report feeling 'patronized, punished or humiliated' in their dealings with health professionals... Discrimination can include negativity about a patient's chance of recovery, misattribution of unrelated complaints to a patient's mental illness, and refusal to treat psychiatric symptoms in a medical setting." This highlights how even at the highest level of healthcare, stigma is still prevalent. Additionally, it shows that those affected by mental health illnesses may not even receive proper treatment for their illness. Furthermore, this demonstrates how mental and physical health are wrongfully regarded as separate ideas, with physical health remaining the top priority.

Pellegrini reveals how Michael Pietrus, the head of an anti-stigma initiative, reported: "a case in which emergency physicians initially failed to investigate a patient's pain symptoms because he had a history of mental illness" (CMAJ). In the most literal sense, this reveals how someone with a mental illness is not treated the same way as someone with a physical ailment. A person with a history of mental illness caused professional doctors to discredit what the person had to say about their physical pain. More importantly, it shows that while the mentally ill may not receive proper psychiatric treatment, the stigma surrounding their illness may prevent physical treatment as well. This should make it easy to recognize how common, and damaging, mental health stigmatization is; from pop culture, to even the medical field. In a statement in the British Medical Journal, Dr. Jim Bolton calls upon medical professionals, and the human race as a whole, to "encourage an integrated biological, psychological, and social view of health care". Bolton asks us to do this by recognizing "our patients as unique individuals, and not as illnesses, it is harder to stereotype and hold stigmatizing attitudes towards mental illness" (BMJ). Bolton's ideas are important because they display a mindset that properly unifies mental and physical health, which can lead people

away from stigmatization.

But even with this guidance, the stigma persists. The stigma surrounding mental health is implicitly built into the minds of those who cannot comprehend what the illnesses actually are. The stigma you build up through news stories, movies, media, or family is what causes that other 80% of the mentally ill to not seek help. Your stigma is what builds that unnecessary wall of fear and caution. The taboo atmosphere that surrounds mental health perfectly represents people's tendency to avoid the unknown, focusing only on their physical health. "You're depressed? Oh, you must be unstable." "You're anxious? Wow, you really can't handle anything on your own, can you?" Discriminatory actions like these lead to the mentally ill convincing themselves that the stigma is justified and that the issue instead lies solely with them.

Like the depths of the ocean, the stigma is dangerous and immense. On the surface of the tide, there are those who put up a front of acceptance, of desire for change. Yet just below remains the polarizing beast. It silently waits, temporarily withholding its ferocious stereotypes and myopic ignorance. It waits for those who courageously make it past the surface, only to be repudiated once again by society. How can the mentally ill be expected to find any willpower to fight their illness, when they are not supported by society? How can we expect the mentally ill to recover when stigma and close-minded individuals make them feel like the problem? How can we expect the world's general health to improve, when we actively suppress and incorrectly label such a large part of it? Without a radical change in the way people view mental health issues, the mentally ill will continue to suffer, crash, burn, and inevitably be forgotten. Stigma is the vice that unnecessarily divides 'health' into two, leaving the mental side of it to eternally drown in false "insignificance".

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My name is Patrick Weir, and I am a current sophomore in the Morrissey College of Arts and Sciences studying Economics with a minor in Finance. I am 19 years old from Orangeburg, New York: a small town just north of New York City. Outside of school, I am a massive sports fan (mostly for the New York Rangers), an avid music listener of every genre, love the outdoors, and especially spending time with my family, friends, and dog, Guinness. As someone who has personally struggled with some of the issues discussed here, I am honored to be sharing this research paper with you all. My goal is to try and raise as much awareness on campus for the wrongful causes and effects of mental health stigmatization as I can.

Globalization and “Big Pharma”: Roles, Relationships, and Testing Within Developing Countries

Sofia Zinis

The choices and methods of actions of large pharmaceutical corporations (“Big Pharma”) can be reviewed in efforts to understand why the clinical drug trials that these companies carry out are overwhelmingly located within developing countries instead of the developed countries that house Big Pharma companies’ headquarters.

Globalization and its Impact on Medicine

As the trend of globalization has developed over time, the way it has transformed the world along with the relationships between states, societies, and populations has developed and changed over time as well. The sphere of influence that globalization has today is constantly growing and extending into new territory. The premise of modern globalization is upheld on an international scale today by two principles: capitalistic market structures and the commodification of goods and services. For capitalism, in terms of economic prosperity and financial potential, the sky's the limit. The theory both requires and enables constant market expansion across all sectors of life. The commodification of materials, services, and anything the human mind can craft is a dominating way for individuals to contend with the constant need for growth that capitalism requires. Transnational corporations (TNCs) are products of capitalistic economies and global markets that allow businesses to continuously grow. They are the mega-businesses that use commodification to their advantage and treat capitalism as their ally in order to achieve economic success. TNCs have control over the majority (if not all) of global markets; medicine and science included.

Thanks to the primary factors of globalization - capitalism and commodification - medicinal cures and breakthroughs that are discovered have developed an additional importance outside of their medical benefits. For pharmaceutical companies, a large part of the motivation for medical successes can be attributed to the financial opportunity they possess.

The competition among pharmaceutical companies has produced top pharmaceutical empires that have spheres of influence that span beyond national borders. The effects that globalization has on the ‘Big Pharma’ industry can be seen in the geographical makeup of these transnational corporations. Pharmaceutical companies are primarily headquartered in developed countries within North America or Europe. Additional research institutions or facilities specific to companies’ specializations are primarily located within these regions as well, depending on the type of pharmaceuticals a company is focused on synthesizing. Overall, pharmaceutical companies have their headquarters and administrative offices along with their synthesis labs and research facilities within nations within the most advanced societies that possess the most high tech equipment or machinery.

Meanwhile, pharmaceutical companies depend on developing countries for the mass reproduction of their medicines as opposed to the scientific creative processes of synthesizing the new compounds. Big Pharma relies on developing countries to provide resources for multiple different processes of drug production. This includes land to build factories

to mass produce and package the drugs as well as plants and ingredients needed for the medicine. The key factors of globalization are what led large pharmaceutical corporations to developing countries in the first place. Pharmaceutical companies see opportunity within the economic, social, and political struggles a developing nation may face and use their conditions to benefit their research. An additional resource pharmaceutical companies utilize within developing countries is the people, often through the borderline exploitation of local impoverished citizens. The vast majority of clinical trials for new drugs companies are looking to get approval for are conducted within developing countries on their citizens. Trials can be conducted in developing countries as well; however, there are a number of factors that pull pharmaceutical companies to developing countries instead.

Why Developing Countries?

There are a number of reasons that large pharmaceutical companies look to developing countries when deciding where to conduct clinical trials for a potential new drug. A common trend that can be identified across all developing countries regarding the overall conditions and state of medical matters can be summarized into this: the relatively low amounts of infrastructure to support necessary medical aid along with lack of funding leads to high numbers of sick populations. These sick populations exist in rural or urban areas and are made up of individuals of all different ages (depending on the disease type and who it affects). The large numbers and groups of people needing all types of medical care provide a prime location for companies to find a sufficient number of infected individuals to complete a successful clinical trial. Companies are likely to find individuals more immediately in need of treatment, which helps improve the efficiency and time period of the trials.

Additionally, the weak economic conditions that most developing states are in along with the poverty levels of the people within these countries is a critical pull factor for corporations. These less-than-ideal conditions allow pharmaceutical companies to come in and perform experiments for significantly

lower costs than if they were to be done within developed countries and regions of the world. As of 2013, The Confederation of Indian Industry made an estimate that “companies save up to 60 percent by undertaking the different phases of testing a new drug in India as compared to developed countries.”¹ Pharmaceutical companies are able to come in and conduct their trials while offering minimal benefits to the governments and populations agreeing to host them. Even if developing nations do offer medical services and treatments that could adequately benefit and care for their citizens, these are rare occurrences. The sparseness of necessary medications, treatments, or other necessary care factors can be due to the lack of funding available to the government to provide such care as well as a lack of funds on the patient end as well.

The types of medical care needed within developing countries differs greatly from the care needed by most medical patients in the developing world. Due to the disparities in medicinal and material resources, diseases and viruses that are not a threat to the populations in developed nations that have been ‘cured’ are still very much a problem for developing countries. For example, diseases like meningitis, HIV/AIDS, or other respiratory infections that children get vaccines for starting at a young age throughout the majority of the Global North are still major threats to populations within the developing world who do not have access to such treatments or do not have the funds to pay for the treatment options that may be available.² People flock to clinical trials out of desperation and hope for any possible treatment that has the potential to cure (or at least help) with their conditions. Sonia Shah, a write and expert on the ethics of drug testing, explained this as follows:

“Under-financed hospitals and clinics gain expertise, funding, and often new equipment when they conduct clinical trials. Patients who lack access to regular care can get treatments otherwise not available to them.”¹

Pharmaceutical companies understand that these patients really have no better options than participating in their studies and clinics, as the potential benefits of the treatment outweigh the

negative possibilities. Pharmaceutical companies and their research teams have the advantage of putting a smaller effort into finding patient candidates when individuals are desperate to seek anything that could help and comes at a low price.

Lastly, the biggest pull factor for clinical trials to be conducted within developing countries is corruption within official domestic institutions (such as government bodies) as well as a lack of legislation and inadequate regulations. Experiments can be done “cheaper and faster, and with less red tape.”³ Due to lacks in regulations protecting citizens from any potential harms they may experience through experimentation, the opportunities and methods open to pharmaceutical companies that may not be legal in the nation states that are home to these companies’ headquarters or potential patient populations. Researchers and doctors can cut corners, cross blurred lines, and tread into gray areas easily, and, more importantly, ‘legally’. Pharmaceutical companies conduct unethical trials in both developed and underdeveloped nations; however, the regulations and complexity of legislation surrounding the rights of patients within each country impacts how closely the trials are monitored and watched. Clinical trials completed in a developed nation with numerous precautionary protective measures in place have less room for error and malpractice in general. Phases of drug trials may be prolonged or experience setbacks due to violations governing authorities may find; whereas absences and gaps in regulations work to pharmaceutical companies’ benefit within developing states.

The same conditions that draw Big Pharma companies towards developing countries for clinical trials are factors that can allow for unethical or illegal trials to be conducted. Unethical trials can be conducted in developed countries too, but developing countries are much more susceptible to being conducted in illegal and unethical ways. An investigation conducted by the Washington Post “into corporate drug experiments in Africa, Asia, Eastern Europe and Latin America reveal[ed] a booming, poorly regulated testing system that is dominated by private interests and that far too often betrays its promises to patients and consumers.”⁴ For

example, over a two year time span, the number of deaths caused by clinical trials in India jumped from 288 deaths in 2008 to 668 deaths in 2010, and this upward trend has continued ever since.⁵ It just so happens that India relaxed its regulations on clinical trials and drug testing in 2005, just 3 years prior. Not all of these trials were conducted in an unethical or harmful manner, however, companies should make it their number one priority to make that number as close to zero as possible. Careful observation of the procedures used in clinical trials has increased exponentially within the last few decades as the universal call to protect human rights has transitioned into becoming a global norm.

Clinical Trials

The Declaration of Helsinki was formed in 1964 by the World Medical Association (WMA) with numerous amendments added on since then. The Declaration outlines ethical norms along with guidelines and ‘rules’ for how clinical trials and research should be conducted by pharmaceutical companies and scientific institutions in an ethical manner.⁶ The document extensively analyzes clinical trial ethics in hopes of reaching the ears of researchers setting out to experiment and research internationally and establish baselines that protect clinical subjects who are citizens of states that may not have the developed legislature to support the human rights of the citizens themselves. Four (of the numerous) key takeaways from the declaration can be summarized as:

1. The research is only justified if there is a reasonable likelihood that the populations in which the research is carried out stand to benefit from the results of the research.
2. Participation in a trial must be voluntary and participants must be informed.
3. Physicians should obtain freely-given informed consent from each participant.
4. Subjects who cannot provide informed consent themselves, for example children, should only be included if the research cannot be performed on other subjects instead.⁷

The declaration contains many more requests and amendments than described above and includes

the desire for transparency within clinical drug trials to be of the utmost importance for pharmaceutical companies conducting research. Unfortunately, more often than not, trials are not conducted under conditions anywhere near those listed above or those that make up the rest of the Declaration of Helsinki. The majority of unethical trials conducted by pharmaceutical companies remain unknown by the rest of the world; as there is no reason for corporations to ever seek to publicize their malpractice. The causal factor of the blanketed nature and secrecy of many clinical trials is a lack of transparency. Transparency within a clinical trial is of the utmost importance, but is most often the first thing forfeited by a company. Trials may not be properly recorded, patients' conditions could be inadequately documented, or failures and costly mistakes in a trial may fail to be included in 'detailed' reports and findings. Just as concerning, these pharmaceutical companies also frequently lack transparency with their test subjects.

The Centre for Research on Multinational Corporations (SOMO) is a Dutch non-profit research organization that observes ecological, economic, and social factors of multinational corporations and their role in sustainable development. SOMO released a detailed report in 2008 regarding a group of pharmaceutical corporations and unethical trials they have conducted fairly recently throughout the developing world. After analyzing and reviewing dozens of cases, author Irene Shipper outlined twenty-two individual cases that drew large amounts of attention around the world. Through the thorough observation over dozens of trials, Shipper concludes that "the lack of voluntary, informed participation and adequately informed consent are probably the most common problems [with ethical trial violations]".⁷ Lacks in the regulation of trials along with the limited transparency of corporations within both their documentation of the trials along with their communication with participants of the studies are two huge reasons that trials conducted by drug companies are deemed unethical.

Pfizer and Trovafloxacin Trials in Nigeria

Pfizer, one of the pharmaceutical supergiants in today's society, was in the process of creating a drug

called Trovafloxacin (Trovan) that, if approved, would have been used to battle a number of sicknesses. The drug could be prescribed for a number of small viruses or low scale sicknesses, but Trovan was created with the intention of combating meningitis. If approved, Trovane would have brought Pfizer over \$1 billion dollars in revenue⁸; so it is safe to say that the company was most definitely seeking to get the drug approved by the FDA for rollout and distribution as soon as possible. The company chose to conduct their trials in the city of Kano, Nigeria where cases of meningitis were rampant during the 1996 meningitis epidemic. Pfizer had 200 Nigerian children who all had intense to severe developments of meningitis to measure the effectiveness of Trovan compared to Ceftriaxone: a well-known treatment for meningitis that has been FDA approved for treatment in adults and children.

Pfizer conducted a first trial on animals to determine any side effects that may ensue. These tests showed "severe side effects, including degenerative joint disease, liver damage, and abnormal bone conditions" in animals. Even knowing this information, Pfizer decided to go on with the drug trials and begin administering the drug to children sick with meningitis. Within the trial, half of the children received Ceftriaxone while the other half received Trovan. It is explicitly stated in the records of the court case *Abudallah vs Pfizer* that this experiment was conducted without the patients' consent or knowledge that they were experiment subjects.⁹ Pfizer offered free treatment, so families believed that they were just getting medical help for their children and had no prior knowledge about the medicine they were being given. Not only did doctors fail to mention that this was an experiment, but the severe side effects that may occur were not addressed. Families and children not only were not aware that they had a 50/50 chance of receiving a medication that had potentially unknown detrimental effects, but receiving experimental medication also had the potential to have no effect on the patient at all; leaving patients in semi-critical condition without medical help at all when an effective and approved medication is readily available. Doctors failed to mention that regulated treatment (Ceftriaxone) was

offered free of charge at a hospital run by Doctors Without Borders nearby.

All of this information that was withheld along with the unethical way Pfizer conducted the trial resulted in 11 children dying and the permanent injuring of dozens of other children with conditions as severe as "paralysis, brain damage or permanent sight or hearing loss"⁸. The causes of these deaths and injuries were vastly due to side effects of Trovan. In a letter documenting his experience with the clinical trials, Dr. Juan Walterspiel notes that:

"Pfizer physicians administered the experimental drug without prior data on its gastro-intestinal absorption in pediatric patients and not knowing whether it would reach sufficient blood and cerebrospinal fluid concentrations in children after oral administration."¹⁰

Pfizer stopped the trials, but found that the low absorption rate of Trovan was limited to children, so still pushed for the drug to be approved for administration to adults. A secret Nigerian government report was conducted in hopes to understand what happened within the clinical trials, which concluded that the pharmaceutical company conducted an "illegal trial of an unregistered drug."⁸ When the results of the clinical trials and the conditions they were conducted under came to light after the Nigerian report was leaked to the Washington Post, Pfizer simply released a statement to the public addressing the issue after seeing the report saying that "Trovan unquestionably saved lives, and Pfizer strongly disagrees with any suggestion that the company conducted its study in an unethical manner."⁸

Results and Reasoning

The information revealed about this Trovan trial through the *Abdullahi* court case makes it a good example to follow. Pfizer is not the only Big Pharma to conduct unethical clinical trials by any means and this case is just one of hundreds of examples that have been exposed just within the last few decades. The decisions made by the company within this incident and the way Pfizer forfeited human rights for their own advancement and relative gain are the same decisions that have been made by numbers of Big

Pharma corporations across countless developing countries.

Pfizer argued that they "conducted this trial with the full knowledge of the Nigerian government and in a responsible way consistent with Nigerian law."⁸ When looking simply at the statistics of the conflict, this may be true. The reason such breaches of ethical practice occur is that pharmaceutical companies are fully aware of the flaws and regulation gaps within developing countries described before and use these to the advantage of the company. In the case of Kano, Nigeria, families of the children who died or were seriously injured tried to seek compensation or relief by bringing cases to court. One group sought to take action in a U.S. court while a second group brought their case to a Nigerian court. While legal action began to develop in New York through the *Abdullahi* case, the *Adamu* case in Nigeria was dismissed by the plaintiffs before it could even properly develop in Nigeria. The group had given up hope of any justice due to "alleged corruption in the Nigerian legal system and the plaintiffs' inability to obtain legal redress in Nigeria."⁹ The victims felt as if the chances of being seen or heard by authorities were so slim that they simply gave up. Luckily, those involved in the *Adamu* case were then incorporated into the *Abdullahi v. Pfizer* case occurring within the U.S.

This goes to show how the corruption and weak governing bodies of most developing countries significantly benefit the pharmaceutical companies coming in. Harmful environments with no repercussions are created, leaving Big Pharma companies to come in and do what they need to do. This avoidable expenditure of human lives for market and monetary gain is a horrible effect of globalization that has plagued these transnational corporations. In fact, it is made very clear that governments not only fully understand the corruption and regulation irregularities within the government branches of developing countries, but they proactively exploit these weaknesses and fuel the already ongoing corruption these nations contain.

The impact of the *Abdullahi v. Pfizer* case would have been significantly smaller if the information revealed in a letter from whistleblower Dr. Juan Walterspiel was not uncovered. The scale of the

corruption could not be properly understood if the information he exposed was not revealed. Dr. Walterspiel had worked for Pfizer during the Trovan clinical trials and knew what was happening in Kano. After raising objections to the methods used by Pfizer within the trials, Walterspiel was terminated from his position. In a letter written to Judge Pauley of the *Abdullahi v. Pfizer*, Walterspiel wrote:

“While the team was in Kano, (8) and (9), with (8) having refused to participate in the study, received a teleconference phone call from (10) reporting that Nigerian officials had shut down the study, needed to be paid off and that the team was under the threat of arrest. A courier with cash was dispatched by the intervention of (9) via KLM through Amsterdam. The study resumed about three days later. The law firm of Millberg Weiss is in possession of an affidavit by (8) in respect to this witnessed phone call concerning US federal subject matter bribing foreign officials.”⁹

An FDA and inspection had to be filed and be started under the suspicion of bribery, which happened to be mysteriously cut short later on. The Nigerian doctors and nurses conducting the experiment realized how illegal and harmful their actions were and only continued because they were paid off by head officials in charge of the trial. A Nigerian physician who was aware of what was occurring within the Trovan clinical trials said he knew what was going on was “a bad thing,” but he decided not to object because it appeared that Pfizer’s trials had been backed by the Nigerian government.

“I could not protest,” said the physician, Amir Imam Yola. “The system you have in America and the system we have here, there is a wide gap. Freedom of speech is still not here.”⁴

Corruption and governmental differences play a role in leading Big Pharma companies (like Pfizer) to conduct their testing in developing countries (like Nigeria), but they also play a role in what keeps the trials going; especially in an unethical manner.

While Walterspiel’s letter was not used as a source of evidence within *Abdullahi v. Pfizer*, he provides detailed insight into the breaches in ethics that occurred. The biggest injustice that had the

largest impact was the little to no knowledge patients and the families of participants received about the parameters and conditions of the trials. Pfizer claims that nurses gave information to the families of the patients involved and explained the research thoroughly; however, they can provide no physical proof of this consent.

“The patients did not know if it was research or not,” agreed a Nigerian laboratory technician who took part. “They just knew they were sick.”⁴

This is a common recurrence that is not unique to the Trovan trials in Kano. Similar cases expressing a lack of consent have been reported from all across the developing world. Patients are sometimes given forms to sign to signal their consent, but many of them are written in English.⁵ The literacy levels of the populations subject to clinical trials is markedly lower than the rest of societies; the chances of them knowing how to read formal English are negligible at best. Some patients are simply not offered any information or chance to express consent at all. A report discussing the ethics of different drug trials that have occurred in India states:

“... freedom of choice and individual agency is intrinsically important to well-being. This lack of free informed consent leads to a major deprivation of human capability. The participants are therefore deprived of their right to make an informed choice.... In most cases, they do not know about the recourse that is to be taken if they suffer from some injury or death due to the trial. Their consent also cannot be called free since the economic incentive obscures their thought process.”¹¹

This type of maltreatment by Big Pharma companies would not be tolerated if conducted in developed countries, so why is it okay for companies to conduct them in developing ones? “I take responsibility at the end of the day,” Dr. Dutse, a Nigerian physician largely involved in the Trovan trials, claimed. “Given their poverty and lack of access to decent medical care, honestly, did they have a choice?”⁴

Unfortunately, the maltreatment and exploitation of trial patients doesn’t end when their clinical trial comes to a stop, and individuals

have to deal with a plethora of complications and disadvantages moving forward. Typically, the medicines tested and introduced to test patients are not made available to them post-trial. The problem of the lack of medical resources, funds, and infrastructure is still faced by developing countries when Big Pharma companies leave. Sengupta describes this trend as she observed it occurring in India:

“... the participants of trials that are conducted in India are used for research while the benefits of the tested drugs are mostly reaped by developed countries... oppression occurs through a steady process of transfer of results of the trials on the impoverished for the benefit of people in developed countries.”⁴

The question is: why have these unethical practices not been stopped? The hard fact of the matter is clinical trials will always be needed to preserve the maximum safety of the global population. There is, however, absolutely no need for trials to continue to be conducted in an unethical manner. The drive for competition and supremacy within the Big Pharma industry is a primary motivator pushing companies to cut corners in any way they can, regardless of the effects.

Implications for the Future

The disparities between the treatment availability and care options in developing versus developed countries has been extremely evident since the start of the Covid-19 pandemic in 2020. As Big Pharma companies rush to create Covid-19 vaccines, clinical trials for vaccines have been occurring all across the globe in a hurried frenzy. Where clinical trials of this magnitude and importance are being conducted, one is sure to find at least one breach in ethical practice. The clinical trials conducted for Covid-19 vaccines were also conducted with urgency due to the time-sensitive nature of the pandemic; so the rushed pressure of clinical trials that often turns them unethical is definitely felt by Big Pharma companies and their test subjects. When discussing what clinical trials for Covid-19 vaccines look like and how they benefit populations: medical ethicist, Harriet Washington, shares her perspective on participating in clinical trials:

“People there are still taking a risk. And in my opinion, they often are taking a higher risk. What happens when drugs are tested, found efficacious and safe and then go on the market? These people who have been subjects are usually barred from the drug. It is priced beyond their ability to pay for it. So if the drug works, will they have access to it afterwards? Typically, the answer is no.”¹²

The vaccination rollout thus far has already proved Washington right. So far, developing countries have been far behind in their vaccination rollout due to lack of supply and access. The trials for Covid-19 vaccines potentially took enough of a toll on populations themselves. Because of the recency and ongoing nature of the trials, not enough documented information has been released about the methods employed by Big Pharma companies like Pfizer, Moderna, and others. Citizens within developing countries are not always so reluctant to accept Big Pharma companies into their lives based on the way they have been treated by the same or other big pharmaceutical companies in the past. For example, unethical trials lead to a distrust in medical efforts to combat epidemics and contagious diseases.¹² Within the *Abdullahi vs. Pfizer* case, the write up of the case results noted that:

“...Pfizer threatened international efforts to prevent the spread of contagious diseases across the international borders by fostering mistrust and opposition not only to future drug trials but also to vital public health programs organized by pharmaceutical companies. For example, after the reports about the Trovan medical trials resulting in alleged deaths of the children came out in Nigeria, the local population boycotted polio vaccination efforts in 2004, in part because of the Trovan drug experiments. The resistance to polio vaccinations in Nigeria resulted in the spread of the disease across Africa and the Middle East.”⁹

The impact these large pharmaceutical companies have on individuals goes far beyond unethical clinical trials within a developing state. Pfizer was one of the leading Big Pharma companies at the forefront of Covid-19 vaccination creation and

testing. It can be inferred that similar sentiments of resentment and skepticism are felt by Nigerian citizens today about vaccination trials, rollouts and approvals, and Pfizer itself. This shaky relationship is a relatively universal condition between developing countries and various Big Pharma companies (and is becoming increasingly apparent thanks to the 2020 pandemic).

The pandemic and the Covid-19 variants that have continued to pop up have put Big Pharma companies in the spotlight in uncharted ways. The time-sensitive worldwide need for Covid-19 vaccines has kept pharmaceutical companies plenty busy in their quest to discover new cures, and clinical trials are important now more than ever. The control and reduction of unethical drug trials has the potential to become an even larger issue as the world wrestles with the repercussions of the pandemic. Pharmaceutical companies will continue to depend on developing countries and their populations for drug trials to ensure safety and success for their patients. Big Pharma must recognize the utmost importance of prioritizing the human rights of well-being of their trial patients, no matter what country the drug trials take place in.

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My name is Sofia Zinis and I am a junior here at Boston College. While I am on the Premed track, I am also an International Studies major concentrating in Conflict and Cooperation. I am on the Varsity Women's Swim Team for BC and specialize in sprint freestyle and backstroke. I grew up in Denver, Colorado and am the oldest of three girls. Outside of school and swimming, some of my favorite things to do are travel and ski whenever I can.

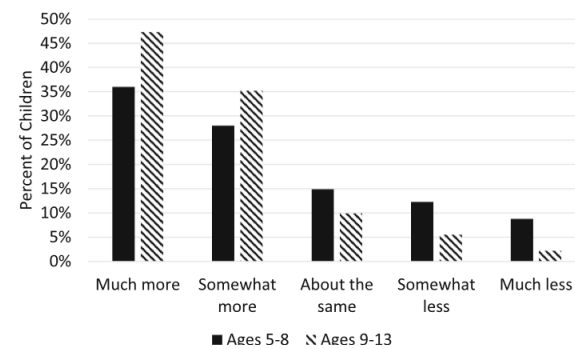
Let's Get Physical ... and Psychological with Social Distancing!

Rita Pennacchio-Harrington

Members of society scroll through their phones for hours as they lay on their couches and watch their anxiety come to life. This is what a typical day in the life of quarantine has looked like for a variety of people from adolescents to adults. Many have been stuck in their homes with family or alone in their apartments for over two years now. With all of what was once considered normal coming to a stark halt, people have found themselves involved in a sedentary lifestyle as opposed to maintaining their pre-pandemic physical activities. In addition to experiencing the Quarantine 15, a variety of people have noticed an uptick in their feelings of anxiety and loneliness. As time has passed, this routine of which consists of limited activity is something many people have become accustomed to. However, people should not resort to such an inactive lifestyle during these unprecedented times. Physical activity has been linked to not only maintaining physical health, but also the well-being of the mind. Frustration caused by the lack of a traditional daily routine, encouraged people to resort to the internet for virtual workouts in order to gain the feeling of some sense of normalcy. Due to social distancing, physical activity has been reinvented to preserve the sake of our sanity as a human race.

As humans have been experiencing social distancing for over six months, now, people's relationship with physical exercise may have varied, yet there appears to be a downward trend in regards to exercise across the board. Although a variety of age groups have been impacted by social distancing, school children have been noted to be one of the most highly affected groups. They are young children who sit behind their computer screens all day long wishing they were playing tag with friends. School children were sent home back in March, at first for only two weeks, and now for an indeterminate amount of time. For the first time, parents had to assume the roles of both teachers and students, getting

acquainted with virtual learning. Following suit with education, youth team sports were canceled across the country. Youth team sports were the main source of recreation for many young athletes. The idea of going to a park to play with friends was also out of the picture for quite some time in accordance with CDC guidelines. These necessary social distancing guidelines for the safety of society's well-being had placed strict limitations on school children's options in maintaining their routine exercise regimen. The lack of physical activity (PA) has raised quite a concern for parents as, "about 36% of parents reported



their child had done much less PA in the past 7 days as compared to February 2020, whereas only about 11% of parents reported their child had done much more PA" (Dunton et al. 6-7). The downward trend in physical activity levels among school children is at a high enough level to be noticed by parents. As seen in the figure to the left, "41% of parents have reported that their children had done much more sitting in the past 7 days compared to February 2020" (Dunton et al 7). The parents' perception of their children's diminishing levels in athletics being correlated with an increase in sluggish behavior establishes a negative correlation between these two factors. Thus, these results confirm that children are participating in less play and in return more idle activities, which may be associated with the transition from in-person learning to that of remote learning.

Although the rise in sedentary behavior is re-

lated to the decline in athletics, parents have discovered alternatives that will provide their children with a simulated version of their usual activities. The virtual varieties are endless in that, "10.4% of children participated in sports training sessions or practice through remote or streaming services, [and] 28.9% participated in activity classes or lessons (e.g., martial arts, dance, yoga) through remote and streaming services" (Dunton et al 2). Parents have taken these measures to resume their child's daily physical regimen to maintain physical health and psychological stability.

With the levels of physical activity beginning to plummet, people have also noticed that their anxiety levels are on the rise. As the length of time for being in confinement progressed, individuals were subjected to new stressors for a prolonged period of time. The data from a recent poll "shows that more than half of the people who lost income or employment reported negative mental health impacts from worry or stress over coronavirus" (Chidambaram 1). Full-time working parents, now at home, had taken on the complex role of being a teacher while also fearing they would lose their source of income. As a result, "from a psychological perspective, citizens in a state of confinement can feel constrained and express fixation on the state of the disease, as well as psychosomatic symptoms such as insomnia, anxiety, loneliness feelings and depression" (de Lima et al 254). These psychosomatic symptoms enhance the isolation factor from society and this can be attributed to a withdrawal from regular activities such as exercising and seeing family members.

In addition to those with families multi-tasking on many new uncharted territories which induce higher stress levels, those who are independent experience more of a sense of loneliness during these unprecedented times. There is some irony in the once enjoyed independence as Hodgson, a 41 year-old divorced teacher, expresses the fact that, "she was thrilled to live alone before the coronavirus pandemic hit, enjoying her "me time" and the newfound ability to date and see friends whenever she wanted" and now that, "she's confined to her apartment almost 24 hours a day, she is feeling the emptiness of her home acutely" (Ducharme). She drives around her neighborhood and is constantly remind-

ed of how others have a family to cherish while she must endure this quarantine alone. Similar to Hodgson, the 35.7 million Americans who live alone experience this ride of emotions as they experience a sense of optimism one day and are challenged by existential questions about their ability to stay sane the next day. This lack of human social interaction for a lengthy period of time only places emphasis on one's state of loneliness. What is most concerning is the fact that, "the share of American households with just one person has been rising for the last 50 years" to being 28% of the population in 2019 compared to only 17% of the population in 1969 (Ducharme). Extending from the rise of anxiety in one person households, doctors fear that these extenuating circumstances may lead to even more severe problems in the long-run.

Beyond passing feelings of loneliness, what raises concern for a group of doctors that are affiliated with Boston Children's Hospital and Harvard Medical School is, "that physical distancing and stress caused by the pandemic, combined with rising firearms sales, could worsen the suicide crisis" (Ducharme). Those who may have heightened stress and already experience emotional disorders will feel the exacerbated effects of depression and loneliness. In addition to this point, "a third of American adults report feeling lonelier than usual, according to an April survey by social-advice company SocialPro" (Ducharme). Thus, it appears that loneliness has grown to become an epidemic in itself due to such extended periods of social distance from friends and family. Being that this poll was taken only a month after the onset of the pandemic, it is reasonable to consider the intensity of anxiety that may transpire over several months. There was a "KFF Tracking Poll conducted in mid-July, 53% of adults in the United States reported that their mental health has been negatively impacted due to worry and stress over the coronavirus" (Panchal et al). In reference to the poll from Time taken back in April, there is approximately a 20% increase in those who experience heightened stress levels in just a three month period. Due to these polls and surveys, it is safe to say that there must be changes made in the way we approach mental illness to stop this anxiety epidemic. In accordance with the desire to feel better about

oneself, many professionals recommend formulating a daily routine, especially for school level children. In addition, it is also equally important to be very aware of one's own mental well-being and for parents to be keen and take a proactive approach on any observable behavior in their child that may seem out of the ordinary. Healthcare professionals stress the importance of how there must be a way "to balance the need for social distancing with the availability of safe places to be for people who are at risk" which is in reference to children or adults who may be prone to crippling mental illness at the onset of this new 'normal' (Galea et al 817). If there were ever a time when psychiatry was a necessary field, such unprecedented times would be quite the example, yet it is important to note that our levels of physical activity may be the solution to our biggest problem.

As the levels of psychological stability begin to decline, one should look to exercise to improve physical and psychological health. During the COVID-19 social distancing period, activity can be a form of reset for the systems of the body along with one's mental psyche. One must recognize that the main influence of physical activity is on that of "(1) the role of exercise in the immune system through regular physical activity and (2) the role of exercise in psychological well-being" (qtd. in Matias 877). The positive impact of physical activity on one's physical well-being has always been evident, however, little attention has gone to an equally important issue on the subject: one's mental health status. As the field of research has begun to delve into psychological research, many researchers have noted that "In the context of social isolation, exercise can be an inherently rewarding activity that contributes joy, happiness and satisfaction" (qtd in Matias et al 877). Learning theory is a major principle in the psychology field on the basis of reinforcement. In this case, if one exercises and feels elated after such an activity (reinforcer) they are more likely to partake in such pursuit again. In studying social isolation and keeping in mind the idea of learning theory, "a daily exercise routine can be crucial to modulating pleasurable situations at some point during the day" (Matias et al 877). In essence, exercise assists in filling their void of happiness. People experience a joy which replaces their sadness and thus they feel a sense of empowerment and control

over their life. All of which they have been seeking. Ironically, it has become quite evident that committing to at-home exercise "might be accompanied by higher self-esteem and lower psychological ill-being, since people are free to choose the types of exercise, schedule, frequency and intensity" (Matias et al 877). One's psychological needs are met in what may be a more psychologically beneficial environment than that of the traditional work-out environment. Thus, the true healthy influence of working out routinely on that of the mind has become quite evident during this period of social distancing.

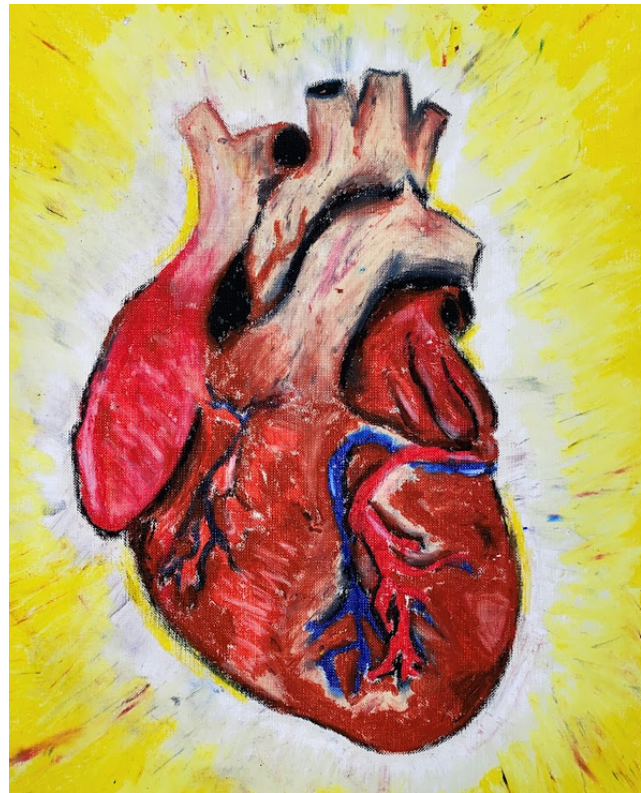
As we have come to recognize the diminishing levels of physical activity, there also appears to be a negative relationship with an uptick in citizens' anxiety levels. What people must come to recognize is that the problem is the solution. Along with maintaining one's physical well-being, physical activity is crucial in also supporting the well-being of the mind. No matter where people view the virus politically, there is a general consensus that physical activity alternatives are necessary health regiments in order to withstand our new normal.

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Rita Pennacchio-Harrington is a sophomore majoring in Biology with a minor in Medical Humanities on the Pre-Med Track. She is the Secretary for Women In STEM. Rita aims to acquire a comprehensive assessment of the role that psychology and sociology play in the medical field. When she is not doing research in the lab or depicting the creative elements of the sciences through writing, you can find her singing in the University Chorale!





Jason Sibrian
Self Acceptance

JASON SIBRIAN: INTENTION IN ART AND MEDICINE

Q: Where do you draw inspiration for your art from?

A: Before college, I'd say that most of my inspiration came from the patients that I encountered at work. By the time I had graduated high school, I had spoken to hundreds of patients and continuously found myself within their most vulnerable states. Because of them, I decided to paint the emotional baggage and do my best at depicting the weight of it. While I was not in their shoes, I could feel the pain that they were in, both mentally and physically. As a result, I felt the need to give them a voice through my artwork. Unfortunately, I paused my artistic side until a few months ago and am now rediscovering my love for it. I'd say that my creative process is one that I am still learning about as it comes spontaneously. I am the product of the stories and personalities of those that surround me, and so I'd say that my creative process stems from that. My best friends here at BC, especially Mikaela Savage who is an incredible artist, all push me to expand my boundaries with respect to art. I would label them as the foundation for my creative process; however, with each piece I create, the process is different in that I do not know where it will take me or my art.



Q: *What's your creative process like?*

A: The inquiry surrounding the paintings I submitted was: "What does dehumanization look like in the medical field?" I wanted to get metaphorical and expressive in my paintings, to show what it can feel like to be a patient. Many of my paintings aim to show that patients are sometimes undervalued. When I start painting, I would mainly work with faces and figure out different ways to show a specific expression. An idea pops into my head and I work with it without really knowing what I am doing until I am halfway through, and then the idea comes with the colors. I don't know if that makes sense.

There isn't really a step-by-step process when it comes to the way I paint. I wanted to express the dehumanization of patients through the body and the face. I would get inspiration from things I've heard: for example, black or Hispanic patients are mistreated and marginalized in the medical field. I draw the faces while thinking about the different expressions that show anger, sadness, pain. After I have those faces down, I make it more dramatic with the use of color. A lot of red sometimes, because red pops and can be violent depending on how you use it, and a good amount of black too, to enhance that dramatic effect.

Q: *When drawing faces, did you use a reference to guide your drawing?*

A: I would search different images online of people's faces, like angry faces for example. I wouldn't make my drawings exactly like the picture, but I would have the photo to get the proportions right, then I would make the drawing my own. The face would never come out the way I want it to, but I'd be happy with the way it turned out.

Q: *Would you say most of your paintings are from the patient's perspective?*

A: I would say so; there are a few that aren't. The one where the surgeons are performing neurosurgery and the person's face is very blurred out; that one was mostly a perspective of what was going on, and obviously was not from the patient's perspective because they're unconscious, but more so represents how the person during surgery is almost completely

erased. Other paintings like the one of the three black women were from a patient perspective. Those were inspired by what I've seen while working in the hospital.

Q: *How did you develop a love for painting? More specifically, why did you choose oil pastels as your medium?*

A: I developed a love for drawing when I was around 4. I remember my mom telling me stories about how I would default to drawing stick figures and create the most arbitrary stories. I always had interesting ideas for stories as I grew up and so drawing was a way for me to express it. I didn't get back into art until senior year of high school. In high school, I began experimenting with oil pastels and fell in love with the movement that can be created with them. I work with oil pastels because they were easier for me at first, and I wanted to mimic the style of Hyman Bloom in my artwork. Hyman Bloom is my favorite artist and the reason I found myself with the style of art that I have, and so I used oil pastels to my advantage to depict emotion, speed, and character. Bloom did an amazing job using lines and texture, and with oil pastel, it's really easy to show those lines and make them dramatic. As of a few months ago I began working with acrylic paint (brain painting, self portraits, unfinished torso) and am still discovering my style. The love for painting is something that I'm starting to dive into again. My senior year of high school ended abruptly with COVID and I put painting on the backburner. I knew we had to fulfill an art core at BC, and I decided to take painting; after a month into the course, I realized I really enjoyed painting, and so now I'm getting back into it. Painting is a way to express what I'm thinking on paper.

Q: *So you're a Neuroscience major, but you also create art. How do you think the two disciplines complement each other? What does one offer to the other? Has your experience making art affected the way you view science, or vice versa?*

A: The painting of the brains was based on a photo I took when I went to an anatomy lab. Being a neuroscience major, I'm always learning about the molecular basis of how our brains work. I'm always



Jason Sibrian
Falling Apart

thinking about the connection between creativity and the mind. I study the part of our body that allows us to do art. I'm always blown away when I engage in those thoughts because it's so amazing how creative and intricate the brain is and how we can express that through art, writing, and music.

Neuroscience only deepens my love for art. Learning about the neural connections and molecular mechanisms that are involved in allowing us to function the way we do fascinates me in ways I cannot describe and looking at my artwork reminds me of those connections and their necessity. I find the brain to be so extremely intricate and beautiful. You can ask anyone I know, the brain might be what excites me the most out of everything, and so as I paint, I am conscious of how I am only able to do so because of my brain.

Painting has also enhanced my appreciation for neuroscience in subtle ways. For example, the figures we see in our biology and neuroscience textbooks were created by people like you and me. All of those figures in our textbooks are art, that's art. People are painting the processes that allow for them to even paint. They were using their brain to

depict what goes on in our brain! It's extremely fascinating how this feedback loop works! My experience making art allows me to truly appreciate what others make, and not just what they made, but how they made it, the time they spent making it, the effort they put into it, and so on. Artwork can be very multifaceted and this is something that I was ignorant to before I got involved in the arts.

Q: *If you had one message to tell the world, what would it be?*

A: If I had one message to tell the world, it would be to put love first. I know it may be cheesy; however, my art touches upon the disparities that are seen within the field of medicine, and as a result of a lack of love, people are hurt. I am not innocent of this either; I have worked in hospitals for about four years now and have fallen into the trap of subconsciously dehumanizing the patients I have worked with. It is easy to stop seeing them as people, but the pain and frustration that it results in within the patients is detrimental. As individuals, we must be proactive in loving and

accepting others. We must do our best in putting love first.

Q: In the future, how do you see yourself continuing to do art, if you become a physician?

A: I love making art for other people like my friends and family; it's a way of giving thanks/showing love. I don't think I'll pursue any paths in art, but I enjoy it a lot and will keep doing it as a hobby or as an outlet to express what I'm thinking about.

Q: What do you think makes a great artist?

A: It doesn't have to do with how amazing we think the painting is because that's obviously subjective and you can think whatever you want about

anyone's art. I think what makes a great artist is being authentic to yourself and your work. People choose to create art for a myriad of reasons, and so a great artist is one who is actively committed to their reasons and expressing it with the use of their paintbrush. These reasons do not require a sense of profoundness either - they can be as simple as enjoying the act of painting. One does not even have to be completely aware of their reasons either, that's the beauty behind all of this. It's a journey that results in self discovery and aids you in growing in authenticity. This is what makes a great artist - being true to you and to your work, even if you are still learning about it.



PAGE TO STAGE: A DRAMATURG'S DUTY

The nature of theatre is inherently collaborative. It is a process that demands teamwork, open mindedness, and communication. It truly takes a village to put a show on its feet, especially in student theatre where the final product is the labor of more than twenty undergraduates who are learning as they go. But theatre is not only a collaborative form internally — it also thrives when put in conversation with other disciplines. Every play or musical has had some connection to issues that stretch beyond the stage — for example, what is *Rent* without its theme of how people in the LGBTQ+ community are treated in the United States and what is *Les Misérables* without its themes of social injustice and revolution?

This is also applicable to *The Other Place*, a play written by Sharr White and produced by the Boston College Dramatics Society in the Bonn Studio Theatre from April 7-9, 2022. The play follows Juliana Smithton, a brilliant neurologist whose life is beginning to unravel. Over the course of the play's eighty-minute runtime, it is revealed that she has developed early-onset Alzheimer's and is imagining conversations with her daughter who ran away as a teenager. It is a text tied intricately with medicine and medical concepts.

The Other Place connects with these themes in two ways: telling and showing. Throughout the play, Juliana is seen giving a lecture about a medication she has developed that combats dementia. These monologues are full of medical jargon that directly discuss medical concepts and scientific explanations for brain disorders.

The play also hints at Alzheimer's in more subtle ways, especially in the character of Juliana, whose symptoms slowly become more noticeable as the play goes on.

The job of a Dramaturg is to draw out the themes of a text and help the cast, production team, and audience connect with and understand the play in its entirety. The primary way a Dramaturg accomplishes this is by asking questions — questions of characters, of settings, of words. These questions, and their answers (or lack thereof), can be communicated in a number of ways. In my work as Dramaturg on *The Other Place*, it took the form of an information packet, slideshow presentation, continuous conversation throughout the rehearsal process, a note in the program, and a post-show lobby display with information and resources.

College spaces are the perfect environment for these types of collaborations to thrive. The conversations I had throughout this process proved that. Most notable was the work with Dr. Karen Lyons of the Connell School of Nursing, an expert in the study of aging, and *The Medical Humanities Journal*, this very publication which perfectly mirrors the dramatic and scientific aspects of *The Other Place*. Altogether, working on this show was a process that reaffirmed my belief in the magic of theatre and reinforced my steadfast commitment to ensuring that "art for art's sake" is replaced by meaningful dialogues about important issues in our immediate and wider community. Theatre must remain collaborative for it to remain relevant.

AN INTERVIEW WITH EMMA THOMPSON, DIRECTOR OF "THE OTHER PLACE"

Q: *Why do you call yourselves "the fishes"?*

A: Why that's our mascot? It just is (laughs). The Fish has been with us for as long as I know. We're the oldest student group on campus, we started in 1865, and I don't think we were the Fish back then, but somewhere along the way that got picked up. I know. It's strange. It was like a group of students. I don't remember what play they were producing, but they just banded together and said, "what if we put on a show" and suddenly the ds was born and that was it.

Q: *So you said you're primarily an actress, what's your experience with that?*

A: Um, I started acting when I was in sixth grade, and I kind of got bit by the bug and it has followed me throughout my entire life. Since then I've been in close to 50 productions in some capacity, whether it be acting, typical work, directing. But yeah, and it's been a huge passion of mine for a long time. When I got to college, I was like, There's no way I'm letting it go. So I picked up the theater major and it just makes me really happy and it's what I love. And yeah, acting is kind of my main faculty.

Q: *But you're the director of this play right? How did that happen?*

A: So directing it is kind of I feel like a lot of the

people I know there's some overlap between acting and directing. It's not always the case, but I think there's a love of character study that comes into both and there's some overlap in that. So instead of the playing one character, you always play all of them. So there's a lot of freedom in both (acting and directing). And I've loved like facilitating other people's discoveries of their characters. This is the first time I've directed in a while. I haven't directed since sophomore year of high school, so it's been really fun.

Q: *How does the biology major fit into everything, since you're a Biology and Theater double major?*

A: So I originally thought I was going to be pre-med. I spent a lot, like pretty much the entirety of my life thinking I was going to be a doctor. It was just like it was my thing. I was interested in anesthesiology, dermatology and so on. And I was like, this is what I want. You know, I'm good at this. This feels right to me. And then I got to college and I started doing a lot of the pre-med coursework and I started to realize that it just kind of wasn't filling my cup the way that I wanted it to. I chose my theater major because I wanted to have both. And I was a bio B.S. with pre-med. And I was just I think part of it was pandemic and like being locked in

a box for, oh, sophomore year and taking organic chemistry online. But I just did not feel fulfilled by what I was doing at that current moment. So I was also taking EcoEvo at the time, and I absolutely loved that because I liked going out on walks in nature and things and I was like, This feels right to me, so I'm going to kind of redirect myself. So I dropped the pre-med, kept the bio, redirected my coursework towards more ecology, organismal biology, physiology type thing. And that has made me a much happier and more balanced person.

Q: What inspired you to direct specifically about the intersection of biology and theater?

A: I thought it was going to be like a couple of bio jokes and then, you know, play. But I asked for feedback a little bit from the playwright. In our conversations the chemistry lucky enough to go with him, it came from talking primarily about his mother and his experiences with her. And then in that, you know, dementia came into the fold and then he was like, okay, we've got to make her the smartest person in the room. Let's bring this jargon into it and see how that affects their perception of her. And when I first read it, I was just like, Oh, these are my interests in mine. And they fit together so beautifully. And her command of these concepts and of these ideas and her ability to communicate them is so intrinsic to who she is that losing that makes us so much more empathetic for her as a character. And I love the way that they work together to make a really cohesive story and to give us a very clear understanding of this person. So it felt very personal to me and it felt like just a really wonderful play.

Q: Do you think you'll direct again in the future?

A: You know, I might direct again in the future. I'm definitely open to it. I love being the Director. Yeah, it's been really fun and I have had the best experience this year. I don't really have any other directing projects lined up, but I'm open to it in the future.

Q: What are the origins of the play?

A: So the play actually was developed back in

like 2012, oh, with the actress Laurie Metcalf, the director Joe Mantello. And it went to Broadway with that whole original company, with that playwright. So in this case, once it went to Broadway, then the playwright Sharr (White), he basically goes to a publishing company and says, I want to license out my work so it can be performed all over the country. And then we go to the licensing service and we say, we want to do this play at this time. They send us the contract; we sign it. So I had no hand in the creative process of the creation of this play. I just happened to find it and love it.

Q: What did (Sharr White) say?

A: What did he say? He was wonderful. He was a little bit surprised, I think, that we were doing the play as undergrads. He was like, Oh yeah, 21 year olds playing 50 year olds. Yeah. I think that's something that's like and yeah, when you're a Broadway playwright, you don't really think about your work, you know, going to younger people. You can do professional contacts. But he was very excited that we were doing it incredibly helpful and answered a lot of our questions beautifully. And he was just very supportive.

Q: What was the process of picking this play, then?

A: Part of the way the DS picks the shows that they produce is that they just have an application process. I'm also a board member on the DS, so I just applied to my own group, and I wasn't a part of the selection conversation, but that was the process. I have this play that I love, and I went to the DS and I said, I'd love to direct this show for you next year. This is my vision for it, This is why I want to do it, I Write everything out. I do an interview, and then they select their season. I was lucky enough to be selected and to have my show selected. There are also cases where they'll select the director for them to be like, we don't love your show for this reason, or it's just not really feasible, So we'll select a different show for you. But they liked the show. They liked me. So I was able to get a slot to produce it. And since then, it's been doing things like picking designers who I know and trust, all students, and casting the show and things like that. So since then, it was a lot of, like, reading it, analyzing it, thinking

about what I wanted, and how I wanted to see it come to life. Then things really started happening over winter break when we started thinking about: "what do we want it to look like?" We did designs, pulled it together, got our budgets in, and then we cast the show back in January and started rehearsing late February.

Q: What's the role of the dramaturg?

A: Yeah. So Tyler is the dramaturg and the assistant stage manager. So as the assistant stage manager, he helps our stage manager, Emily, with anything that she needs. So he'll be backstage with a headset on, like handing props to people, moving set pieces, things like that. And he also does a lot more, like paperwork, things like tracking the props throughout the entire show on a spreadsheet.

He's wonderful. And then as a dramaturg, the role of a dramaturg gets a little bit fuzzy, and it's a bit of a newer concept, but I think that the best way to describe it is kind of as an audience advocate. So he's someone in the room to help clarify things for designers, actors, me, and he's someone who does research and answers questions, poses thoughts about the way the play is constructed and how that can help us in our interpretation of it, things like that.

Q: Let's say I'm someone who's been deeply affected by dementia. What message do you want to get across to these kinds of people?

A: It's hard because it's very personal for me, too. So I'm, like, kind of speaking for myself. I'm trying to think of what I want myself to take away from it as well. And I think it's largely that even when we no longer really have the people we loved in the same capacity, if they're not there with all their memories, we have to watch them kind of go through this process, and we feel like we're losing them. I want the audience to know that the essence of who they are is still there and that they're still that person even without their memories or without the things that we may have thought made them them before. And I think we can walk away with it with just a tremendous amount of empathy and love and extra care for those people and thinking of them just knowing that in some way they're still present, even it's not as clear.

Q: If you could describe the play in one word, what would it be?

A: I think that the play is—this is going to sound so strange when I say it— pulsating. In your experience of it, it just drives forward and it has its own life and it's quick and it's strong, and it just has this kind of underlying wave of energy throughout it where we're building and building, and it feels like you're on a roller coaster that's about to lose control, but you kind of are and everything feels slippery. But there's this energy and electricity underneath it, and you know that it's just going to get more and more off course the further you go. And there's excitement to that. So it's kind of like your own heart is racing. And I think it lives and breathes and it changes a lot. So, yeah, I think of it as like a heartbeat and a pulse.

Q: If your middle school self could see you now, what would she think?

A: Yeah. I mean, I think she'd be very happy with where I am and that even though I'm no longer planning on going to Med school, seeing that desire and those interests live on in a new context, I think it's still really powerful. And I'd like to think that 6th grade me would be proud of me and would be happy with where we are. Yeah. I think I'd be very proud of how far I've come since then and how Theater has given me an Avenue to appreciate my love of science in a new light.

Q: What was the first play that you directed about? What is also biologically related?

A: It was very different. It wasn't even, like a full thought through play. It was a cabaret. So it was just musical numbers taken from different musicals, all different ones kind of glamorated together. So we had, like a cast of 15, and one person would do a solo from one musical, and then there'd be a group number from another musical just back to back. It was really fun to do, but a very different ballgame in terms of how you direct that.

Q: What are your plans for the future with this play specifically, or if you're looking to move in a different direction? What are you aiming to do as a part of DS?

A: I mean, I love this play, and I just want to take next weekend and really share it with the BC

community and allow them to enjoy it. And then for anyone who might miss it, we're also going to be at Arts Fest. We're going to perform a small selection there. That's the immediate future of the play—Just looking forward to performing it. Unfortunately, theater is a non permanent art form and in College there's no way for us to get funding to take it anywhere else. So this play will, in this production, live and die on BC's campus but I don't think that that's a bad thing at all. I think it's a very special thing at this moment. For me personally, I definitely want to continue doing what I do in theater and enjoying my time here at BC as an artist.

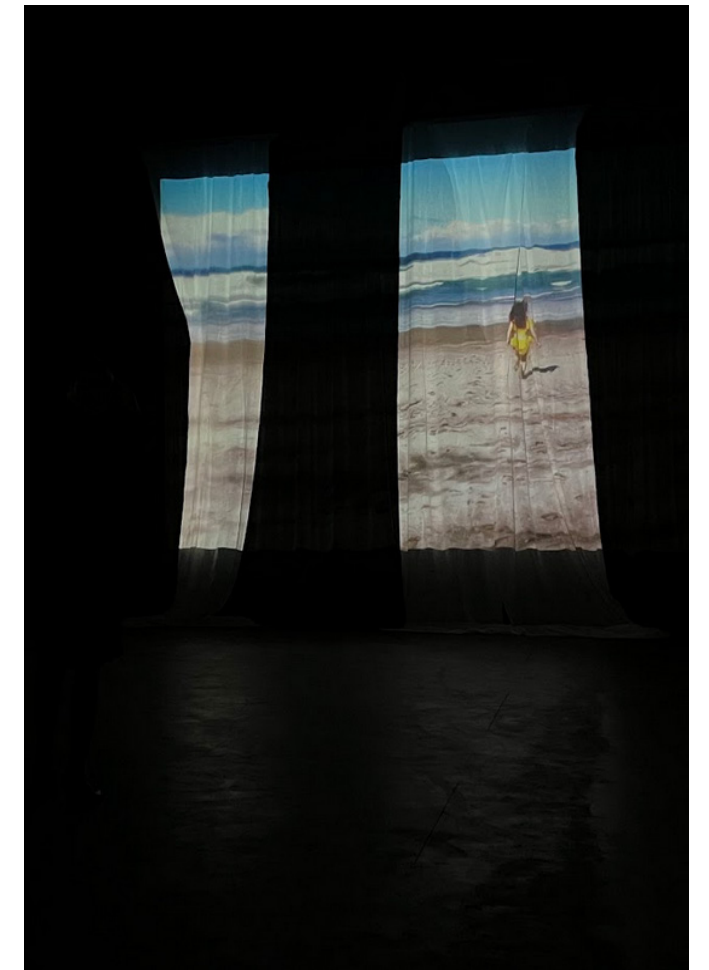
Q: What do you want to happen for your future specifically? I know that you said you wanted to be a doctor but then now what's happening?

A: Yeah, right now it's very up in the air. I definitely thought when I dropped Premed last year that I'd have an answer by now but I'm open to a lot of things. I'm open to pursuing theater. Seeing where that takes me. I love it and it makes me really happy. Unfortunately, it's just not a super secure career option, so I'm also interested in law school, potentially vet school, even going on to get a Ph.D. and teach ecology. Things like that I think would all make me very happy and very fulfilled and it's great to have a lot of doors open and just not know which one to choose yet.

PHOTOS FROM "THE OTHER PLACE"



Juliana and Laurel



The Girl in the Yellow Bikini



The Woman and Juliana



Juliana and Ian



Juliana's Final Lecture



Juliana, Ian, and Dr. Teller



Juliana



The Woman and Juliana

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